

INTERVIEW TRANSCRIPT

PARTICIPANT NINETEEN

DATE: 28th July 2016 TIME: 03:00pm

Researcher – R

Participant – M (Midwife)

/ - speaks at the same time

= - immediate response

[] – non-verbal communication

Beginning on interview

R: I'm going to read a little statement for the recording. Welcome, and thank you for agreeing to take part in this research, I am Naomi Simpson and I am the researcher for the study, a case study of a maternity service development programme and its influence on maternity services and interagency collaboration. I'll be conducting this interview, I'd like you to confirm for the recording that you've provided consent, which you have, yes?

M: I have.

R: And you're happy with that. The current date is the 28th July and the current time is 3pm. You've been allocated the participant number Participant 19. I'm going to start with some general questions and then move on to the use of some vignettes. You didn't take part in any observational episodes of data collection for this research but I would encourage you to reflect upon your general practice as well so if you have any examples that you think fit your questions or answers then do use it, like I say it's all confidential. OK, so what in your experience contributes to good working relations with professionals in this Children's Centre?

M: Good communication, working as part of a team, just I think for me here it's important that they understand a bit of my job role and I understand a bit of their job role. They always keep me informed of the developments within what's going on with the Children's Centres, if they are closing and which ones are closing and obviously if that would impact on my clinics. They also know who I am seeing and at what time. I try not to impact on their work too much by meeting my own women.

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R: OK, so that's great. You said initially about communication and you said obviously that the team here keep you well informed and you think that really helps. Just to say for the recording obviously you are working here as a midwife so you run your antenatal clinics here. So, talk a little bit about this communication, do you think the communication you have with the staff is very effective, how do they communicate, can you talk a little bit about that for me?

M: So, I think that my communication with the team here is quite effective in as much as we both have very different roles but we work with the same demographic of women, so the women that are coming here to see me for their antenatal check-ups haven't necessarily been to a Children's Centre before, know what a Children's Centre is for, know what's on offer or not even registered. So by keeping them informed of who is coming through the door but also by talking to my women about what's going on in the Children's Centre and staff here come in every couple of weeks or so and have a catch-up with me about what sessions they are running, baby massage, who I've got that's a new booking, everything that's going on here so that I can then signpost women through instead of it just being somewhere where they come, have an appointment and leave again. Another thing is a lot of my women especially now because it's the summer holidays have children of their own already and it's a really nice place for them to come and bring their children whilst attending the antenatal clinic.

R: That's great. So, when you say "they" who is it that normally communicates with you from the staff here?

M: It's normally [RECEPTIONIST] on reception or the other two girls.

R: Whose names you can't remember. Is it mainly [RECEPTIONIST] you see then?

M: Yes, because she's at the reception when I come in so I sign in with her and I give her my appointment lists and I sign out with her as well.

R: So you don't really deal much with the other core staff here?

M: Not really.

R: Do you ever meet them during TAC or anything like that or not really?

M: Not for me so much but that's because I haven't attended any TAC here yet so I imagine going further forward we would have a lot more interaction. My caseload, touchwood, doesn't have that much safeguarding or TAC involvement at the moment.

R: Great. You also mentioned about what contributes to good working relations and understanding of each

1 other's roles, can you give me examples of how that has been expressed or how do the staff here know what
2 your role is, how do they understand that do you think? If you don't know that's fine.

3
4 M: I don't know, we have conversations about what my workload is.

5
6 R: Are they informal or just?

7
8 M: Yes. I think everyone who is working here who works with children and with parents has an understanding of
9 what antenatal care is involved in. I'm not the only midwife that works out of here, so they do come into
10 contact three/four days a week with midwives running clinics here.

11
12 R: Can you give me an example from your experience where you think you've had a good experience with
13 communication or just a good experience with working with this centre team with potentially some good
14 outcomes for a woman? Or if you haven't that's fine.

