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## "Just an extra pair of hands"? Obstetric service users' and professionals' views towards 24-7 consultant presence on a maternity unit: A thematic analysis

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3 **Full title: “Just an extra pair of hands”? Obstetric service users’ and professionals’**  
4 **views towards 24-7 consultant presence on a maternity unit: A thematic analysis**  
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## **Abstract**

### **Objectives**

To explore the views of maternity service users and professionals towards obstetric consultant presence 24 hours a day, 7 days a week.

### **Design**

Semi-structured interviews conducted face-to-face with maternity service users and professionals in March and April 2016. All responses were analysed together (i.e. both service users' and professionals' responses) using an inductive thematic analysis.

### **Setting**

A large tertiary maternity unit in the North West of England that has implemented 24-7 obstetric consultant presence.

### **Participants**

Antenatal and postnatal inpatient service users (n=10), midwives, obstetrics and gynaecology speciality trainees and consultant obstetricians (n=10).

### **Results**

Five themes were developed: 1) *'Just an extra pair of hands?'* (The consultant's role), 2) *The context*, 3) *The team*, 4) *Training*, 5) *Change for the consultant*. Respondents acknowledged that obstetrics is an acute speciality and consultants resolve intrapartum complications. However, variability in consultant experience and behaviour altered perception of its impact. Service users were generally positive towards 24-7 consultant presence but were not aware that it was not standard practice across the UK. Professionals were more pragmatic and discussed how the implementation of 24-7 working had affected their work, development of trainees and potential impacts on future consultants.

### **Conclusions**

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2  
3 The findings raised several issues that should be considered by practitioners and policy-  
4 makers when making decisions about the implementation of 24-7 consultant presence in other  
5 maternity units, including attributes of the consultants, the needs of maternity units, the team  
6 hierarchy, trainee development, consultants' other duties and consultant absences.  
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### 10 11 12 13 **Strengths and limitations of this study**

- 14  
15 • To our knowledge this is the first study to qualitatively explore views towards 24-7  
16 consultant presence in any speciality.  
17
- 18 • A diverse sample of service users was recruited in terms of ethnicity, (anticipated)  
19 mode of birth and antenatal and postnatal women.  
20
- 21 • All professionals were white females and therefore the views of males and  
22 professionals of other ethnicities were not captured in this study which may limit the  
23 transferability of findings.  
24
- 25 • The service users were sampled from a large tertiary unit, specialising in complex  
26 births and therefore, the findings should be extrapolated to non-tertiary units with  
27 caution.  
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## **Introduction**

In the United Kingdom (UK) maternity care for low-risk women is midwifery-led. Involvement of obstetricians occurs when a woman's pregnancy and/or birth is deemed high-risk or intrapartum complications occur.<sup>1</sup> In response to the burden of obstetric complications, rising birth rate and medicolegal claims, national organisations have recommended that obstetric consultant presence should be increased in UK NHS maternity units.<sup>2-7</sup> Recently, guidelines have shifted focus to extend consultant presence to seven days a week.<sup>8</sup> Whilst recommendations imply that increased consultant presence in the maternity unit translates into safer labour and delivery outcomes, there is a lack of evidence to demonstrate that this is the case.<sup>9,10</sup>

A meta-analysis of six studies compared resident consultant presence to on-call consultant cover and found that the risk of instrumental delivery was 14% higher in the on-call group than the resident group.<sup>11</sup> A larger meta-analysis of 15 studies comparing maternal and neonatal outcomes during increased consultant presence found that the likelihood of emergency caesarean section decreased and likelihood of normal vaginal delivery increased when hours of rostered consultant presence per week increased.<sup>12</sup> However, studies that compared times during no consultant presence (e.g., a registrar-led shift) versus a consultant-led shift or compared weekend consultant presence with weekday consultant presence showed no significant difference in outcome. Thus, something other than consultant presence impacts upon obstetric outcomes, such as concomitant increase in midwifery staffing or strengthened cohesiveness of the team. Consultant presence 24 hours a day, 7 days a week (24-7 CP) may also affect service users (SUs) and staff in ways that cannot be detected using quantitative measurements of outcomes alone.

In September 2014, St. Mary's Hospital, Manchester, implemented 24-7 CP; one of a small number of hospitals to do this. A recent commentary highlighted the need to investigate

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3 staff provision in maternity units through quantitative and qualitative approaches and  
4 recommended the exploration of patient and staff perceptions.<sup>13</sup> As qualitative methodology  
5 offers flexibility and scope to capture the impact beyond quantitative measurements of  
6 obstetric outcome, this study aimed to a) understand how SUs and professionals at this unit  
7 viewed and experienced 24-7 CP and b) highlight any issues around 24-7 CP on the maternity  
8 unit that could further improve SU and professionals' experiences.  
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## 16 **Methods**

### 17 **Participants**

18 SUs were included if they were 18 years or older and inpatients at St. Mary's maternity unit  
19 after 28 weeks gestation or prior to discharge after giving birth. Women with limited ability  
20 to speak and understand English were excluded due to difficulties in obtaining informed  
21 consent and conducting interviews. Eligible professionals were over 18 years old and  
22 included midwives, obstetrics and gynaecology speciality trainees (ST1-ST7) and consultant  
23 obstetricians.  
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### 37 **Procedure**

38 Eligible SUs were identified by a member of the clinical team. Professionals were  
39 approached by email and during team handovers. Prior to the interview, participants were  
40 asked to provide written consent and demographic information. Interviews were conducted  
41 face-to-face by HR in a private office or by the woman's bedside. Two semi-structured  
42 interview schedules were developed; one for SUs and one for professionals (see Appendix S1  
43 and S2) and were initially piloted with two service users and two professionals. Interviews  
44 were audio-recorded and lasted 10 to 25 minutes. All interviews were professionally  
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3 transcribed verbatim and all transcripts were double checked for consistency. Pseudonyms  
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5 were used and identifiable information was removed.  
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### 8 9 **Analysis**

10 Inductive thematic analysis was used and adopted a realist epistemology, which asserts truth  
11 is as it appears.<sup>14</sup> Triangulation of findings by realist researchers demonstrates more  
12 reliability across the findings.<sup>14</sup> The analysis employed an interrelated data collection and  
13 analysis process in order to focus on emerging matters of interest in subsequent interviews.<sup>15</sup>  
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15 All transcripts were analysed together following the step-by-step guide outlined in Braun and  
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Clarke.<sup>16</sup>

### 26 27 **Reflexivity and methodological quality**

28 Reflexivity sees the researcher consider their position and influence on the research and it can  
29 be used to promote rigour.<sup>17</sup> HR, a Research Assistant, is a female with no experience of  
30 childbirth but experience of interviewing mothers and fathers during the postnatal period. HR  
31 had no prior relationship with the participants prior to the study commencement. AW is a  
32 senior lecturer, clinical psychologist and mother, has extensive experience of and expertise in  
33 perinatal mental health and qualitative research. SV is a consultant obstetrician (since 2001)  
34 and a mother. AH is an academic consultant obstetrician with over 10 years of working at this  
35 unit and a father. All authors met regularly to discuss recruitment, the interview schedules,  
36 data collection and theme development.  
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48 Theoretical and methodological memos were recorded throughout the research to  
49 record additional points of interest during the interviews and to record any decisions made by  
50 the research team.  
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## **Results**

### **Sample**

During March and April 2016 we recruited a convenience sample of 10 SUs and 10 professionals, whereby data saturation was reached (see Tables 1 and 2 for SUs' and professionals' demographics, respectively).

### **Findings**

Five broad themes were developed with 10 corresponding sub-themes: 1) *'Just an extra pair of hands?'* (*The consultant's role*), 2) *The context*, 3) *The team*, 4) *Training*, 5) *Change for the consultant* (see Figure 1 for thematic diagram). Antenatal and postnatal SUs, trainees, midwives and consultants provided data for themes 1, 2 and 3. Trainees, midwives and consultants contributed to theme 4, and theme 5 only consisted of consultants' contributions. Diversity is reported to ensure openness regarding disconfirmatory findings. Quotations are presented to facilitate judgements of trustworthiness in Table 3.

#### ***Theme 1: 'Just an extra pair of hands?' (The consultant's role)***

Many SUs and professionals mentioned consultants as supernumerary. The theme title was taken from their descriptions of consultant input as *"an extra person"* (Helen, Postnatal) and *"it's more pairs of hands than necessarily needing the seniority"* (Karen, Consultant). The theme was equally salient for both SUs and professionals and outlines how they viewed the consultant's role both positively and negatively with regards to 24-7 CP. This theme was divided into three subthemes: *Prevention of poor outcomes*, *The job title* and *Variability between consultants*.

