

## INTERVIEW TRANSCRIPT

PARTICIPANT SIXTEEN

DATE: 13<sup>th</sup> June 2016      TIME: 12:00pm

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 read this statement for us, OK. 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.

HV: Yes, I have.

R: Which we've just seen. The current date is the 13th June and the time is just gone midday. You've been allocated the participant number Participant 16, that's for my reference for later on so I can link up data. I'm going start with some general questions and then move on to the use of some vignettes. As you took part in some observational episodes I would encourage you to reflect upon this in your answers or generally any of your practice if there is any good examples you feel to back up what we're saying. Like I say, it will all be confidential.

HV: Fine.

R: Good to get some examples as well. Can you tell me to start off with just a little bit about your role, so what it is that you do and how you work in the Children's Centre here as well and your link here?

1 HV: Well I'm a health visitor, I work full time in an area which is quite deprived. Basically, my work is extremely  
2 busy, a lot of non-universal mainly to be quite honest. I work very closely with my local Children's Centre [LOCAL]  
3 Children's Centre. I know the staff, they are very supportive. I normally attend and co-run a clinic on a  
4 Wednesday, a healthy child clinic Wednesday afternoons. We can refer our clients to the Children's Centre for  
5 extra support which we do in a written form but I can also ring up the Children's Centre at any time and I do this  
6 often whilst I'm in families' homes to just either try and get appointments for them to attend Children's Centre  
7 groups or just to get general advice for the families. So, I work very closely with the Children's Centre and I often  
8 say to families, it's almost like a triangle, so it's parents, health and Children's Centres.

9  
10 R: OK, fab. Now can I ask just a little bit of a separate question but it would be good to I think compare but how  
11 long have you been in your role?

12  
13 HV: 3½ years trained and then I did a year previous to that within the same area, so overall about 4½ years.

14  
15 R: So that's in your role as a health visitor?

16  
17 HV: Yes.

18  
19 R: Can I ask what you did before health visiting?

20  
21 HV: Yes, I was a midwife.

22  
23 R: OK. How long were you a midwife for?

24  
25 HV: Oh, six months.

26  
27 R: Oh, really?

28  
29 HV: Yes. Just six months, yes.

30  
31 R: I can understand that actually sometimes. OK, that's super. So what in your experience do you feel  
32 contributes to good working relationships with the professionals in this Children's Centre?

33  
34 HV: I think it's definitely got to be open communication and I do find the staff at this Children's Centre, and  
35 other Children's Centres I work with they are always very welcoming, always very eager to help, so I think it's  
36 just having that two-way open communication and I've not had a problem with it.

1 R: Yes, can you talk a little bit about this two-way communication, so what sort of methods of communication  
2 do you use, is it always, are you talking about face to face communication?

3  
4 HV: Not always, it can be face to face obviously when I'm in the Children's Centre or I will just pop in to maybe  
5 ask if a family have been in to attend a particular group or we do written referrals, so if we discuss with families  
6 that they might need some extra help coping with their children we will write referrals and send them off to the  
7 Children's Centre to be allocated. Emails, we often send emails to each other. Michaela, the manager here, we  
8 quite often have emails between each other where she's asking about something to do with families and then  
9 we're replying back but it's a two-way thing, so it's basically those three methods.

10  
11 R: OK, fabulous. Can you give me an example from your experience where you feel this communication has  
12 been particularly effective, maybe just general working or in the care of any of your families where it has been  
13 essential or maybe not worked efficiently?

14  
15 HV: I've never found a time it hasn't worked. What I find most useful or found most useful because what I'm  
16 going to talk about has stopped from this Children's Centre but quite often we need to refer our mothers for  
17 referrals to Talking Change and not so long ago we could ring this Children's Centre and book appointments for  
18 mums to be seen within one week/two week at [LOCAL] Children's Centre. Now we don't ring here we have to  
19 ring another Children's Centre, which I believe is, I don't know because I haven't done it for a while, [LOCAL]  
20 Children's Centre.

21  
22 R: That's it [LOCAL], I'm sure I've heard somebody call there for Talking Change.

23  
24 HV: Yes, so there was a period of time when I was ringing almost every week, a couple of times a week, and I've  
25 always found Kerry on reception very approachable, very professional and nothing is ever too much trouble. So  
26 that was a particularly good working arrangement we had but we can't ring this Children's Centre now for that.

27  
28 R: Right, OK. There have been lots of changes, haven't there?

29  
30 HV: Yes.

31  
32 R: Especially recently. How about how do you find your working relations with midwives, with, I mean do you  
33 work closely with any other professionals in the centre? I know obviously you work, do you work with the  
34 midwives much?