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16 M: I think it's more about signposting them to what's on at the Centre for me in as much as knowing about
17 things like the baby massage, even things like baby safety, they are always greeted really nicely here, it feels
18 really informal, the women are made to feel comfortable here. They're always registered so they are always
19 checked if they are aware of what is going on and, yes, by mutually promoting the service as in what they need
20 it for, like the sensory experience and the babies and stuff like that, then yes, that's beneficial for my women as
21 well because then also for people who are pregnant perhaps for the first time who have had no experience of
22 Children's Centres they are aware of somewhere to come and something to do with their babies and
23 somewhere to seek support and advice ongoing after their baby is born because obviously we step out normally
24 at day 10.

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26 R: That's great. You say you feel they make your women feel particularly welcome?

27
28 M: Yes.

29
30 R: Do you think the core team here also make other professionals such as yourself in your experience do you
31 think they make professionals feel welcome and part of a team or do you think they are not necessarily part of a
32 team but still welcomed into the centre?

33
34 M: Well, yes, I am a newly, I can't say that for very much longer can I? I'm a newly qualified midwife who took
35 over a caseload from a really long-standing midwife, so I'm fitting into an already established team and they
36 made me feel really, really welcome and they showed me around and they made an effort to tell me about
37 everything that was going on, they've always kept me in the loop kind of in an informal way of what's going on
38 with proposed closures and room changes and scheduling. They're just really friendly and welcoming when I

1 come in every week, so yes.

2

3 R: Lovely. If we just move on a little bit, how does the documentation, well saying that actually, so you've taken
4 over from a long-standing midwife, so how long have you been based here then?

5

6 M: Since November.

7

8 R: OK, so seven-ish months. Now I wanted to talk a little bit about documentation, now I know obviously in
9 maternity we have notes which generally stay in maternity but also documentation is key for collaboration in
10 terms of obviously if we make any referrals within the team – have you used any documentation to make any
11 sort of referrals for any of your caseload?

12

13 M: Yes, I've done some extra midwifery input referrals so that's liaising with the mental health team. What else
14 have I done recently? I've done some safeguarding referrals so that's to social workers and our safeguarding
15 team. I've got a few more coming up actually that I'm just booking, rebooking.

16

17 R: But will need referring to social workers?

18

19 M: Yes. Then obviously there will be some TACs as well involved in that but I haven't had any, I'm not going to
20 be very helpful, I haven't had anything really yet.

21

22 R: That's fine, this is all helpful so don't worry about that. If you think about maybe those referrals to social work
23 or any of the other referrals you make, how do you think this sort of documentation helps contribute good
24 communication?

25

26 M: So most of my referrals are done via either me handwriting them or typing them and sending them via NHS
27 Net. I try to be very clear and concise and evidence based, no opinions. I have a really good relationship with my
28 health visitor for the area as well so we can have informal discussions. I send requests in quite a lot to the social
29 care team to ask if they are aware of certain families. It's mostly done by email, sometimes done by telephone if
30 it's with a health visitor and I know who I'm speaking to but again it's about being professional but friendly and
31 sharing information.

32

33 R: In your experience what is your opinion on how, if you think OK I've got to fill out a single assessment
34 frameworks aren't they?

35

36 M: Yes.

37

38 R: Do you think great? Do you think that's naff? I mean the whole process obviously it's there to help us but

1 what are your opinions on maybe good points, bad points?

2

3 M: I think that they are there to help us, I think that they're a common tool now that more people and more
4 professionals are having an understanding of which puts us all on a better footing.

5

6 R: Do you think that's just because they are being used more frequently?

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8 M: I think they're being used more frequently and I think we're being trained better in filling them out. I
9 personally spent an extra day in safeguarding just because I wanted to get my head around it because it is very
10 complex. From my own personal point of view they are timely and it's not ever time that is allocated to us in our
11 working day, so I have to be honest and say my heart sinks if I have to do additional paperwork because
12 additional paperwork inevitably means it cuts into my own time. It doesn't mean that I don't do it properly it
13 just means that I think with anything safeguarding and anything that's more timely then someone who is normal
14 and routine we should be allocated a bit more time.