#### ***Prevention of poor outcomes***

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3 This subtheme consisted of mostly positive views towards 24-7 CP. SUs often perceived  
4 consultants to be the individuals who made decisions and could rectify intrapartum problems  
5 quickly; speed and decision-making were mentioned in the majority of SUs' responses. Very  
6 few SUs and professionals provided an experience when a consultant had been required to  
7 prevent a poor outcome. However both spoke about the need to have a consultant  
8 prospectively, i.e. the consultant's ability to prevent poor outcomes. Specifically, trainees  
9 were fearful of negative outcomes when a consultant was not available to support them  
10 quickly. However, consultants often cited the limited evidence to support increased  
11 consultant presence and did not comment on whether they felt it had a positive impact on  
12 patient outcomes.  
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### 26 ***The job title***

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28 Responses were mixed with regards to whether consultant presence on a maternity unit was  
29 essential. Some professionals felt that a consultant should be present 24-7 in the same way as  
30 other members of the team were (e.g., midwives). The identity as a consultant-led unit was  
31 used to strengthen the argument for continuous consultant presence. However, trainees and  
32 consultants felt that SUs did not understand the staff hierarchy and therefore SUs did not  
33 differentiate between consultant-, trainee- or midwifery-care. Thus, from a SU's view,  
34 competent medical care provided by any labour ward professional was more important than  
35 the job title of the provider. Furthermore, some SUs voiced negative views towards  
36 consultants' continual presence on the unit, expressing that having rapport with other  
37 professionals and very limited contact with consultants negated the need for 24-7 CP.  
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### 52 ***Variability between consultants***

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3 Some SUs expressed that 24-7 CP was a positive change, but this was dependent on  
4 individual consultants. Professionals, particularly consultants, stated that variable behaviour  
5 and abilities of consultants could compromise the impact of 24-7 CP. The implementation of  
6 24-7 CP required that several new consultant posts were filled. One consultant strongly  
7 expressed concerns that rapid filling of these posts had resulted in the appointment of  
8 consultants with varying competence, inferring that consultants' skills and attributes should  
9 be considered alongside their presence on the unit.  
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### 20 ***Theme 2: The context***

21 Participants often compared the area of obstetrics to other areas of medicine and/or the unit to  
22 other maternity units in order to highlight the reasons why 24-7 CP was a positive change.  
23 This theme, pertinent for both SUs and professionals, encapsulates the contextual factors that  
24 surround birthing and the maternity unit. It was divided into three subthemes: *This unit is*  
25 *different*, *Characteristics of birth* and *Expected as standard*.  
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#### 35 ***This unit is different***

36 All SUs cited the unit's reputation and the perceived expertise of professionals as a reason for  
37 choosing to give birth at St. Mary's, often expressing that they felt safer than at other  
38 maternity units. However, as most SUs were not aware that the unit has been providing 24-7  
39 CP or that this cover is not routinely implemented nationwide; they did not cite this as a  
40 reason for perceiving the unit as different to others. The varied, high-risk and complex patient  
41 population cared for by the unit was cited as a feature which made St. Mary's different to  
42 other units and was the main reason given for the necessity of 24-7 CP by professionals.  
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51 Some believed that complexity and risk would only increase in the future.  
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### ***Characteristics of birth***

The varied and unpredictable nature of labour and birthing was also deemed an important reason for 24-7 CP, although more salient for SUs. The potential for ‘things to go wrong quickly’ was expressed by both professionals and SUs as a unique characteristic of obstetrics as opposed to other specialities. Interestingly, the issue of unpredictability during birth was focused on more by postnatal SUs, perhaps because they were able to consider and articulate the risks of birth. Professionals held similar views, that complications could arise quickly, obstetrics is an area of medicine that is truly 24-7 and indicated that consultant presence was needed due to these characteristics.

### ***Expected as standard***

It came as a surprise to all SUs that not all maternity units have 24-7 CP because they had expected that it was standard practice. Hence, they expressed appreciation for St. Mary’s but also overwhelmingly endorsed that it should be a requirement for all maternity units.

Although this subtheme was more pertinent to SUs, one professional also highlighted SUs’ expectation of continual consultant presence.

### ***Theme 3: The team***

The impact of 24-7 CP on the workings of the multidisciplinary maternity team was an important issue raised. Although a more pronounced theme for professionals, particularly midwives, some SUs discussed multidisciplinary relationships. The theme, divided into the subthemes of *The hierarchy* and *Working relationships*, outlines the mixed views towards the relationships between consultants and other professionals and the consultants’ position within the team.

### ***The hierarchy***

The leadership provided by 24-7 CP due to the consultant's position within the team hierarchy was viewed favourably. SUs expressed that the consultants' authority was a support for other professionals and professionals reported that consultants directed the team and took responsibility; it was suggested this started to occur more when 24-7 CP was implemented. Thus, strong leadership was valued by other professionals in this team. However, one consultant reported that midwives were less likely to seek the support of trainees, favouring the authority of consultants, which could disadvantage trainees' professional development.

### ***Working relationships***

In contrast to the desire for a consultant leadership role, some participants expressed negative views regarding working relationships between consultants and midwives. Some SUs felt that midwives were not able to voice their opinion when clinical decisions were being made which was particularly salient for SUs who had a negative experience of consultant contact. Although this was not discussed as a perceived consequence of the change to 24-7 CP, it was suggested that this strain on working relationships occurred more frequently. However, some midwives felt that the similar working hours had a positive impact, made the team more cohesive and reduced the power imbalance between the two professional groups.

### ***Theme 4: Training***

Although views were mixed, all professionals spoke about how the training of midwives and trainees had been affected by 24-7 CP. The theme, pertinent to trainees and consultants, was divided into two subthemes: *Teaching* and *Trainees' development*.

#### ***Teaching***

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3 Two factors for improving training were identified: time and consultant engagement.

4 Trainees and consultants felt there were more opportunities for out-of-hours training and  
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6 midwives also reported that they learnt more from consultants than trainees due to  
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8 consultants' knowledge and time to train others. However, the role of consultant engagement  
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10 was highlighted by trainees and consultants: although consultants were on the unit out-of-  
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12 hours, this could actually reduce consultant engagement in training others. One consultant  
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14 stated that consultants were more inclined to carry out procedures themselves out-of-hours  
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16 than train others in order to save time.  
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### 22 ***Trainees' development***

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24 Although professionals held some favourable views towards the impact of 24-7 CP on  
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26 training opportunities, they expressed negativity when discussing the development of trainees  
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28 as consultants of the future. Both trainees and consultants felt 24-7 CP could reduce trainees'  
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30 autonomy, confidence, clinical judgement and their ability to cope with stress. Participants  
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32 spoke of how the presence of a more senior clinician impeded trainees' ability to develop  
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34 autonomy as practicing doctors; an important issue to be acknowledged by other maternity  
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36 units and specialties considering implementing 24-7 CP.  
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### 42 ***Theme 5: Change for the consultant***

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44 Consultants spoke about how their lives had changed as a result of 24-7 CP, both in and out  
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46 of the unit. This theme was one of the main focal points of consultants' responses and  
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48 encapsulates the issues that have and will affect consultants' lives. Responses were more  
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50 anecdotal for this theme and consultants drew on their positive and negative experiences  
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52 before and after the implementation.  
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3 Many consultants expressed concerns regarding the competency of trainees under *Trainees'*  
4 *development*, but this issue was also raised in relation to consultant workload. Consultants,  
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6 who felt that trainees' capabilities had reduced, also felt that consultants were now required  
7  
8 to do lower-grade work to fill the skills-gap of the trainees.  
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11 Change to the length of consultants' shifts was also deemed a consequence of the  
12  
13 implementation. Prior to 24-7 CP, consultants could work their rostered shift in the hospital  
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15 then stay on-call from home (with the possibility of being called to the hospital). Hence  
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17 consultants could have worked for 24-48 hours, whereas, since 24-7 CP, consultants work set  
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19 shifts on the unit of 12.5 hours. This consequence was viewed positively because of the  
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21 certainty that consultants could rest after a shift.  
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24  
25 Some consultants reported that 24-7 CP had had a negative impact on consultants'  
26  
27 professional development opportunities. The issue of balancing off-ward duties, such as  
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29 meetings, with wards shifts was difficult, especially when working on the night-rota and  
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31 because NHS management operate in office hours. Furthermore, issues for workers such as  
32  
33 management of absences, and the impact they have on the labour ward team, were also  
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35 highlighted as an area that required improvement when looking ahead.  
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## 38 39 **Discussion**

### 40 41 **Main findings**

42  
43 Five themes and 10 subthemes were developed. Both SUs and professionals acknowledged  
44  
45 that consultants resolved intrapartum complications, in an acute speciality in which  
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47 complications arise quickly, although the effect was dependent on individual consultants'  
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49 skills and behaviour. SUs responses were generally positive towards the implementation and  
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51 they were surprised when made aware that 24-7 CP was not standard practice across the UK.  
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3 Professionals' responses were more pragmatic and included how 24-7 CP had affected their  
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5 own work, development of trainees and the impact on the consultants of the future.  
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### 8 9 **Strengths and limitations**