35  
36 HV: Well, personally within my team I do midwifery liaison on a monthly basis and there are three midwives that  
37 I normally, two I do normally by telephone liaison and Lois who works in [LOCAL] Children's Centre I will come in  
38 and see her just because she does her clinic here. Basically what that's all about is once a month after the 20

1 week scan health visiting gets sent a list of mums that are expecting a baby and due within the next two months  
2 but before we contact mums we always have our liaison, well I do the liaison for our team, we have a liaison  
3 with the midwife to discuss the families that we've been notified of just to see that they are still pregnant for a  
4 start and if there are any concerns. Yes, again we have, I believe, certainly with our term in the north of the city  
5 we have a good relationship between midwives and health visitors. One annoying thing is that very often I don't  
6 know what happens on the 20 week scan but we've quite often got two or three people maybe sometimes five  
7 or six that are just not, their names are not appearing on the scan list but midwives know about them so the  
8 midwives inform us at that stage but it just seems a bit strange that they would have had their scan but they're  
9 not on this scan list that health visitors are informed of, so that's a bit strange and a bit frustrating. But anyway  
10 once we've done our liaison then we contact the family and make our appointments to see them before baby is  
11 due.

12  
13 R: Do you have much involvement with the midwives aside from that liaison meeting?

14  
15 HV: Not really to be honest. I mean if there are families that are on child protection then we will see each other  
16 probably at a conference but apart from that no, that's about it.

17  
18 R: OK, that's great.

19  
20 HV: Oh, I'm fibbing, I'm going to say something – it's only because I'm not involved with this but obviously we  
21 have pre-birth and beyond, is it pre-birth and beyond? PBB?

22  
23 R: Yes, something like pre-birth or pregnancy birth.

24  
25 HV: Pregnancy, birth and beyond, yes. I know my health visiting colleagues work closely with midwives to  
26 present this which I think is a two weekly session for parents to be.

27  
28 R: Yes, because I've heard about it but I have to say I don't know much about it.

29  
30 HV: No, and I don't. I did originally go to the very early meetings where it was all going to be considered but due  
31 to other circumstances I never got fully involved after that but I've got my colleagues that tell me that it works  
32 well and yes, they just work together offering a programme sort of antenatally to parents.

33  
34 R: So, do differing health visitors then work more closely with the midwives?

35  
36 HV: I think so. I think that is about it really, it would either be the monthly liaison or the pregnancy, birth and  
37 beyond. That is about it.

1 R: Is there anything which dictates how frequently or that sort of relationship, is there a specific health visitor  
2 that will take on the pregnancy, birth and beyond?

3  
4 HV: No, it's volunteers really and as with all things it's considered by health visitors to be just a bit extra work so  
5 you've got that core of health visitors that will say, yes, I can do it because it's in the evening, it's delivered in  
6 the evening so it's normally, yes, it's a variety of health visitors that do it and it just depends on how busy I think  
7 their schedule is, whether they can do it or not and of course they would need the training beforehand. I can't  
8 really remember the original question.

9  
10 R: Well I'm just looking at relationships with other professionals and obviously if some potentially were maybe a  
11 bit more involved with the midwife and what I was basically just trying to explore is whether there was anything  
12 which identified, you know, because I know sometimes with the midwives some teenage pregnancies work very  
13 closely with the family nurses and therefore maybe will collaborate a little bit less with others because actually  
14 it's the FNs that do everything. So, just looking a little bit about the roles and maybe then how that will  
15 influence you working together, but no that's lovely. I'm just going to move to talking about communication and  
16 the documentation because obviously you say you do referrals. I just want to explore what sort of  
17 documentation you use as a general anyway, do you have notes that you write in, do you have computer  
18 systems?

19  
20 HV: Yes, all our notes will be put on a computer system, System One, that's what we work with at the moment.  
21 Any referrals we do I handwrite and then I would get our admin team to upload them, well it depends, no, I  
22 don't. Referrals – it depends. If it's an in-depth referral, for example to the paediatricians or to early years panel  
23 then I will get the admin team to upload it because sometimes they might go missing and we don't want to have  
24 to do all the referrals again and then go and get the parents signature again but for your common or garden  
25 referrals to maybe the Children's Centre which are quite short and sweet then I just handwrite them, post them  
26 off to the Children's Centre. There was a time when we could hand them in here but that all stopped, and that  
27 would be great if we could just come in, oh can you just, but no we don't we have to post them off to.

28  
29 R: Right, so are you saying that you upload them so that essentially you still have your main copy, is that right?

30  
31 HV: For particular referrals, for the ones that are more in-depth that we wouldn't want to lose because it would  
32 take too much work to do again but your straight forward one page referrals we would just post off and then  
33 update our records that the referrals had been done.