15

16 R: But that's not the case?

17

18 M: It's not the case.

19

20 R: OK. Can you suggest any ways in which paperwork could improve communication?

21

22 M: I think if we all have the same forms, I think there is a bit of conflict working in [PARTRIDGE CITY] between
23 the boundaries, between [PARTRIDGE CITY and COUNTY], I think that really inhibits communication because we
24 can have people who sit on [POSTCODE] and it will be one set of paperwork and [POSTCODE] and it's a
25 completely different set of paperwork.

26

27 R: In what sort of referrals is that true to then?

28

29 M: That's true with anything to do with social care and also with mental health, any kind of mental health
30 involvement we have one for the city and then we have one for [COUNTY] which makes it for a newly qualified
31 much more confusing – who do I need to speak to, what do I need to send them, what paperwork is it? Mostly
32 they are quite good and they will accept paperwork because they are kind of standard but standardised
33 paperwork would, standardised paperwork for everybody would be better so that everyone was singing from
34 the same song sheet basically. I think that really inhibits.

35

36 R: OK. We've talked about this a little bit, what in your experience how do other people perceive and
37 understand your role? So obviously we mentioned a little bit about the core staff here, so again maybe thinking
38 about that, but also the other professionals, all the other professionals you might work with within an inter-

1 agency team?

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3 M: It's really difficult.

4

5 R: Well it is because essentially I'm asking you to give somebody else's opinion.

6

7 M: Yes, of what we do.

8

9 R: Yes, but..

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11 M: I don't think a lot of other professions have an understanding of just how wide and varied our roles can be in
12 as much as if it was just obstetrically are they well, are they fit, are they healthy, is their pregnancy progressing?

13 It's one very, very small aspect of what our roles have evolved into. I think with the social side of it of being
14 aware for domestic violence and for social care and being really switched on to if we need to refer or if we have
15 any concerns who do we voice those concerns to? I think then mental health side of our roles is now massive so
16 we're not just providing antenatal care we're also screening, we are also having to do lots of health promotion
17 and talk about smoking and drugs and alcohol use and BMI, all the time risk assessing, all the time looking for
18 any deviations from the norm and any aspects of that woman's life going on at the time of their pregnancy. I
19 don't feel that everyone has an understanding of that aspect. If you go to the doctors because you are sick they
20 will talk to you about your sickness whereas I think we're kind of holistically much more involved with the
21 women and also the family as well because you can have someone come in and never see their other half and
22 potentially you have to ask questions about how involved or how much support they have or social isolation or
23 someone comes in and sometimes a referral is sparked just by the way they interact with their children or how
24 their children look and questions from there. So yes, our role is very diverse and I'm not sure everyone knows
25 that.

26

27 R: Do you think they need to know that?

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29 M: I don't think they need to know all of it but I think when speaking, health visitors get it I'm sure they do,
30 when speaking to other people about our roles it seems that they think that we're very health orientated and
31 obstetric orientated.

32

33 R: To what extent has working within this Children's Centre, so obviously it's different because you've only ever
34 worked with an antenatal clinic in a Children's Centre, you've not been based in GP surgeries.

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36 M: Oh, I'm based in GP surgeries as well.

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38 R: So you are in a GP surgery as well?

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M: Yes.

R: So how often do you do that then?

M: Every Thursday morning I'm in GPs and every Thursday afternoon I'm here and then every other Friday in [LOCAL HOSPITAL].

R: OK, so you run a [17 mins 55 secs] clinic then?

M: Yes

R: OK, well that's good actually because you can run a bit of a comparison, basically what I want to ask is to what extent has working with a Children's Centre helped others understand your role? So do you think working here helps other professional centre staff understand your role as a midwife more than potentially if you were working solely out of a health clinic?