10 To our knowledge this is the first study to qualitatively explore views towards 24-7 CP in any  
11  
12 speciality and addresses Prior et al.'s<sup>13</sup> call for research to explore perceptions in relation to  
13  
14 staff provision in maternity units. Furthermore, a diverse sample of SUs was recruited in  
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16 terms of ethnicity, (anticipated) mode of birth and antenatal and postnatal women. However,  
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18 all professionals were white females and therefore the views of males and professionals of  
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20 other ethnicities were not captured in this study and may limit the transferability of findings.  
21  
22 However, 79% of speciality trainees are women,<sup>18</sup> and midwifery is overwhelmingly female  
23  
24 (in 2001 the midwifery workforce in England and Wales was 99% female and 1% male).<sup>19</sup>  
25  
26 Furthermore, the service users were all inpatients at St. Mary's which suggests they had  
27  
28 chosen to give birth in a hospital or were required to receive hospital care. Some women in  
29  
30 high-income countries are choosing to give birth away from the labour ward setting.<sup>20</sup>  
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32 Although, these individuals may not be directly affected by the move to 24-7 CP, qualitative  
33  
34 researchers should approach such individuals in order to obtain more varied views towards  
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36 consultant presence. Finally, St. Mary's is a large tertiary unit, specialising in complex births  
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38 and admits women from a large geographical area. Therefore, these findings should be  
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40 extrapolated to non-tertiary units with caution.  
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### 50 **Interpretation**

51 Participants spoke of consultants' ability to rectify intrapartum problems and make decisions  
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53 quickly, suggesting that an increase in consultant presence would improve patient outcomes.  
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3 However, the impact of increased consultant presence on outcomes is not fully understood<sup>9-12</sup>  
4 and this was highlighted by consultants. Participants also believed that SUs were happy to be  
5 seen by any competent member of staff not just a consultant. This view is disputed in the  
6 surgical literature, which advocates that the consultant role is a 'quality kite mark' and  
7 reduces a patient's concern about whether they are receiving the best quality care as well as  
8 worrying about their illness.<sup>21</sup> However, maternity services in the UK are organised  
9 differently to other specialities and a normal birth is not a medical procedure. Most women  
10 (57%) report just seeing a midwife during pregnancy and birth<sup>22</sup> and consultant intervention  
11 is not deemed a necessity in all births. Therefore, the consultant job title alone was not reason  
12 enough to implement 24-7 CP. Furthermore, the variability of consultants' behaviour and  
13 attributes was seen as an issue that could compromise the impact of 24-7 CP. Attitudes and  
14 behaviours of caregivers have been found to influence women's birth experiences more than  
15 pain relief and intrapartum interventions.<sup>23</sup>

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18 As a large, tertiary maternity unit, St. Mary's cares for a high-risk, complex  
19 population. Increasing case complexity is cited as one of the drivers for increasing obstetric  
20 consultant presence.<sup>24</sup> However, this rationale is not fully applicable to smaller non-tertiary  
21 units. Participants noted the acute and unpredictable nature of complications in pregnancy  
22 and birth. Women were aware that emergencies can happen during birth as described in  
23 Larkin et al.'s<sup>25</sup> mixed methods study, which found women preferred not to have a consultant  
24 present during the birth but appreciated their presence during an emergency. To attend in  
25 such circumstances requires 24-7 CP and this study found that SUs expected 24-7 CP as  
26 standard across all maternity units. As 80% of women were not aware of the four possible  
27 places to give birth (home, freestanding midwifery unit, alongside midwifery unit, consultant-  
28 led unit),<sup>22</sup> the reason all SU respondents felt 24-7 CP should be standard may be due to an  
29 inaccurate perception that all maternity units are consultant-led.

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3 Although participants highlighted that 24-7 CP could strain working relationships, the  
4 benefits of consultants' leadership at the top of the hierarchy for the team was highlighted.  
5  
6 The Royal College of Obstetricians and Gynaecologists states "the consultant's role starts with  
7 demonstrating leadership: teaching and supporting trainees, midwives and nurses at all  
8 times".<sup>6</sup> However, midwives describe finding it difficult to facilitate normal births in an  
9 obstetric-led unit due to the obstetrician's powerful position at the top of the hierarchy and  
10 dominant decision-making.<sup>26</sup> This raises the question of whether more detailed guidance on  
11 how consultants should support other professionals is needed to ensure a more cohesive  
12 labour ward team.  
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22 Trainees and consultants highlighted that 24-7 CP should result in more training  
23 opportunities out-of-hours. A systematic review of several specialities found enhanced  
24 supervision of trainees had a positive impact on patient- and education-related outcomes.<sup>27</sup>  
25  
26 Despite this, respondents identified that in practice this increased supervision could also have  
27 a negative impact on trainee development; an issue also identified in a debate against 24-7 CP  
28 on the labour ward.<sup>28</sup> A more in-depth analysis of confidence, clinical judgement and  
29 obstetric ability of trainees trained in hospitals of varying levels of consultant presence  
30 should be undertaken to shed light on this important issue for the future.  
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40 Consultants were positive towards the predictability of shift-duration and appreciated  
41 uninterrupted rest when at home. However, they also felt they were carrying out more low-  
42 grade work, struggled to balance day-time duties when working night-shifts and that absences  
43 were not managed adequately. These negative issues highlight the importance of thorough  
44 preparation prior to implementing a change to consultant working and future consultations  
45 with staff offer a direction to resolve these issues.  
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## Conclusion

This is the first qualitative study to understand how maternity SUs and professionals view 24-7 CP. The findings raised several major issues that should be considered by practitioners and policy-makers when deciding whether to implement 24-7 CP in maternity units across the UK. These issues were the attributes of the consultants, necessity on non-tertiary units, the team hierarchy, trainee development, consultants' other duties and consultant absences. This study paves the way for more detailed research into each of these issues, which is required for further evaluation of 24-7 working and to further improve maternity services.

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### **Competing interests**

All authors have completed the ICMJE uniform disclosure form at [www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) and declare: no financial, personal or other relationships with other people or organisations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, the submitted work.

### **Contributors**

HR, AW, SV and AH contributed to the study concept and design. HR conducted all interviews. HR, AW and AH contributed to the analysis and interpretation of the data.

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3 HR developed the first draft of the manuscript and AW, SV and AH revised all manuscript  
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5 drafts and approved the final version.  
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9 **Data sharing statement**

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11 No additional data are available from a repository. Anonymised transcripts are available on  
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13 request.  
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17 **Ethical approval**

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19 The study was approved by the 'South Central – Hampshire A' Research Ethics Committee  
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**Table 1.** Service users' demographics**Antenatal**

Pseudonym	Age (years)	Ethnicity	Marital status	Educational attainment	Occupation	Birth risk (low/moderate/high)	Gestation (weeks)	Anticipated mode of delivery	Number of other child(ren)	Age(s) of other child(ren) (years)	Previous mode(s) of delivery
Amelia	22	White	Cohabiting	A-levels	Part-time student	High	33	NVD	2	4 / 2	NVD / NVD
Jessica	27	White	Married	Undergraduate	Dental nurse	Moderate	30	EICS	1	4	EmCS
Natasha	29	Black	Married	GCSE	Care worker	High	28	NVD	3	9 / 8 / 5	NVD / NVD / NVD
Lindsey	30	White	Married	GCSE	Legal PA	High	38	EICS	0	-	-
Claire	31	White	Cohabiting	Undergraduate	Retail manager	Moderate	39	NVD	0	-	-

**Postnatal**

Pseudonym	Age (years)	Ethnicity	Marital status	Educational attainment	Occupation	Birth Risk (low/moderate/high)	Age of baby(s) (days)	Mode of delivery	Number of other child(ren)	Age(s) of other child(ren) (years)	Previous mode(s) of delivery
Helen	39	White	Married	GCSE	Administrator	High	3	EICS	1	15	EmCS
Sarah	32	White	Married	A-levels	Nursing assistant	Low	1	NVD	2	4 / 2	NVD / NVD
Ava	34	Asian	Married	Postgraduate	Solicitor	Low	1	Forceps	0	-	-
Ella	27	White	Cohabiting	GCSE	Clerical officer	High	5	EmCS	0	-	-
Katie	35	White	Cohabiting	GCSE	Caterer	High	6	NVD	1	17	NVD

EICS = elective caesarean section, EmCS = emergency caesarean section, NVD = normal vaginal delivery.