34  
35 R: OK. Can you tell me a bit about that documentation you use helps contribute towards good communication?

36  
37 HV: Well for example, from memory, if we, and this doesn't have to be just to do with midwifery does it?

1 R: No, no.

2

3 HV: For example, paediatrician and early years' panel referral we always have to inform the GPs – actually on  
4 the form it says discuss with GPs. We haven't got time for that, we just inform GPs because the GPs were  
5 ordinarily, I'm sure they would say yep if you are finding that refer, so as a shortcut we just inform the GPs by  
6 email, that's how I do it, I email our GP practice manager and she's brilliant and she will just let the GPs know  
7 that a particular child has been referred for paediatricians. That's about it really.

8

9 R: Yes. Do you find the forms and the documentation you use fairly easy to use?

10

11 HV: No.

12

13 R: No?

14

15 HV: In particular the one which we all hate which is fairly new, maybe within the last year, maybe a little bit  
16 longer and that is when we refer to Speech & Language. That is an absolute nightmare because it is a form that  
17 is used for referral to children's therapies, so it's children's services and I think it's, well it's two other services  
18 that we don't refer to, so it's, I don't know off the top of my head I can't think who it's for. But anyway it's a  
19 referral service we wouldn't do it, it would normally be a GP that does that but the form is quite long and it asks  
20 questions, for example, I'm going to give you an example here: you will go and do a home visit or see somebody  
21 at a clinic and you realise that their 2 year old or maybe 2½ year old needs some real in depth help with speech  
22 and language so it's not just your normal they're not attending clinic and they haven't had the opportunity or  
23 there's an older sibling talking to them, you know there is something more than that and what you are doing as  
24 a health visitor and advising mum to do with their child has not worked before, you know it needs referring. So,  
25 you will do your referral but you will discuss the referral with mum, this is how I do it, discuss the referral,  
26 haven't got time at that appointment to do that in depth referral I'll get mum's signature, I'll fill it in back at the  
27 office but a lot of the stuff on the form you haven't had time to ask and it's stuff that wouldn't even be on our  
28 system, like what age did baby start to roll over, and some of those we would think well that has got no bearing  
29 obviously on speech and language so we leave that. But I in particular have had issues before with Speech &  
30 Language therapy because they will get the referral and then they will think a couple of sessions with the family  
31 down the line this family needs to be referred on to either a specialist speech and language therapist or maybe  
32 to an early year's panel. So they'll come back to the health visitor and say, can you furnish us with all this info,  
33 well no we can't unless we then have to go out and do another home visit – it then has an impact on our work  
34 so to be quite honest that is a real pain in the backside. I am about to start doing some work with the Speech &  
35 Language service to see how we can streamline this and I know the whole point of it is that parents don't get  
36 asked things more than once. Well unfortunately sometimes that has to happen but what Speech & Language  
37 and I are trying to do is to get together and yes, as I said streamline the service so that we both do as much as  
38 we can to stop parents having to give that same information more than once.

1

2 R: Do you have these sorts of issues with filling out with any other documentation or do you find your general  
3 referrals, say things like, it's not CAFs anymore is it? Single assessment frameworks, are they relatively easy to  
4 use in comparison?

5

6 HV: They are, I find, oh, I find them difficult and it's not. We obviously have training offered to us, it's not a case  
7 of training needed for it it's time consuming, it's quite, dare I say quite arty farty air fairy, it's not just basic facts  
8 they want to know. That's another one that could take at least two homes visits or two contacts with the family  
9 to fill in. That done once you do a SAF and then you realise that a TAC should be held and you are going to be  
10 the lead professional the review SAFs are, it repeats itself. Again, time consuming, annoying, who has got the  
11 time to do it. Yes, SAF review forms are quite horrendous to be honest.

12

13 R: So it sounds like time consuming, complexity of questions as well seems to be a bit of a?

14

15 HV: Yes, because they are very, very open questions that you would ask family and you could write reams on it  
16 but you have to obviously get it really concise and compact and, yes, sometimes that is quite difficult to do and  
17 also what has a bearing on filling in these forms is where we're based and currently we've changed location,  
18 we've just moved in Medina House in Cosham, we've literally last week moved in and it's very early days but at  
19 the moment until the network centre closes, which I've been told the last day we can attend is the 24th of this  
20 month then I'll be going over there because you've got the time and the peace and quiet to actually do these  
21 referrals. I can't imagine writing a report for a conference or doing an in depth referral at Medina House.