M: Yes, there is a real difference between the two so in the GP surgery I think I always have that safety net of having the GPs there, so if I need to instantly refer somebody or make them make an appointment for something else or have some questions about something that's not pregnancy related then there is that benefit of working out of the GP surgery but there is very little interaction in as much as understanding our roles or anything with the GP, whereas here the benefits are probably more for the women in as much as they it enables them to come into a Children's Centre, see what's on offer, it means that they are registered here, it means they are comfortable and familiar here and because we are all focusing our care around the women and the children it feels like it's a good place to have our clinics. Does that make sense?

R: Yes, completely. Do you have a preference as to where you work?

M: If I could be in one place all the time?

R: Yes. It could be down to actually I'd rather be in the hospital for convenience, things like that. There's no right or wrong answer.

M: No there isn't. I'm quite happy with the mix really in as much as like I said there are definite benefits to working in a GP surgery, it feels sometimes that we can be more proactive and reactive about issues in as much as we can make instant referrals, I can go and knock on a doctor's door but for low risk normal women I like being here. I think the set-up is really nice, I feel like the communication feels a lot more about the women and the family rather than the medical and I don't know if that's a psychological flip for the women because they are

1 seeing me in a GP surgery. It would be interesting research to see how many more medical complaints there are
2 in an antenatal in a GP surgery than here. But here I think they are welcomed, it's always busy, it's always really
3 informative with all of the boards that they do – we don't have any involvement but they are promoting
4 breastfeeding. They are communicating the same messages that we are trying to and sometimes feel that we
5 don't have enough time to and for the benefit of the family to come into a Children's Centre at the very start of
6 their journey into being a parent is much more beneficial than to come into a GP centre and also in a GP centre
7 they are sitting next to people in the waiting room who are sick and poorly whereas here you don't get that.

8
9 R: You mentioned there about feeling potentially in the GP surgery you can be more reactive and make referrals
10 quicker, what sort of referrals are you talking about? Are you talking about exclusively health referrals or social
11 as well?

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13 M: No, but in my GP surgery there is the benefit of it being a small family practice so informally I can talk to the
14 doctors about if there are any other issues, so it can be mental health, it can be social, it means that I can find
15 things out a lot quicker whereas here my referrals would be made after I leave here. Does that make sense? I
16 would go back to LOCAL HOSPITAL and then I would, I don't think I would necessarily ask them about a
17 particular woman.

18
19 R: OK.

20
21 M: Does that make sense?

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23 R: Yes, I mean why is that?

24
25 M: I don't know.

26
27 R: Do you feel that they would have an understanding?

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29 M: No I definitely feel like they would get where I was coming from if I had initial concerns but I always think my
30 initial concerns would go through the social worker or the social care team first. Does that make sense?

31
32 R: Yes. OK, that's great. To what extent do you feel the nurture programme, and again when I'm talking about
33 the nurture programme I'm talking about you just being here actually, to what extent do you feel that being
34 here has enabled you to work more effectively with other agencies and professionals? We'll probably then
35 touch on a little bit maybe around what we've talked about before but specifically.

36
37 M: Well I think it puts everyone in everyone's pathway whereas before if you are in GP surgeries or ultimately a
38 lot of midwives, because Children's Centres are now closing, are going back to LOCAL HOSPITAL it makes us very

1 insular in maternity. You could be a community midwife and not actually be in the community at all. We don't
2 routinely do postnatal visits anymore, we don't routinely go and see women in their own homes, we don't go to
3 people at home. We've no idea of their home circumstances so in any way that we can keep ourselves and our
4 presence in the community be it through Children Centres, GP surgeries, anything like that I think is really, really
5 important otherwise we are going to disappear into B level and I don't think that our role is bigger than that, I
6 think especially as a community midwife you can't really call us community midwives if we are all based up in
7 the hospital.