**Table 2.** Professionals' characteristics

Pseudonym	Gender	Age (years)	Ethnicity	Marital status	Post	Time in post (years)
Karen	Female	45	White	Married	Consultant	5
Carla	Female	35	White	Married	Consultant	0.75
Annie	Female	42	White	Married	Consultant	4.5
Cathy	Female	45	White	Cohabiting	Consultant	5
Jocelyn	Female	31	White	Cohabiting	ST1	0*
Imogen	Female	33	White	Cohabiting	ST6	1.5
Erin	Female	32	White	Married	ST4	
Olivia	Female	28	White	Single	Midwife	
Milly	Female	24	White	Cohabiting	Midwife	
Beth	Female	54	White	Married	Midwife	

\*not employed at St. Mary's prior to the implementation of 24-7 consultant presence

ST = speciality trainee

**Table 3.** Representative quotations to illustrate themes 1, 2, 3, 4 and 5

Themes	Subthemes	Quotes	
1. 'Just an extra pair of hands?' (The consultant's role)	1.1 Prevention of poor outcomes	"...you would want consultants to be there and making all the major decisions" (Sarah, Postnatal).	
		"A consultant can just make that decision there and then... whereas the doctors have got to wait then go and speak to their consultant" (Ella, Postnatal)	
		"If I'm a trainee at a district hospital and I'm the only one at night time and I have to wait for my consultant to come on site... you're in a position where something could potentially really go wrong and that support might not be there" (Jocelyn, ST1)	
	1.2 The job title	"The main problem is there isn't any evidence that it improves patient care" (Cathy, Consultant)	
		"in a consultant-led, high-risk unit you need to have a consultant there 24/7, you wouldn't have a midwifery-led unit without midwives overnight" (Milly, Midwife)	
		"I think the reality is for most women in labour, they're pretty happy to see a doctor. Most people don't actually understand the difference between a junior reg[istrar] and a senior reg[istrar]. Quite frankly, as a woman in obstetrics, they just think you're the midwife anyway, so it doesn't really matter" (Erin, ST4)	
		"I don't think it makes much difference because you don't really get to see them" (Katie, Postnatal)	
	1.3 Variability between consultants	"If you've got a good rapport with the midwife, I don't see why the consultants necessarily need to be present all the time" (Lindsey, Antenatal)	
		"It is a good idea depending on the consultants" (Katie, Postnatal)	
		"I do think there are some of the consultants who still go to bed... who maybe go to bed inappropriately and there are some incidents coming through where, actually, that consultant should have been present and they're not" (Karen, Consultant)	
	2. The context	2.1 This unit is different	"I think the filling of 10 posts all at the same time, which we didn't achieve, but even trying to do that all at the same time meant that we've appointed some people who, if we'd only been appointing one or two people, wouldn't have got appointed" (Cathy, Consultant)
			"They tried to move us to [another hospital], but I know that this has got a really good reputation for the maternity, so I opted to stay here" (Lindsey, Antenatal)
		2.2 Characteristics of birth	"I thought it was the best hospital, and with having twins, with all the top doctors" (Katie, Postnatal)
"The kind of things that we get here are not anywhere near as simple as other units. Here we get life threatening haemorrhages at four to eight litres, in another smaller unit like the tiny one I was working in before I came here, they would consider 500mls, which here is a normal blood loss, they consider that serious" (Imogen, ST6)			
"We are such a high-risk unit, you need to have that consultant input constantly" (Beth, Midwife)			
2.3 Expected as standard		"every woman is different, every baby is different and every situation is different so here it is very important to have a consultant with that" (Jessica, Antenatal)	
		"...just in case things go wrong, things can quite quickly go wrong" (Helen, Postnatal)	
		"I think it can only ever be a good thing, especially if you're in obstetrics which is so quick in how things can so suddenly deteriorate" (Erin, ST4)	
		"I wasn't very aware of it [24-7CP] at all actually" (Ava, Postnatal)	
			"I can't even believe that I didn't know that they didn't have a consultant on 24-7 everywhere else" (Ella, Postnatal)
	"So we are the lucky ones... I think it should be spread to every hospital in England. It is not only Manchester or St. Mary's that people would need consultants" (Natasha, Antenatal)		

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		<i>"The general public expect to be seen by a consultant day or night, and I think it's the way that most acute specialities are going to go"</i> (Carla, Consultant)
		<i>"I think it's support for the midwives as well because you could have a really inexperienced midwife that is put in a position and if they don't have that authority to go to and ask that question or make that decision on the ward, then it's not really fair on them"</i> (Claire, Antenatal)
3. The team	3.1 The hierarchy	<i>"Before we kind of felt a bit like we were just left to our own devices, no one wanted to take charge or responsibility for the postnatal ward... we needed a bit of control from consultants in order to help us manage it more effectively"</i> (Olivia, Midwife)
		<i>"One negative that I could potentially see from it is that the midwives might tend to, not ignore, but not go to the junior doctors if they know that there is someone senior there that's able to make a definite decision"</i> (Carla, Consultant)
		<i>"I just don't like the fact that the midwives aren't able to say anything. It's up to the consultant"</i> (Lindsey, Antenatal)
	3.2 Working relationships	<i>"There's a bit more of, how shall I say it, butting of heads if you like from certain people. They just want it done their way because they're in charge"</i> (Beth, Midwife)
		<i>"I guess it breaks down barriers between us and them, because if they're doing the same terrible shifts then you know that they're not just swanning in as and when they feel like it. They're doing the grind, they're doing the nights and weekends... you feel that you're all in it together, rather than them kind of lording it over you when they come in"</i> (Milly, Midwife)
		<i>"I have a bit more knowledge than them [junior doctors] on certain things. So I don't feel I learn as much from junior doctors whereas I learn more from consultants who sometimes have a bit more time or a bit more knowledge about certain things"</i> (Olivia, Midwife)
		<i>"you get better training overall, because I think you have access to supervision 24-7, there's more availability to get supervised in more procedures out of hours"</i> (Erin, ST4)
	4.1 Teaching	<i>"Even though you have the so-called presence of a consultant it also depends on how much they're involved with or their engagement with trainees"</i> (Jocelyn, ST1)
		<i>"They should get better training in the middle of the night on delivery suite because we are there. Equally there can be more of a temptation to just get on and do it because it's three in the morning and if you do it yourself, you're back doing something else in 20 minutes rather than 40 minutes"</i> (Cathy, Consultant)
4. Training		<i>"I think one problem with 24-7 consultant presence is some of our junior registrars, there are one or two who are relaxed all the time from an educational putting-themselves forward perspective... I think actually you can then get away with a hell of a lot because they constantly step back... the more senior they get, the more the stress increases. If they don't learn that and learn to cope with that early on, they're never going to manage as a consultant"</i> (Imogen, ST6)
	4.2 Trainees' development	<i>"I know some of my colleagues, when I was a registrar, felt that the presence of a consultant there could be quite interfering and perhaps they wouldn't be able to use their own clinical judgement and make independent decisions"</i> (Carla, Consultant)
		<i>"If individuals are never left to make decision on their own, they never learn that autonomy to be able to make decisions. I think that's one issue that we will find moving forward, the consultants of the future will be much less experienced"</i> (Annie, Consultant)
5. Change for the consultant	-	<i>"Junior doctors are becoming less and less competent at the sort of things that I might have been competent at as a senior registrar and so more and more you find yourself needing to do things that as a senior registrar or a registrar I would have dealt with without bothering a consultant"</i> (Annie, Consultant)
		<i>"I don't care how busy I am, because the most I'm normally going to be in is 13 hours. I don't have that nagging feeling all the time - 'am I going to have to try to keep this pace for 24 hours?'"</i> (Karen, Consultant)

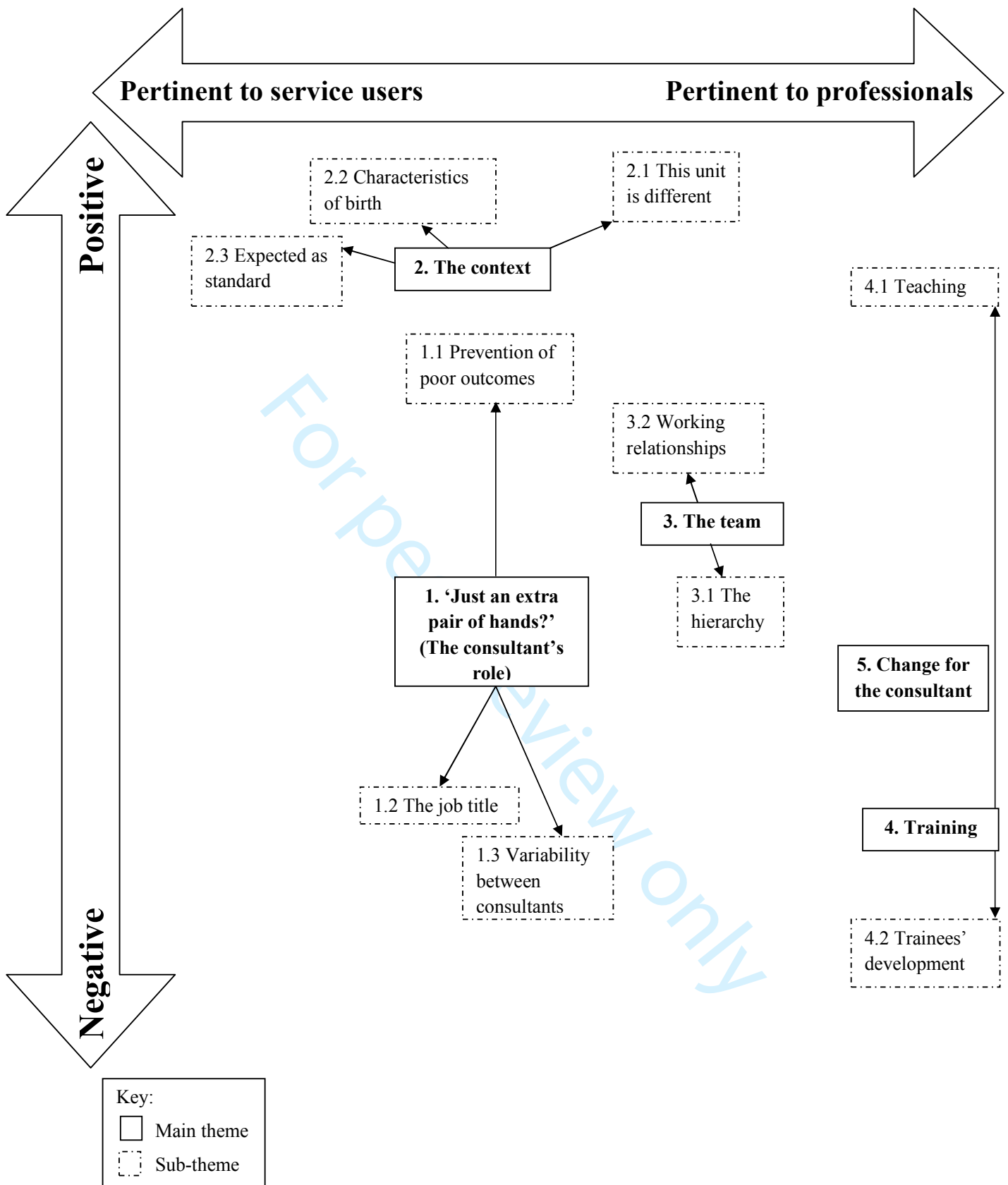
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3 *“It makes work much more difficult because the day before and the day after night shift, you’re*  
4 *technically not in work meetings even though I think I’m reasonably good at planning... The Trust*  
5 *[...] is terrible at giving you a week’s notice - ‘we’ve changed that meeting to that date’. Then if*  
6 *it’s the day after your night on call you either don’t go or you go when you’re supposed to be in*  
7 *recovery time” (Cathy, Consultant)*