22

23 R: Because of?

24

25 HV: It's too, the room is too packed with all professionals, you know, we've now got social workers, we've got  
26 Barnardo's, we've got school nurses and we are all absolutely jam packed into this one room. It's so noisy you  
27 cannot hear yourself think, people are having telephone conversations and I know I do it myself your voice  
28 tends to be a bit louder when you are talking on the phone so everyone is the same and it's just, so far, not a  
29 good place to work.

30

31 R: Right.

32

33 HV: So I find that already difficult and I will work at home as much as I can.

34

35 R: I was going to say that's another thing about working, being colocated with other services, it's generally all  
36 normally maybe seen as a positive thing but you are finding actually not so, does it have its positives?

37

1 HV: Yes, it does have its positives it really does, it was so nice to be able to, like for example, last week I only  
2 went into Medina probably three times and this is a plus and a minus really, two of the social worker that are  
3 working with two of my families they asked if they could have a discussion about a family which ordinarily we  
4 probably wouldn't have had because they would have tried to get hold of me by phone, I'd be in visits and not  
5 able to take the call, when I phone them back they wouldn't be in the office. So, that took at least 15 minutes  
6 for each family, I only wanted to pop in to write something up quickly and then I wasn't able to, so it's got those  
7 minus points which I can see happening more and more but on the flip side of course it's great to, it is great just  
8 to be over the other side of the room from, so there are swings and roundabouts. I'm sure things will settle  
9 down but at the moment it's very early days and it's quite hard.

10  
11 R: Right. How about the System One you use, can you tell me a little bit about how that impacts on your working  
12 with other professionals as well? I mean does it link up with other professionals?

13  
14 HV: Yes, we can see GP notes if the families have, I believe, opted in to permission to be able to have their notes  
15 shared – that is really useful because obviously you might have gone to a home visit and discussed with mum  
16 something that she feels is not quite ready with the child and I would say you should really take the child to the  
17 GP, and then I can see whether they've gone or not and what the outcome is. Quite often obviously before a  
18 visit I'll just quickly review my notes on System One, if I've got time, and I will see things that the GP has written  
19 that give me some great information for my visit, useful information that mum might not have shared with me.  
20 So, yes, certainly for GPs. Speech & Language, obviously we can see letters that have been, so paediatrician  
21 letters, that have been sent to us but electronically and they are all on System One. Yes, I like System One, it's  
22 great, you can get some good views of other professionals on there.

23  
24 R: But you say that's very much down to the parents actually giving permission for this share?

25  
26 HV: Yes.

27  
28 R: OK.

29  
30 HV: I find more and more parents seem to be, I seem to be able to see the GPs appointments and what's  
31 happened at their appointment. So, that seems to be happening more and more which is really good, so maybe  
32 the GPs are on the case of not pushing parents but saying can we do this, sort of thing. So yes, it's very useful.

33  
34 R: Are there or can you suggest anyways in which paperwork or documentation could be improved to improve  
35 communication?

36  
37 HV: I think forms need to be more simplistic, much more basic so that you can give the person you are referring  
38 to a really good reason for referring but then once the child is referred and they can see yep, this child needs to



1 be seen, then they take it from there. All these, loads of other questions, you know, come on if a health  
2 professional such as a health visitor sees a need for a referral do a good referral but just quite basic and that  
3 would be so much quicker and yes, I think it would just save a lot of time. So, I think forms need to be simpler.  
4 And they need to be more easily accessible. We've just come from working in the Civic offices where most of  
5 the forms were available for us in paper form in some filing, well, some of the forms, some of the social care  
6 forms like the SAF reviews and so forth they were never available to us we had to go online. I know a lot my  
7 colleagues and I haven't got the time to search for them online, it's too difficult and we're constantly going to  
8 admin, oh can you print this one off so we've got one, and I've had admin put some of these forms on my, or  
9 send it to me and I've put them on my desk, saved it on my desk top so now I've got it. Its having the availability  
10 of the form and at the moment we haven't got any paper referral forms at our new base at Medina – apparently  
11 those are in the pipeline of coming but of course it doesn't help you in the short term. But to be on the positive  
12 side we were all advised take a few referral forms, I do have quite a wodge of forms that I carry with me, as we  
13 all do. But, yes, sometimes they are just not available unless you are on the internet and that's just, say like you  
14 are not at your base how can you print that off? It's just things like that that are so frustrating and time  
15 consuming.

16  
17 R: So do you only have, yes, so ability to print, can you check emails outside of your bases and things like that?