8
9 R: What are your thoughts on the needs to collaborate within your role anyway, do you feel you need to
10 collaborate as a midwife?

11
12 M: Yes, absolutely. It enables effective practice from every aspect in as much as sharing information with the
13 consultants when we make referrals to talking to the GPs and the health visitors. If we don't collaborate we
14 could be experiencing something and no one else does or it's not been picked up, so yes, especially with the
15 consultants and the health visitors and then with women who need extra input then the mental health teams or
16 the safeguarding teams. We couldn't work otherwise, we can't work isolated anymore.

17
18 R: No. Thank you. We've answered a lot of the key questions here, which is great, so I'm just going to pass that,
19 that's the first scenario I'm going to pass to you so I'd just like you to read the scenario and have a peek at the
20 questions but then I'll ask you those as well for the recording. Just let me know when you've read through. OK?
21 So in this scenario we've got a bit of a barrier for the communication from the GP to the midwife basically about
22 this lady, that's what it's key about. What are your views on what might inhibit effective communication
23 between professional agencies, so not just talking about midwife and GP although that's an example but maybe
24 other professionals, so if you wanted to speak to the health visitor, the core team here, what do you think might
25 stop that communication?

26
27 M: I think it's about perception of people's job roles. I think the GP would maybe be very tunnel visioned into
28 treating her depression and feeling that they are effectively treating that as a medical condition without
29 realising the impact that it has on the pregnancy and that we would need to know those things. I do feel like as
30 midwives because we spend time building up relationships with women that we could be the people that break
31 down those barriers because we can put stuff in place before it gets to this point of view. What are your views
32 on what inhibits effective communication between the professional agencies? A little bit maybe of I've done my
33 job perhaps not understanding what everyone else needs to do.

34
35 R: Yes. You saying that obviously if you have anybody, earlier we were talking about if you have anybody out of
36 the ordinary or that's taking up extra time, do you think that potentially, have you had an example where that's
37 affected your ability to communicate with any other professionals, that extra workload or?

1 M: Well yes, because my clinic days are from, well I start work at 7.40am and I work short days so I finish at
2 4.10pm. My clinic is all of that time and especially because I travel between two sites I have 20/30 minutes
3 where I need to pack up from one clinic and set up another one. That doesn't allow anytime during my working
4 day to communicate with health visitors or make referrals, I don't have access to apart from on my phone, I
5 don't have access to internet and a computer.

6
7 R: You've got a computer in front of you but you can't use it?

8
9 M: Yes.

10
11 R: That's ridiculous.

12
13 M: Yes. So, it would be really, really helpful if one we could have more time and to act on things as they arrive,
14 you can see here this is my worksheet for today so I need to make, this is just my to do list, so I need to make an
15 appointment for somebody later on, I need to refer someone, re-refer someone to the physio, I need to refer
16 someone to the consultant because they've disclosed that they are on anti-depressants, I need to send
17 somebody out a maternity exemption form and I need to refer someone for CBT who saw the [29 mins 57 secs]
18 yesterday, is 36 weeks and the [30 mins 02 secs] has asked me to refer to CBT before she delivers.

19
20 R: Before she delivers. Wow.

21
22 M: So that's just my workload from this morning but I can't act on any of those things until I go back to the
23 office and by the time I get back to the office and I park and I walk through and all that stuff there are no other
24 professionals around at the times when I need to do the referrals. A lot of them will be faxed overnight and then
25 picked up. With something like CBT I would need to ask one of my more experienced colleagues to find out how
26 to do that, so there's lots of things going on that I don't have time within a normal working day to action. It
27 means going back and sitting there and sending emails whereas it would be much nicer I think to be able to
28 sometimes pick up the phone or have an instant response but then also because I have got clinic tomorrow so
29 I'm at LOCAL HOSPITAL tomorrow but as you can see that's crazy busy again as well. So that's my full working
30 day really with nothing, no time for catch-up, no time for anyone that needs any extra input which I can see that
31 there are people that need that anyway, and then we'll get round to 3pm and then the routine paperwork that
32 this has generated, just routine, will take me past my time of finish, so if anything that is extra will take me
33 longer. Then it's not instantaneous because although I do have access to my emails on here I don't have access
34 to NHS net but then I might not be back working clinically in community until next Thursday. So there is a time
35 lag there as well to chase things up and take ownership. Does that make sense?