8 *“I think one of the big problems with it is that we didn’t quite anticipate how you manage sick leave*  
9 *and short-term absences, which I don’t think have been properly sorted out” (Annie, Consultant)*

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**Figure 1.** Thematic diagram of service users' and professionals' views of 24-7 obstetric consultant presence.

**Appendix S1.** Semi-structured interview schedule for service users

**Opening Statement:**

**Thank you for participating in this research study investigating service user views towards 24-7 consultant presence at St. Mary's Hospital. My name is Holly Reid and I am a research assistant at the University of Manchester. Through this research we aim to describe the effect that 24-7 consultant presence has on patient care and birthing experiences. Do you have any questions?**

1. Why did you choose to give birth at St. Mary's?
  - Did you look at other units? If so, what made you choose St. Mary's?
2. How aware are you of 24-7 consultant presence on the maternity unit?
  - If they are not aware: **24-7 consultant presence was introduced to St. Mary's Hospital on 1<sup>st</sup> September 2014 and ensures that a consultant is available 24 hours a day 7 days a week.**
  - When/where did you hear about it?
3. What are your thoughts on consultants?
  - In general?
  - On a maternity unit?
4. What are your views on consultants being present at the unit?
5. Could you tell me about your experiences of St Mary's during your pregnancy/birth?
6. Could you tell me about how your family have experienced St Mary's during your pregnancy/birth (if involved)?
7. Was a consultant involved in the care of you/your baby at any point?
  - If so, how did you experience their involvement?
8. How do you feel about 24-7 consultant presence on the unit?
  - Why?
  - Have you ever felt differently? Why?



## Appendix S2. Semi-structured interview schedule for professionals

### Opening Statement:

**Thank you for participating in this research study investigating staff views towards 24-7 consultant presence at St. Mary's Hospital. My name is Holly Reid and I am a research assistant at the University of Manchester. Through this research we aim to describe the effect that 24-7 consultant presence has on staff's clinical work. Do you have any questions?**

1. How long have you been in your current role?
2. Could you tell me about how consultants are involved in your work?  
or  
Could you tell me about your duties as a consultant?
3. How aware are you of 24-7 consultant presence on the maternity unit?
  - If they are not aware: **24-7 consultant presence was introduced to St. Mary's Hospital on 1<sup>st</sup> September 2014 and ensures that a consultant is available 24 hours a day 7 days a week on the maternity unit.**
  - When/where did you hear about it?
4. How do you feel about 24-7 consultant presence on the unit?
  - Why?
  - Have you ever felt differently? Why?
5. Has 24-7 consultant presence changed your work in any way?
  - How has your work changed?
6. Could you tell me about any aspects of others' work that may have changed as a result of 24-7 consultant presence?
  - Work/life balance?
  - Dynamics of multidisciplinary team?
7. Could you tell me about any aspects of patient care that may have changed as a result of 24-7 consultant presence?
  - Mother and baby?
  - Family of mother and baby?
  - Antenatal vs. postnatal?

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# BMJ Open

## "Just an extra pair of hands"? A qualitative study of obstetric service users' and professionals' views towards 24-7 consultant presence on a single UK tertiary maternity unit

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3 **Full title: “Just an extra pair of hands”? A qualitative study of obstetric service users’**  
4 **and professionals’ views towards 24-7 consultant presence on a single UK tertiary**  
5 **maternity unit**  
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## 1 **Abstract**

### 2 **Objectives**

3 To explore the views of maternity service users and professionals towards obstetric  
4 consultant presence 24 hours a day, 7 days a week.

### 5 **Design**

6 Semi-structured interviews conducted face-to-face with maternity service users and  
7 professionals in March and April 2016. All responses were analysed together (i.e. both  
8 service users' and professionals' responses) using an inductive thematic analysis.

### 9 **Setting**

10 A large tertiary maternity unit in the North West of England that has implemented 24-7  
11 obstetric consultant presence.

### 12 **Participants**

13 Antenatal and postnatal inpatient service users (n=10), midwives, obstetrics and gynaecology  
14 speciality trainees and consultant obstetricians (n=10).

### 15 **Results**

16 Five themes were developed: 1) *'Just an extra pair of hands?'* (The consultant's role), 2) *The*  
17 *context*, 3) *The team*, 4) *Training*, 5) *Change for the consultant*. Respondents acknowledged that  
18 obstetrics is an acute speciality and consultants resolve intrapartum complications. However,  
19 variability in consultant experience and behaviour altered perception of its impact. Service  
20 users were generally positive towards 24-7 consultant presence but were not aware that it was  
21 not standard practice across the UK. Professionals were more pragmatic and discussed how  
22 the implementation of 24-7 working had affected their work, development of trainees and  
23 potential impacts on future consultants.

### 24 **Conclusions**

1  
2  
3 25 The findings raised several issues that should be considered by practitioners and policy-  
4  
5 26 makers when making decisions about the implementation of 24-7 consultant presence in other  
6  
7 27 maternity units, including attributes of the consultants, the needs of maternity units, the team  
8  
9 28 hierarchy, trainee development, consultants' other duties and consultant absences.  
10  
11 29

### 12 13 14 30 **Strengths and limitations of this study**

- 15  
16 31 • To our knowledge this is the first study to qualitatively explore views towards 24-7  
17  
18 32 consultant presence in any speciality.
- 19  
20 33 • A diverse sample of service users was recruited in terms of occupation, (anticipated)  
21  
22 34 mode of birth and antenatal and postnatal women.
- 23  
24 35 • All professionals were white females and therefore the views of males and  
25  
26 36 professionals of other ethnicities were not captured in this study which may limit the  
27  
28 37 transferability of findings.
- 29  
30 38 • The service users were sampled from a large tertiary unit, specialising in complex  
31  
32 39 births and therefore, the findings should be extrapolated to non-tertiary units with  
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34 40 caution.  
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## 50 **Introduction**

51 In the United Kingdom (UK) maternity care for low-risk women is midwifery-led.  
52 Involvement of obstetricians occurs when a woman's pregnancy and/or birth is deemed high-  
53 risk or intrapartum complications occur.<sup>1</sup> In response to the burden of obstetric  
54 complications, rising birth rate and medicolegal claims, national organisations have  
55 recommended that obstetric consultant presence should be increased in UK NHS maternity  
56 units.<sup>2-7</sup> Recently, guidelines have shifted focus to extend consultant presence to seven days a  
57 week.<sup>8</sup> Whilst recommendations imply that increased consultant presence in the maternity  
58 unit translates into safer labour and delivery outcomes, there is a lack of evidence to  
59 demonstrate that this is the case.<sup>9,10</sup>

60 A meta-analysis of six studies compared resident consultant presence to on-call  
61 consultant cover and found that the risk of instrumental delivery was 14% higher in the on-  
62 call group than the resident group.<sup>11</sup> A larger meta-analysis of 15 studies comparing maternal  
63 and neonatal outcomes during increased consultant presence found that the likelihood of  
64 emergency caesarean section decreased and likelihood of normal vaginal delivery increased  
65 when hours of rostered consultant presence per week increased.<sup>12</sup> However, studies that  
66 compared times during no consultant presence (e.g., a registrar-led shift) versus a consultant-  
67 led shift or compared weekend consultant presence with weekday consultant presence  
68 showed no significant difference in outcome. Thus, something other than consultant presence  
69 impacts upon obstetric outcomes, such as concomitant increase in midwifery staffing or  
70 strengthened cohesiveness of the team. Consultant presence 24 hours a day, 7 days a week  
71 (24-7 CP) may also affect service users (SUs) and staff in ways that cannot be detected using  
72 quantitative measurements of outcomes alone.