18  
19 HV: Oh, yes. I mean I've just got a new work phone, left it over in the other office, it's an, is it an iPhone? I don't  
20 know but it's pretty good and I can get my emails I mean just because I go in and log on to NHS.net, so I get my  
21 NHS.net emails which is great. With our laptops we get them and with our laptops we can check our outlook  
22 emails as well. So, really with our laptops which are all singing all dancing, they're fabulous, as long as you  
23 haven't got one of those that you have a problem getting on wherever you are in the City. Mine, touchwood, is  
24 OK, then yes, you can pretty much do everything from your, the only thing you need to go into your base for  
25 really is to see what's been put in your sling paperwork wise and to maybe pick up some forms for referrals or  
26 visits that you need, forms that you need to take to visits. So, yes, it's pretty good for mobile working, laptops  
27 and emails, yes.

28  
29 R: OK. Just thinking, sorry, I'm spending a lot of time talking about documentation here, but have you seen since  
30 you've been working as a health visitor much evolution in forms themselves? So have you seen them change  
31 much?

32  
33 HV: Yes, they are always changing.

34  
35 R: For the better or for the worse?

36  
37 HV: Well, I think certainly the Speech & Language forms is not for the better as far as I'm concerned. I wouldn't  
38 say, when they are reviewed and new ones are highlighted to us they never look simpler, you never think wow

1 this is good, this is an improvement. No, we never do that, we never see that. Some of them might even be  
2 changed because either their logo or address has changed. You know, for God's sake.

3  
4 R: Yes, or change in team names and things like that.

5  
6 HV: Yes, yes.

7  
8 R: So it's more so about that when that happens is it rather than actually trying to streamline and make the  
9 forms more efficient do you think?

10  
11 HV: I don't believe any forms that have changed have ever made a massive, positive impact.

12  
13 R: OK, interesting, thank you. Checking that's still recording. OK, just moving away from the documentation, in  
14 your experience how do the other people you work with and collaborate with perceive and understand your  
15 role as a health visitor?

16  
17 HV: I don't believe anyone really knows what anybody else's job is. I'm lucky I know what midwives do because I  
18 was a midwife and it really helps me in my job. I think it's like the follow on dream job from midwifery so I think  
19 I've been really, really lucky. What we are going to do where we are working at the moment, New Medina, is we  
20 are going to have a time, so our team lead tells us, that we are going to have a massive meeting and let each  
21 professional like social care, Barnardo's, know exactly what we do and I think that would be great because no I  
22 don't believe any professionals really know. I've got a good idea what social care do, they know we deal with  
23 children's health but I don't think they know exactly what we do and I think that would be really useful.

24  
25 R: Yes, I was going to say how do you think that impacts then if you feel that actually there's not the greatest of  
26 understanding, well not the.

27  
28 HV: It's not poor understanding.

29  
30 R: It's not bad but do you think that impacts how people work with you maybe understanding when they should  
31 be referring or what your scope of practice is?

32  
33 HV: Yes, definitely and the biggest example I can give you of this is when I was newly qualified as a health visitor  
34 and I went to a child protection meeting and I think it was the first one where I was on my own because once  
35 you qualify you get some child protection meetings, you get a number of them that you are accompanied with  
36 another health visitor and then you are let loose to attend on your own. I never forget a social worker saying to  
37 me, right you will do this baby's weight every two weeks then, and I went, oh OK, like that. So, when I went back  
38 obviously you feed back to your manager and she said well what you've got to remember first of all is you are

1 the lead in health, for this particular child there is no issue with this child's weight and so you've got to think OK  
2 we're advising via the healthy child programme that children under six months only need to be weighed  
3 monthly and of course yes, we can do it sooner and whenever mum wants but for a social worker to say and  
4 you will do it. Yes, so I've always kept that with me now and we don't have to fight our own corner but you just  
5 calmly and firmly tell somebody no they don't need it and give them a rationale as to why. So, I think that's just  
6 a little example of how social workers don't really know our role but then do you know why would they because  
7 it's quite in depth, it's like the nitty gritty of what we do, how would they know that the healthy child  
8 programme says once a month for babies under six months. They probably don't know that and probably don't  
9 need to know that but I think it would be good for them to get an overall understanding more of what we do.

10  
11 R: And you say you think actually being a midwife previously helps you with your relationship with your midwife  
12 as well?

13  
14 HV: Yes, I think it does because although I never knew Lois before and the other two midwives I liaise with I  
15 don't know who they are, and I don't think there are many that are still working when I did my midwifery. I think  
16 it certainly helps me because I know what they're talking about and I think it helps the midwife because they  
17 know that I understand. So yes, I think it really does help.

18  
19 R: OK, great. To what extent does the midwives having clinics here, do you think that exposure, well, I'm going  
20 to skip that question actually because we're talking about how maybe midwives understand your role but I  
21 mean do you think midwives have a good understanding of a health visitor's role? Do you think that's influenced  
22 by them being here and having their clinics maybe when you have your clinics?

23  
24 HV: Yes, although the midwife will be in here and now we are in the kitchen, we used to be next door but now  
25 we're in the kitchen.