36
37 R: It does indeed.

1 M: It's just me moaning about work.

2

3 R: No, well that's what it's about, it's the realities of working as well isn't it and the practical aspects which make
4 it difficult to collaborate and to work together.

5

6 M: Yes, it is.

7

8 R: We've mentioned a little bit about allocation of time but what are your views on what else do you think might
9 make communication between professional agencies easier? Is there anything you can think of?

10

11 M: I think that we should take ownership of our own women more.

12

13 R: Can you explain that a little bit more?

14

15 M: I think that where there is the need to communicate inter-agency between midwives and other people it's
16 obviously because there is that extra input needed which potentially could mean that these women are
17 vulnerable in one way or another, socially, mental health, or extra input. I think our model of working at the
18 moment inhibits effective communication because if we need to go to a TAC meeting or a case conference it's
19 not organised in such a way that it always includes the midwife. Occasionally, like for I don't know holiday cover
20 or sickness cover somebody else should be sent in their place but it seems to be that whoever is free or
21 whoever is on flexi that day could go and potentially sit in an important case conference meeting or a TAC or
22 perform a PRAM or something on a woman and not know them and it seems to be about an allocation of time
23 instead of about the women. I've got a case conference that I need to go to for another midwife on Monday, I
24 know nothing about the woman and I just think that it's almost so ineffective to be asked an opinion on
25 something when the opinion that I would have is formed on the paperwork, which means that anyone could
26 form that opinion and have no deeper understanding of the woman or the family or the situation. It almost
27 makes it a box ticking exercise instead of it actually being about that woman and her family.

28

29 R: Yes, most definitely.

30

31 M: I think that we potentially, I think there is a real argument for actually case loading vulnerable women.

32

33 R: Lovely. Can you take a peek at that for me?

34

35 M: Yes. Completely off this but I'd love to do that, I'd like to be a case-loading midwife.

36

37 R: Would you?

38

1 M: Yes, absolutely. I find it really frustrating.

2

3 R: OK, so with this scenario to what extent do you consider in your role as a midwife that you are able to meet
4 the health and social care needs of this family, if at all?

5

6 M: I cannot support them on social if they need housing, fundamentally it's not my role. I can support them and
7 signpost them and I can be a driving factor working from the other side, so referring and re-referring and
8 speaking potentially to the right people or finding out the reasons why they are not engaging.

9

10 R: Who would you signpost to?

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12 M: It would be the social worker to start with. I would want to know why she didn't have a named social worker
13 so I would probably go higher than that and speak to the team leader. I would put a referral in because
14 hopefully that would trigger something.

15

16 R: If social workers were not interested do you know of any other services that you could refer to?

17

18 M: No, not really. I would ask.

19

20 R: Who would you ask?

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22 M: Someone like [TEAM LEADER].

23

24 R: OK, so somebody maybe with different experience?

25

26 M: Yes, a colleague. I would also refer them to the safeguarding so that we are aware but also to see if we can
27 help them but also to cover myself documentation-wise, to prove through a paper trail that I had done
28 everything I could to enable them to access the care that they needed.

29

30 R: Do you think that's a bit of a trend at the moment with documentation, a lot of it is to cover?

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32 M: Yes.

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34 R: Yes?

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36 M: Yes, absolutely.

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38 R: Do you think that's becoming more important than providing the care?