73 A recent commentary highlighted the need to investigate staff provision in maternity  
74 units through quantitative and qualitative approaches and recommended the exploration of

1  
2  
3 75 patient and staff perceptions.<sup>13</sup> As qualitative methodology offers flexibility and scope to  
4  
5 76 capture the impact beyond quantitative measurements of obstetric outcome, this study aimed  
6  
7 77 to a) understand how SUs and professionals at this unit viewed 24-7 CP and b) use these  
8  
9 78 views to identify any issues around 24-7 CP on the maternity unit that could further improve  
10  
11 79 SU and professionals' experiences.  
12  
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14 80

## 81 **Methods**

### 82 **Setting**

83 St Mary's Hospital, Manchester, UK is a tertiary maternity unit delivering over 9,000 babies  
84 per year. The maternity unit serves an ethnically and socially diverse population with a high-  
85 level of need. The population has high levels of deprivation and perinatal and child mortality.  
86 Maternity services in Manchester were reconfigured in 2012: two smaller adjacent units were  
87 closed and St Mary's capacity increased. 24-7 CP was introduced in St Mary's Hospital in  
88 September 2014.  
89

### 90 **Participants**

91 SUs were included if they were 18 years or older and inpatients at St. Mary's Hospital  
92 maternity unit after 28 weeks gestation or prior to discharge after giving birth, because  
93 consultants are involved in the care of antenatal as well as postnatal women. Women with  
94 limited ability to speak and understand English were excluded due to difficulties in obtaining  
95 informed consent and conducting interviews. Eligible professionals were over 18 years old  
96 and included midwives, obstetrics and gynaecology speciality trainees (ST1-ST7) and  
97 consultant obstetricians.  
98

### 99 **Procedure**



1  
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3 100 Eligible SUs were identified by a member of the clinical team who had been briefed on the  
4  
5 101 study eligibility criteria. Professionals were approached by email and during team handovers.  
6  
7 102 Prior to the interview, participants were asked to provide written consent and demographic  
8  
9 103 information. Interviews were conducted face-to-face by HR in a private office or by the  
10  
11 104 woman's bedside. Two semi-structured interview schedules were developed; one for SUs and  
12  
13 105 one for professionals (see Appendix S1 and S2) and were initially piloted with two service  
14  
15 106 users and two professionals. Both interview schedules were developed after careful  
16  
17 107 consultation of the existing literature and through several research group discussions. Both  
18  
19 108 interview schedules were amended after piloting to include clear explanations of what 24-7  
20  
21 109 CP is and specific prompts were added, which were informed by the pilot interviews.  
22  
23 110 Interviews were audio-recorded and lasted 10 to 25 minutes. All interviews were  
24  
25 111 professionally transcribed verbatim and all transcripts were double checked for consistency.  
26  
27 112 Pseudonyms were used and identifiable information was removed.  
28  
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### 34 114 **Analysis**

35  
36 115 Inductive thematic analysis was used and adopted a realist epistemology, which asserts truth  
37  
38 116 is as it appears.<sup>14</sup> Triangulation of findings by realist researchers demonstrates more  
39  
40 117 reliability across the findings.<sup>14</sup> All transcripts were analysed together following the step-by-  
41  
42 118 step guide outlined in Braun and Clarke.<sup>15</sup>  
43  
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### 47 120 **Reflexivity and methodological quality**

48  
49 121 Reflexivity sees the researcher consider their position and influence on the research and it can  
50  
51 122 be used to promote rigour.<sup>16</sup> HR, a Research Assistant, is a female with no experience of  
52  
53 123 childbirth but experience of interviewing mothers and fathers during the postnatal period. HR  
54  
55 124 had no prior relationship with the participants prior to the study commencement. AW, a  
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125 senior lecturer, clinical psychologist and mother, has extensive experience of and expertise in  
126 perinatal mental health and qualitative research. SV is a consultant obstetrician (since 2001)  
127 and a mother. AH is an academic consultant obstetrician with over 10 years of working at this  
128 unit and a father. All authors met regularly to discuss recruitment, the interview schedules,  
129 data collection and theme development.

130 Theoretical and methodological memos were recorded throughout the research to  
131 record additional points of interest during the interviews and to record any decisions made by  
132 the research team.

## 134 **Results**

### 135 **Sample**

136 During March and April 2016 (~18 months after introduction of 24-7 CP) we recruited a  
137 convenience sample of 10 SUs and 10 professionals, whereby data saturation was reached  
138 (see Tables 1 and 2 for SUs' and professionals' demographics, respectively).

### 140 **Findings**

141 Five broad themes were developed with 10 corresponding sub-themes: 1) *'Just an extra pair*  
142 *of hands?'* (*The consultant's role*), 2) *The context*, 3) *The team*, 4) *Training*, 5) *Change for*  
143 *the consultant* (see Figure 1 for thematic diagram). Antenatal and postnatal SUs, trainees,  
144 midwives and consultants provided data for themes 1, 2 and 3. Trainees, midwives and  
145 consultants contributed to theme 4, and theme 5 only consisted of consultants' contributions.  
146 Diversity is reported to ensure openness regarding disconfirmatory findings. Quotations are  
147 presented to facilitate judgements of trustworthiness.

#### 149 ***Theme 1: 'Just an extra pair of hands?' (The consultant's role)***

1  
2  
3 150 Many SUs and professionals mentioned consultants as supernumerary. The theme title was  
4  
5 151 taken from their descriptions of consultant input as “*an extra person*” (Helen, Postnatal) and  
6  
7 152 “*it’s more pairs of hands than necessarily needing the seniority*” (Karen, Consultant). The  
8  
9 153 theme was equally salient for both SUs and professionals and outlines how they viewed the  
10  
11 154 consultant’s role both positively and negatively with regards to 24-7 CP. This theme was  
12  
13 155 divided into three subthemes: *Prevention of poor outcomes*, *The job title* and *Variability*  
14  
15 156 *between consultants*.

### 157 158 ***Prevention of poor outcomes***

159 This subtheme consisted of mostly positive views towards 24-7 CP. SUs often perceived  
160 consultants to be the individuals who made decisions and could rectify intrapartum problems  
161 quickly; speed and decision-making were mentioned in the majority of SUs’ responses.

162 “...you would want consultants to be there and making all the major decisions”  
163 (Sarah, Postnatal).

164 “A consultant can just make that decision there and then... whereas the doctors have  
165 got to wait then go and speak to their consultant” (Ella, Postnatal)

166  
167 Very few SUs and professionals provided an experience when a consultant had been required  
168 to prevent a poor outcome. However both spoke about the need to have a consultant  
169 prospectively, i.e. the consultant’s ability to prevent poor outcomes. Specifically, trainees  
170 were fearful of negative outcomes when a consultant was not available to support them  
171 quickly.

172 “If I’m a trainee at a district hospital and I’m the only one at night time and I have to  
173 wait for my consultant to come on site... you’re in a position where something could  
174 potentially really go wrong and that support might not be there” (Jocelyn, ST1)

175

176 However, consultants often cited the limited evidence to support increased consultant  
177 presence and did not comment on whether they felt it had a positive impact on patient  
178 outcomes.

179 *“The main problem is there isn’t any evidence that it improves patient care”* (Cathy,  
180 Consultant)

181

### 182 ***The job title***

183 Responses were mixed with regards to whether consultant presence on a maternity unit was  
184 essential. Some professionals felt that a consultant should be present 24-7 in the same way as  
185 other members of the team were (e.g., midwives). The identity as a consultant-led unit was  
186 used to strengthen the argument for continuous consultant presence.

187 *“in a consultant-led, high-risk unit you need to have a consultant there 24/7, you  
188 wouldn’t have a midwifery-led unit without midwives overnight”* (Milly, Midwife)

189

190 However, trainees and consultants felt that SUs did not understand the staff hierarchy and  
191 therefore SUs did not differentiate between consultant-, trainee- or midwifery-care.

192 *“I think the reality is for most women in labour, they’re pretty happy to see a doctor.*

193 *Most people don’t actually understand the difference between a junior reg[istrar] and  
194 a senior reg[istrar]. Quite frankly, as a woman in obstetrics, they just think you’re the  
195 midwife anyway, so it doesn’t really matter”* (Erin, ST4)

196

197 Thus, from a SU’s view, competent medical care provided by any labour ward professional  
198 was more important than the job title of the provider. Furthermore, some SUs voiced negative  
199 views towards consultants’ continual presence on the unit, expressing that having rapport

1  
2  
3 200 with other professionals and very limited contact with consultants negated the need for 24-7  
4  
5 201 CP.