26  
27 R: Oh, so now you are in the room further, oh, right, OK.

28  
29 HV: So we've never really, I don't know if Lois has ever sat in with a health visiting clinic, I'm alright because I've  
30 been able to do clinics midwifery wise. So I'm not sure that, if there is any positive impact at all because, yes, I  
31 don't think the midwives, no I don't think they wouldn't really know.

32  
33 R: No. Do you think it's enabled you to work more effectively with the midwives with them being located here  
34 for their clinics?

35  
36 HV: Yes, because occasionally you might want to ask a question if you are in clinic for whatever, it might not be  
37 about a family you are seeing, it might be you've got a lull in seeing mums and you think, oh I must just see if  
38 Lois is free so I'll go and have a quick word with her. I think now certainly what happens on a Wednesday is we

1 have a midwife clinic, I don't know if it's Lois that runs it on a Wednesday, I'm not sure, but there is a midwife  
2 clinic and there's health visiting and there is breastfeeding, just started breastfeeding and that's got to be good,  
3 all three of us together. Good for families to know that they can come here on a Wednesday afternoon and they  
4 could see a midwife or a health visitor or a breastfeeding support worker. So, yes, I think that does help.

5  
6 R: Do you think it's impacted where you are working now if you are working down in a different room, working  
7 opposite ends. I know it sounds simple but.

8  
9 HV: No, I don't think so because Lois, I don't know who works here on a Wednesday but whoever works they  
10 would know we are just down the corridor so they can come and chat to us and vice versa so we know where  
11 each other's clinics are.

12  
13 R: OK. Were you working within the centres, I'm just trying to think how long you've been a health visitor, have  
14 you ever worked with midwives when they've been in their GP surgeries?

15  
16 HV: Yes, one of the midwives that I normally liaise with by phone she does, she sits in the GP surgery on the day  
17 I normally have contact with her. But if I'm at the GP surgery to do health reviews on children it would normally  
18 be on a Friday and I'm not aware when the midwife is there. It might not be a Friday, I'm not sure, so I would  
19 never say like pop in to the GP practice to see the midwife because I'm not quite sure when she's there.

20  
21 R: OK.

22  
23 HV: But I know I can always ring them by mobile, because I've got to know them they are very good at getting  
24 back to me. Before I knew them it was a nightmare to get hold of a midwife to be honest.

25  
26 R: Right, OK.

27  
28 HV: Absolute nightmare because there could be days before they were at work because of their long, long shifts  
29 and they would either not be the facility to leave a message on their phone or it never said when they would be  
30 back, and I understand that what a palaver having to change your message every time you maybe have a day off,  
31 it's ridiculous so I think it's only because I've got to know the midwives I liaise with that it's easier to liaise with  
32 them.

33  
34 R: OK, great. That's really interesting. I'm going to go through a couple of these scenarios, well I've got three  
35 scenarios so we'll go through those if that's OK?

36  
37 HV: Yes.

1 R: So I'm going to give you that to have a read if that's alright.

2

3 HV: Yes, indeed.

4

5 R: And then we'll go over the questions together if that's OK.

6

7 HV: Yes, no problem, let's have a look. OK, there's a lot going on here isn't there?

8

9 R: Yes.

10

11 HV: I'm just going to quickly read through it again.

12

13 R: Of course.

14

15 HV: OK, so she was alright until the baby was born. She was being managed, that's good. So new medication

16 from the GP, didn't want to see anyone, no communication from her GP. OK, right.

17

18 R: So, whatever is happening with Lucy now in this scenario really nobody has let either the midwife or maybe

19 the health visitor know. We just want to explore because obviously that communication is, well you know,

20 essential for the care that you are providing, you need to know what's happening. What are your views on what

21 inhibits that effective communication, so that communication barrier is there and it's stopped that path of

22 communication but what are your views on what might be causing that? Or is there an excuse?

23

24 HV: Well, first of all no I don't think there should be any excuses. So many times horrific things have happened

25 in the past and we're always told communication was an issue, well for God's sake how dense do us

26 professionals have to be, how thick do we need to be if we don't get our act together and just keep

27 communicating. With this particular scenario the baby is only six days old so although we would have visited

28 mum antenatally and realised, because we would have asked about mood, realised that and hopefully mum

29 would have told us, and midwife should have told us at the liaison, that mum's got a history of postnatal

30 depression or a history of depression. It was managed before she had baby, so things have started to go wrong

31 since she's had the baby, so we would expect, we would have made contact by phone already to mum to

32 arrange a new birth visit but we don't visit now until, anytime from day 10 up to day 21, we've got that massive