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2 M: Personally, no but you have to strike that balance. It's something that as a newly qualified, I think we knew it
3 but we didn't know it I think it's a massive responsibility to go to work everyday and know that everything that
4 you do or don't document could impact so detrimentally on your career and I do feel that our registration sits in
5 the balance and it's always around documentation and it doesn't mean that you are not giving really good care
6 or outstanding care but I feel that you have to double your workload because you have to passionately want to
7 give good care but then you have to document your socks off to prove that you've done it, which takes twice as
8 long. Does that make sense?

9

10 R: Yes, it does, completely. So now I've got four questions here but I'm not going to go over all of them because
11 we've covered little bits and if you are talking about understanding the support that you might offer potentially
12 we are talking about maybe going to other colleagues to get maybe a bit more knowledge about who you could
13 refer to. Is there anything else that you can think of that might challenge you or that you would anticipate
14 challenging you in achieving the appropriate level of care for the family?

15

16 M: Yes, well one, knowing who to access and who to refer them to and, two, making them fit everyone's criteria.
17 Everyone has different criteria and sometimes I think the things that we see doesn't fit or tick a certain box
18 which then means that people lose out on care and obviously if they don't have a social worker and they don't
19 have effective or any housing then from our point of view we would be massively concerned whereas somebody
20 else's point of view they might not be as concerned about that. Does that make sense?

21

22 R: Yes, completely. Like you said about different criteria and somebody might be flagging up as vulnerable to us
23 whereas social work are like no.

24

25 M: Yes, not high enough.

26

27 R: Not interested, yes.

28

29 M: There is a good example of that in as much as I discharged a lady from B5 who had been kept on B5 because
30 she was waiting for her social worker to organise, she was going into Mother and Baby foster care and she
31 wasn't being kept there but she stayed for two or three days whilst that was being organised. Now I think there
32 is a real breakdown in communication between what the social worker wanted us to achieve and what we
33 perceived our referral process was. So the social worker had stipulated on two occasions that they wanted a
34 perinatal mental health referral done for this girl and from our point of view we had done everything, the
35 documentation was fine and she was really well cared for and her parenting obs were perfect. Hers was social
36 and neglect but it wasn't a mental health as such, she did have depression and she was taking anti-depressants
37 for depression but our referral criteria for the perinatal mental health service are extreme psychotic or
38 damaging mental health behaviour, psychosis, being medicated and it says is this referral likely to end up in

1 them being admitted to the Mother and Baby unit? That was their kind of level but I do feel that because it was
2 asked for and it was documented for and it was handed over to me I was looking after that woman for the day
3 she was discharged, felt like I wasted some of my time doing an unnecessary referral because it was
4 documented that it had been asked for. I could very easily verbalise that it wasn't necessary but I still did it
5 anyway so it's an absolute box ticking exercise. That's frustrating.

6
7 R: Thinking about that it seems to be a lot of guidelines take away the autonomy of practitioners by creating
8 these sort of – what are your thoughts on that?

9
10 M: I think it's really hard to strike a balance between autonomous care that is woman centred and the need to
11 tick a box. We all work within agencies and we can't be everything to everybody and I think sometimes people
12 have to understand the confines of what service we offer and what we can offer and what support we can
13 provide and I feel sometimes we feel like we have to do everything for everybody and it leaves us short because
14 you can't have guidelines and protocols for every single woman when their pregnancy, labour and birth is so
15 individual and then their social situation is so individual and their previous medical history is so individual that I
16 feel that by working within the confines of policies and protocols it makes us exist very much in the black and
17 white and when you are dealing with women we do exist in the grey and I think sometimes we push people into
18 black and white so we can tick a box and demonstrate that we've done the work and we are doing the work but
19 it doesn't fit everybody does it.

20
21 R: That's really interesting. This is the last one, so have a peek at that third one for me. The Dictaphone is lasting
22 which is a bonus.

23
24 M: Oh, interesting.