6  
7 202 *“If you’ve got a good rapport with the midwife, I don’t see why the consultants*  
8  
9 203 *necessarily need to be present all the time”* (Lindsey, Antenatal)

10  
11 204 *“I don’t think it makes much difference because you don’t really get to see them”*  
12  
13 205 (Katie, Postnatal)

14  
15 206

### 16 17 18 207 ***Variability between consultants***

19  
20 208 Some SUs expressed that 24-7 CP was a positive change, but this was dependent on  
21  
22 209 individual consultants.

23  
24 210 *“It is a good idea depending on the consultants”* (Katie, Postnatal)

25  
26 211

27  
28 212 Professionals, particularly consultants, stated that variable behaviour and abilities of  
29  
30 213 consultants could compromise the impact of 24-7 CP.

31  
32 214 *“I do think there are some of the consultants who still go to bed... who maybe go to*  
33  
34 215 *bed inappropriately and there are some incidents coming through where, actually,*  
35  
36 216 *that consultant should have been present and they’re not”* (Karen, Consultant)

37  
38 217

39  
40 218 The implementation of 24-7 CP required that several new consultant posts were filled. One  
41  
42 219 consultant strongly expressed concerns that rapid filling of these posts had resulted in the  
43  
44 220 appointment of consultants with varying competence, inferring that consultants’ skills and  
45  
46 221 attributes should be considered alongside their presence on the unit.

47  
48 222 *“I think the filling of 10 posts all at the same time , which we didn’t achieve, but even*  
49  
50 223 *trying to do that all at the same time meant that we’ve appointed some people who, if*

224 *we'd only been appointing one or two people, wouldn't have got appointed"* (Cathy,  
225 Consultant)

226

227 ***Theme 2: The context***

228 Participants often compared the area of obstetrics to other areas of medicine and/or the unit to  
229 other maternity units in order to highlight the reasons why 24-7 CP was a positive change.

230 This theme, pertinent for both SUs and professionals, encapsulates the contextual factors that  
231 surround birthing and the maternity unit. It was divided into three subthemes: *This unit is*  
232 *different, Characteristics of birth and Expected as standard.*

233

234 ***This unit is different***

235 All SUs cited the unit's reputation and the perceived expertise of professionals as a reason for  
236 choosing to give birth at St. Mary's, often expressing that they felt safer than at other  
237 maternity units. However, as most SUs were not aware that the unit has been providing 24-7  
238 CP or that this cover is not routinely implemented nationwide; they did not cite this as a  
239 reason for perceiving the unit as different to others.

240 *"They tried to move us to [another hospital], but I know that this has got a really*  
241 *good reputation for the maternity, so I opted to stay here"* (Lindsey, Antenatal)

242 *"I thought it was the best hospital, and with having twins, with all the top doctors"*  
243 (Katie, Postnatal)

244

245 The varied, high-risk and complex patient population cared for by the unit was cited as a  
246 feature which made St. Mary's different to other units and was the main reason given for the  
247 necessity of 24-7 CP by professionals. Some believed that complexity and risk would only  
248 increase in the future.

1  
2  
3 249 *“The kind of things that we get here are not anywhere near as simple as other units.*  
4  
5 250 *Here we get life threatening haemorrhages at four to eight litres, in another smaller*  
6  
7 251 *unit like the tiny one I was working in before I came here, they would consider*  
8  
9 252 *500mls, which here is a normal blood loss, they consider that serious” (Imogen, ST6)*  
10  
11 253 *“We are such a high-risk unit, you need to have that consultant input constantly”*  
12  
13 254 (Beth, Midwife)  
14  
15  
16 255

### 17 18 256 ***Characteristics of birth***

19  
20 257 The varied and unpredictable nature of labour and birthing was also deemed an important  
21  
22 258 reason for 24-7 CP, although more salient for SUs.

23  
24 259 *“every woman is different, every baby is different and every situation is different so*  
25  
26 260 *here it is very important to have a consultant with that” (Jessica, Antenatal)*  
27  
28

29 261  
30  
31 262 The potential for ‘things to go wrong quickly’ was expressed by both professionals and SUs  
32  
33 263 as a unique characteristic of obstetrics as opposed to other specialities. Interestingly, the issue  
34  
35 264 of unpredictability during birth was focused on more by postnatal SUs, perhaps because they  
36  
37 265 were able to consider and articulate the risks of birth.

38  
39 266 *“...just in case things go wrong, things can quite quickly go wrong” (Helen,*  
40  
41 267 *Postnatal)*  
42  
43

44 268  
45  
46 269 Professionals held similar views, that complications could arise quickly, obstetrics is an area  
47  
48 270 of medicine that is truly 24-7 and indicated that consultant presence was needed due to these  
49  
50 271 characteristics.

51  
52 272 *“I think it can only ever be a good thing, especially if you’re in obstetrics which is so*  
53  
54 273 *quick in how things can so suddenly deteriorate” (Erin, ST4)*  
55  
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3 274 ***Expected as standard***

4  
5 275 It came as a surprise to all SUs that not all maternity units have 24-7 CP because they had  
6  
7 276 expected that it was standard practice.

8  
9 277 *“I wasn’t very aware of it [24-7 CP] at all actually”* (Ava, Postnatal)

10  
11 278 *“I can’t even believe that I didn’t know that they didn’t have a consultant on 24-7*  
12  
13 279 *everywhere else”* (Ella, Postnatal)

14  
15 280

16  
17  
18 281 Hence, they expressed appreciation for St. Mary’s but also overwhelmingly endorsed that it  
19  
20 282 should be a requirement for all maternity units.

21  
22 283 *“So we are the lucky ones... I think it should be spread to every hospital in England.*

23  
24 284 *It is not only Manchester or St. Mary’s that people would need consultants”* (Natasha,  
25  
26 285 Antenatal)

27  
28 286

29  
30  
31 287 Although this subtheme was more pertinent to SUs, one professional also highlighted SUs’  
32  
33 288 expectation of continual consultant presence.

34  
35 289 *“The general public expect to be seen by a consultant day or night, and I think it’s the*  
36  
37 290 *way that most acute specialities are going to go”* (Carla, Consultant)

38  
39 291

40  
41  
42 292 ***Theme 3: The team***

43  
44 293 The impact of 24-7 CP on the workings of the multidisciplinary maternity team was an  
45  
46 294 important issue raised. Although a more pronounced theme for professionals, particularly  
47  
48 295 midwives, some SUs discussed multidisciplinary relationships. The theme, divided into the  
49  
50 296 subthemes of *The hierarchy* and *Working relationships*, outlines the mixed views towards the  
51  
52 297 relationships between consultants and other professionals and the consultants’ position within  
53  
54 298 the team.



1  
2  
3 299 ***The hierarchy***

4  
5 300 The leadership provided by 24-7 CP due to the consultant's position within the team  
6  
7 301 hierarchy was viewed favourably. SUs expressed that the consultants' authority was a support  
8  
9 302 for other professionals

10  
11 303 *"I think it's support for the midwives as well because you could have a really*  
12  
13 304 *inexperienced midwife that is put in a position and if they don't have that authority to*  
14  
15 305 *go to and ask that question or make that decision on the ward, then it's not really fair*  
16  
17 306 *on them"* (Claire, Antenatal)

18  
19  
20 307  
21  
22 308 Similarly, professionals reported that consultants directed the team and took responsibility; it  
23  
24 309 was suggested this started to occur more when 24-7 CP was implemented. Thus, strong  
25  
26 310 leadership was valued by other professionals in this team.

27  
28 311 *"Before we kind of felt a bit like we were just left to our own devices, no one wanted*  
29  
30 312 *to take charge or responsibility for the postnatal ward... we needed a bit of control*  
31  
32 313 *from consultants in order to help us manage it more effectively"* (Olivia, Midwife)

33  
34 314  
35  
36  
37 315 However, one consultant reported that midwives were less likely to seek the support of  
38  
39 316 trainees, favouring the authority of consultants, which could disadvantage trainees'  
40  
41 317 professional development.

42  
43 318 *"One negative that I could potentially see from it is that the midwives might tend to,*  
44  
45 319 *not ignore, but not go to the junior doctors if they know that there is someone senior*  
46  
47 320 *there that's able to make a definite decision"* (Carla, Consultant)

48  
49  
50 321

51  
52 322 ***Working relationships***

1  
2  
3 323 In contrast to the desire for a consultant leadership role, some participants expressed negative  
4  
5 324 views regarding working relationships between consultants and midwives. Some SUs felt that  
6  
7 325 midwives were not able to voice their opinion when clinical decisions were being made  
8  
9 326 which was particularly salient for SUs who had a negative experience of consultant contact.

10  
11 327 *“I just don’t like the fact that the midwives aren’t able to say anything. It’s up to the*  
12  
13 328 *consultant”* (Lindsey, Antenatal)

14  
15  
16 329

17  
18 330 Although this was not discussed as a perceived consequence of the change to 24-7 CP, it was  
19  
20 331 suggested that this strain on working relationships occurred more frequently.