33 gap. So when we ring basically we're ringing to see how things are, see how mum is, see how baby is, see how

34 baby is feeding and then arrange the appointment, so, unless mum's going to tell us something at that stage we

35 would expect, in my experience I've never been told by a midwife if somebody has got low mood I've always

36 been maybe contacted by the GP and that's either a phone call from the GP to us, it's normally a phone call,

37 they're normally pretty good they want to talk to us. Of course, then that will make our visit, we'll go sooner and

38 see how she is. We can do a postnatal maternal, what's it called, it's not an Edinburgh postnatal score, we

1 wouldn't do that necessarily we would do a postnatal maternal attachment assessment, we do that  
2 questionnaire. This is what we think, right, as long as mum is on medication, she's engaging with services we can  
3 offer a series of up to, I think it's two listening visits now but it used to be four, or we would make sure that she  
4 was referred and we would refer her to say like Talking Change and I know the midwifery have their own, I don't  
5 know how long that's going to last but their own counselling service now. I can't even remember what it's called,  
6 is it Respond?

7  
8 R: I tell you what I couldn't tell you at the moment, it's bad isn't it.

9  
10 HV: Well, no, because these things change so quickly don't they?

11  
12 R: They do, yes.

13  
14 HV: But can't even remember your question, tell me what it was again.

15  
16 R: So you are thinking about obviously what should be happening, in your experience has there been an  
17 example like this where that communication hasn't been there?

18  
19 HV: Well, yes, from memory I can't think of anything specific or any occasion specifically but I'm sure when I've  
20 gone to visit mum and they've not been discharged by midwifery yet there has been low mood that might have  
21 occurred since birth but midwives have not got in contact with us. I'm sure that has happened, because  
22 obviously when we see each other as health visitors we say oh my God, and midwife didn't even let us know and  
23 of course, yes, it does happen. It's not frequent but it has happened but then do you know what we're so busy  
24 we don't do anything about it apart from just get on and do what we have to do. I know we should refer it back  
25 or refer our findings back to midwifery as, what do you do online now? Report a, sort of like a, not a near miss  
26 but, do you know what I mean?

27  
28 R: Yes, the safety incidents.

29  
30 HV: Yes, but do you know what in all honesty who has got time to do that, so what we do normally is just say  
31 right OK, so here we are today get on with it. That's what we do.

32  
33 R: What in your experience do you think might have contributed to those midwives not letting you know?

34  
35 HV: I think it's, I don't know how often mums are seen in their postnatal period by midwifery. I know home visits  
36 have been cut greatly and a lot of the time families have to go up to the hospital but it said here didn't it, she's  
37 missed planned postnatal appointments. So that would immediately make me think that midwifery should have  
38 liaised with us, to ring us, they never email us but to ring us and say I can't get hold of this mum, have you

1 managed to get hold of her? I've had GPs do that for a postnatal review, I can't get hold of mum, but no  
2 midwives and I don't know why. I think it's because going back to your original question I think it's because no  
3 continuity of care, no continuity of midwife and I also, and this is just my impression not that I've ever really  
4 seen this happen but when I left midwifery I know they started to employ lots of, is it midwife assistants?

5  
6 R: Yes, healthcare support workers.

7  
8 HV: Yes, and what is their training like? Do they have to go through at least three years of midwifery training?  
9 No, because they are just going to be just support workers, I don't mean just support workers but no because  
10 they are going to be support workers but I worry that they have enough understanding of mental health,  
11 maternal mental health to be able to do much about it. So I think that's contributed to it it's the continuity and  
12 it's the qualification of the person that's visiting. I think that's what it is, and staff shortages and time constraints,  
13 all these things add up to it so that would be my impression of why the communication wasn't good.

14  
15 R: So, taking into consideration those things you think may be influencing a barrier, may be barriers to this  
16 communication, what in your views what would make communication easier or is there anything you think that  
17 would make it easier?

18  
19 HV: Yes, pick up the phone. I think that's what professionals need to do to each other and also just because you  
20 haven't managed to get through to somebody don't just leave it because maybe you think oh my God, I can't  
21 ring them and maybe they forget. I don't know. Maybe they might think, OK I've tried to ring the health visitor  
22 and she's not there. If I get a missed call on my phone I don't waste my time ringing it back I want a message left  
23 on my phone, I know who it is and I'll ring them back. Absolutely. So I think a barrier is just possibly other  
24 professionals just not picking up the phone – I think that's what it is. That's the main one if they sense  
25 something is wrong. But I think although it shouldn't be an issue, you know, time is an issue, it's having the time,  
26 and I think everybody's case load, you know midwifery caseload is always horrifically, been historically been very,  
27 very heavy. Health visitor's caseloads are very, very heavy. There are not enough staff for the work that needs  
28 to be done to be honest and so I think it's that. I think it's staffing issues and I think it's, yes, it's just having the  
29 time to do it. That's what I think.