25
26 R: So in this scenario we are talking about maybe some informal discussions from being co-located. In your
27 experience what are the advantages of being co-located with other agency professionals? Can I quickly ask, you
28 work here on a Thursday you say?

29
30 M: Yes.

31
32 R: Aside from the Children Centre staff here are your clinic days running when there are any other things
33 running?

34
35 M: Yes, so there is always a playgroup, there always is some parent support going on always in there, yes so
36 there's always that. Individual parents can come in and book the sensory room, there is always children here in
37 the afternoon, always.

1 R: OK. Yes, so what are your experiences of being, well do you think there are advantages of being co-located
2 here when you do your clinics?

3
4 M: Yes, do you know I think yes definitely but I think we all struggle a lot with this informal discussion at the
5 Children's Centre because I think it's also about knowing what their roles are and who you can talk to. I think
6 there perhaps needs to be some more clarity the other way because there seems to be some core staff who I
7 would speak to but I would feel very reluctant to have an informal discussion around the photocopier about a
8 family. The other way round if they had concerns about a family I think that they would know that it would be
9 OK to speak to me but you don't know with the confidentiality where the boundaries lie between that. So, yes, I
10 think there are definite benefits, there are benefits to having their knowledge of the families which is really
11 beneficial but also then having the women here potentially with their other children as well in a more informal
12 environment than a GP surgery. You actually get to see them interacting with their children while we are doing
13 an appointment and the toys.

14
15 R: Yes, this room is very child friendly isn't it.

16
17 M: It is, but you get to see a lot when you are here for 20 minutes. We're talking about the emotive things,
18 we're talking about them asking how they feel about them having a new sibling or talking about what's going on
19 in their family. I think women feel more comfortable here because it is a family centre to talk about their family
20 and what is going on and maybe that aids disclosure and I think from an observational point of view it definitely
21 gives us better insight here than it does anywhere else. Does that make sense?

22
23 R: Yes. Lovely. What about in your experience are there any limitations to co-located working in the centre, or
24 co-located working in a GP surgery as well?

25
26 M: I have it pretty easy here because it's a nice set up, it's a lovely room, maybe some confidentiality issues
27 between meetings running.

28
29 R: How do you mean? So, can you hear meetings running?

30
31 M: Yes.

32
33 R: Right, OK.

34
35 M: I don't think there are many disadvantages to be honest because the women enjoy coming here, they get a
36 really nice welcome, it's friendly, they feel that they can bring their children here, there's lots of information
37 that backs up our health promotion messages, it's also somewhere where we can signpost women for
38 breastfeeding support or helping them know where to come because a lot of the health visitors run their clinics

1 from here as well so it seems like it's their port of call where it shouldn't really be a GP surgery or, you know,
2 LOCAL HOSPITAL costs our women a lot of money to come if we are going to ask our women from all financial
3 backgrounds to attend all of their antenatal in LOCAL HOSPITAL, it's going to cost them an awful lot of money in
4 car parking and it's not as convenient, whereas here I think it's good.

5
6 R: That's lovely. Good, thank you. Last thing I'm just going to quickly ask you.

7
8 M: Go on then.

9
10 R: What are your thoughts on working here if there is anything else that you feel that maybe you haven't
11 addressed?

12
13 M: I think it's really beneficial. I think the women like coming here, I feel like it's just the best of both worlds
14 really. We don't get to see women in their own homes but there is no parking charges here, we are convenient
15 for the women. Yes LOCAL HOSPITAL would be massively convenient for me because I've got a computer and I
16 can book people in for inductions there and then without having to get on my phone. I can send bloods. It's
17 massively convenient for me but I think being involved in the community is something that we as community
18 midwives really should hold on to and I think it can only get better the more that we work together. Does that
19 make sense?

20
21 R: Yes. That's lovely. Thank you.

22
23 M: Welcome.

24
25 R: We've reached a suitable stage to end the interview, I'd like to take this opportunity to thank you for taking
26 part in this research.

27
28 **End of Interview**