30  
31 R: OK, that's great, thank you. OK, let's move on to the next scenario, same thing, have a look and then we'll  
32 discuss those questions together.

33  
34 HV: OK. OK, right.

35  
36 R: OK, so this, like I say the scenarios themselves are focused on different areas so the last one communication,  
37 this one really thinking about different roles and perhaps your role in providing care. So to what extent do you

1 consider that you would be able to meet the health and social care needs of this family, considering your role as  
2 a health visitor.

3  
4 HV: Yes, what I would do, so she's not had baby yet.

5  
6 R: No.

7  
8 HV: Currently we're only visiting first time mums antenatally, we haven't got the staff to do, we normally use to  
9 see every mum. That will change because we're currently training up child health nurses – just started their  
10 training last week so in six months they'll be fully qualified and they'll be able to do universal visits of all  
11 antenatal mums. So, hopefully I would have met this mum in the antenatal period. With her situation, I would  
12 have done a CAF, sorry a SAF, I would have done a SAF. I would have had liaison with her midwife and her  
13 midwife hopefully would have brought all these issues up as well and I definitely would have, so anyone  
14 obviously anyone can do a SAF, in my experience midwives don't do them. Again I know they are horrifically  
15 busy, historically health visitors feel like we have to pick up, most times we have to pick up because midwives  
16 from our experience tend not to do anything about it. They might run it past their safeguarding, I know that  
17 happens, but like if we are particularly worried, like this scenario we would definitely do a SAF and the lead  
18 professional we would see as being the midwife, so we would assume she should have done it and also started  
19 the CAF process, sorry the TAC process. Oh my God!

20  
21 R: That's alright, I know what you mean.

22  
23 HV: So, yes, but if the midwife hadn't done it then we would do it as health visitors because someone has got to  
24 do it, someone has got to pick it up and because this family obviously need help, yes, that's what we would do.

25  
26 R: Yes. So do you feel, with those agencies, so we've sort of answered the second question here as well with the  
27 midwives, do you think drawing together the care that you've just discussed would that meet the health and  
28 social care needs of this family?

29  
30 HV: I think it might not meet it but it would be a beginning, definitely a beginning because then we could invite  
31 to the TAC meeting we could invite obviously the midwife, and we can invite, obviously social care wouldn't  
32 want to know yet because we'd need to see if we could manage it under a SAF and a TAC. Then we would invite  
33 Housing as well to say come on what's going on with the housing, what are you doing about it? Yes, so we could  
34 start addressing those needs, definitely. We certainly wouldn't just leave it but hopefully SAFs and TACs have  
35 already been arranged but if not we would do it.

36  
37 R: Are there any challenges that you would anticipate in achieving the appropriate level of support for the family?



1 HV: No, not really apart from the fact I don't, I was just about to say I've not known a midwife to attend a TAC  
2 but that's not true because I've had two TACs recently; one that I led and a midwife came along and one that  
3 Barnardo's are leading and a midwife came along and she actually went out of her way to come along after a  
4 nightshift which I thought was brilliant. Honestly, she was very, very good and it was a very, very long TAC, very  
5 challenging. So, but no because I think if something is as important as this if that's my family I would just put in  
6 place everything they need and push for what they haven't got and I'm sure every other health visitor would do  
7 it.

8  
9 R: Great. OK, well we're going to go on to our final.

10  
11 HV: OK.

12  
13 R: Have a look at that one.

14  
15 HV: Okey doke.

16  
17 R: OK, so in your experience what are the advantages of being colocated with other agency professionals in the  
18 same building? So this little scenario there obviously you are in the same place, all the other professionals are  
19 about and you maybe have concerns and you just wanted to have an informal discussion. So, is that a regular, is  
20 that an advantage to collocation?

21  
22 HV: Yes, definitely, it's definitely an advantage because obviously before it's quite a process, not now, but it's  
23 quite a process to get through to a social worker for example. You had to ring the Civic, they wanted the mum's  
24 name, the child's name, the date of birth and then if they couldn't find it on their system, well sorry I can't find  
25 it on our system, well just put me through to a social worker. So that was quite hard, sometimes, to get through  
26 to a social worker but obviously collocating with them now it would be quite advantageous because then I could  
27 maybe go and have a word with whoever the duty social worker is to see if maybe young mum with learning  
28 needs, toddler and baby on the way, maybe needs some advice on whether this child and the unborn should be  
29 on some sort of plan but that's possibly going a bit heavy handed, you know, [recording just ends]

30  
31 **End of Interview**