21  
22 332 *“There’s a bit more of, how shall I say it, butting of heads if you like from certain*  
23  
24 333 *people. They just want it done their way because they’re in charge”* (Beth, Midwife)

25  
26  
27 334

28  
29 335 However, some midwives felt that the similar working hours had a positive impact, made the  
30  
31 336 team more cohesive and reduced the power imbalance between the two professional groups.

32  
33 337 *“I guess it breaks down barriers between us and them, because if they’re doing the*  
34  
35 338 *same terrible shifts then you know that they’re not just swanning in as and when they*  
36  
37 339 *feel like it. They’re doing the grind, they’re doing the nights and weekends... you feel*  
38  
39 340 *that you’re all in it together, rather than them kind of lording it over you when they*  
40  
41 341 *come in”* (Milly, Midwife)

42  
43  
44 342

#### 45 343 **Theme 4: Training**

46  
47  
48 344 Although views were mixed, all professionals spoke about how the training of midwives and  
49  
50 345 trainees had been affected by 24-7 CP. The theme, pertinent to trainees and consultants, was  
51  
52 346 divided into two subthemes: *Teaching* and *Trainees’ development*.

53  
54  
55 347

1  
2  
3 348 **Teaching**

4  
5 349 Two factors for improving training were identified: time and consultant engagement.

6  
7 350 Trainees and consultants felt there were more opportunities for out-of-hours training and

8  
9 351 midwives also reported that they learnt more from consultants than trainees due to

10  
11 352 consultants' knowledge and time to train others.

12  
13 353 *“you get better training overall, because I think you have access to supervision 24-7,*

14  
15 354 *there's more availability to get supervised in more procedures out of hours” (Erin,*

16  
17 355 ST4)

18  
19 356 *“I have a bit more knowledge than them [junior doctors] on certain things. So I don't*

20  
21 357 *feel I learn as much from junior doctors whereas I learn more from consultants who*

22  
23 358 *sometimes have a bit more time or a bit more knowledge about certain things”*

24  
25 359 (Olivia, Midwife)

26  
27 360

28  
29 361 However, the role of consultant engagement was highlighted by trainees and consultants:

30  
31 362 although consultants were on the unit out-of-hours, this could actually reduce consultant

32  
33 363 engagement in training others.

34  
35 364 *“Even though you have the so-called presence of a consultant it also depends on how*

36  
37 365 *much they're involved with or their engagement with trainees” (Jocelyn, ST1)*

38  
39 366

40  
41 367 One consultant stated that consultants were more inclined to carry out procedures themselves

42  
43 368 out-of-hours than train others in order to save time.

44  
45 369 *“They should get better training in the middle of the night on delivery suite because*

46  
47 370 *we are there. Equally there can be more of a temptation to just get on and do it*

48  
49 371 *because it's three in the morning and if you do it yourself, you're back doing*

50  
51 372 *something else in 20 minutes rather than 40 minutes” (Cathy, Consultant)*

1  
2  
3 373 ***Trainees' development***

4  
5 374 Although professionals held some favourable views towards the impact of 24-7 CP on  
6  
7 375 training opportunities, they expressed negativity when discussing the development of trainees  
8  
9 376 as consultants of the future. Both trainees and consultants felt 24-7 CP could reduce trainees'  
10  
11 377 autonomy, confidence, clinical judgement and their ability to cope with stress.

12  
13 378 *"I think one problem with 24-7 consultant presence is some of our junior registrars,*  
14  
15 379 *there are one or two who are relaxed all the time from an educational putting-*  
16  
17 380 *themselves forward perspective... I think actually you can then get away with a hell of*  
18  
19 381 *a lot because they constantly step back... the more senior they get, the more the stress*  
20  
21 382 *increases. If they don't learn that and learn to cope with that early on, they're never*  
22  
23 383 *going to manage as a consultant"* (Imogen, ST6)

24  
25 384 *"I know some of my colleagues, when I was a registrar, felt that the presence of a*  
26  
27 385 *consultant there could be quite interfering and perhaps they wouldn't be able to use*  
28  
29 386 *their own clinical judgement and make independent decisions"* (Carla, Consultant)

30  
31  
32  
33 387

34  
35 388 Participants spoke of how the presence of a more senior clinician impeded trainees' ability to  
36  
37 389 develop autonomy as practicing doctors; an important issue to be acknowledged by other  
38  
39 390 maternity units and specialties considering implementing 24-7 CP.

40  
41 391 *"If individuals are never left to make decision on their own, they never learn that*  
42  
43 392 *autonomy to be able to make decisions. I think that's one issue that we will find*  
44  
45 393 *moving forward, the consultants of the future will be much less experienced"* (Annie,  
46  
47 394 Consultant)

48  
49  
50  
51 395

52  
53 396 ***Theme 5: Change for the consultant***

1  
2  
3 397 Consultants spoke about how their lives had changed as a result of 24-7 CP, both in and out  
4  
5 398 of the unit. This theme was one of the main focal points of consultants' responses and  
6  
7 399 encapsulates the issues that have and will affect consultants' lives. Responses were more  
8  
9 400 anecdotal for this theme and consultants drew on their positive and negative experiences  
10  
11 401 before and after the implementation.  
12

13 402

14  
15 403 Many consultants expressed concerns regarding the competency of trainees under *Trainees'*  
16  
17 404 *development*, but this issue was also raised in relation to consultant workload. Consultants,  
18  
19 405 who felt that trainees' capabilities had reduced, also felt that consultants were now required  
20  
21 406 to do lower-grade work to fill the skills-gap of the trainees.  
22

23  
24 407 *"Junior doctors are becoming less and less competent at the sort of things that I*  
25  
26 408 *might have been competent at as a senior registrar and so more and more you find*  
27  
28 409 *yourself needing to do things that as a senior registrar or a registrar I would have*  
29  
30 410 *dealt with without bothering a consultant"* (Annie, Consultant)  
31

32 411

33  
34  
35 412 Change to the length of consultants' shifts was also deemed a consequence of the  
36  
37 413 implementation. Prior to 24-7 CP, consultants could work their rostered shift in the hospital  
38  
39 414 then stay on-call from home (with the possibility of being called to the hospital). Hence  
40  
41 415 consultants could have worked for 24-48 hours, whereas, since 24-7 CP, consultants work set  
42  
43 416 shifts on the unit of 12.5 hours. This consequence was viewed positively because of the  
44  
45 417 certainty that consultants could rest after a shift.  
46

47  
48 418 *"I don't care how busy I am, because the most I'm normally going to be in is 13*  
49  
50 419 *hours. I don't have that nagging feeling all the time - 'am I going to have to try to*  
51  
52 420 *keep this pace for 24 hours?'"* (Karen, Consultant)  
53

54 421

1  
2  
3 422 Some consultants reported that 24-7 CP had had a negative impact on consultants'  
4  
5 423 professional development opportunities. The issue of balancing off-ward duties, such as  
6  
7 424 meetings, with wards shifts was difficult, especially when working on the night-rota and  
8  
9 425 because NHS management operate in office hours.

10  
11 426 *“It makes work much more difficult because the day before and the day after night*  
12  
13 427 *shift, you’re technically not in work meetings even though I think I’m reasonably good*  
14  
15 428 *at planning... The Trust [...] is terrible at giving you a week’s notice - ‘we’ve*  
16  
17 429 *changed that meeting to that date’. Then if it’s the day after your night on call you*  
18  
19 430 *either don’t go or you go when you’re supposed to be in recovery time”* (Cathy,  
20  
21 431 Consultant)

22  
23  
24 432

25  
26 433 Furthermore, issues for workers such as management of absences, and the impact they have  
27  
28 434 on the labour ward team, were also highlighted as an area that required improvement when  
29  
30 435 looking ahead.

31  
32  
33 436 *“I think one of the big problems with it is that we didn’t quite anticipate how you*  
34  
35 437 *manage sick leave and short-term absences, which I don’t think have been properly*  
36  
37 438 *sorted out”* (Annie, Consultant)

38  
39 439

## 40 41 42 440 **Discussion**

### 43 44 441 **Main findings**

45  
46 442 Five themes and 10 subthemes were developed. Both SUs and professionals acknowledged  
47  
48 443 that consultants resolved intrapartum complications in an acute speciality in which  
49  
50 444 complications arise quickly, although the effect was dependent on individual consultants'  
51  
52 445 skills and behaviour. SUs responses were generally positive towards the implementation and  
53  
54 446 they were surprised when made aware that 24-7 CP was not standard practice across the UK.

1  
2  
3 447 Professionals' responses were more pragmatic and included how 24-7 CP had affected their  
4  
5 448 own work, development of trainees and the impact on the consultants of the future.  
6

7 449

### 9 450 **Strengths and limitations**

11 451 To our knowledge this is the first study to qualitatively explore views towards 24-7 CP in any  
12  
13 452 speciality and addresses Prior et al.'s<sup>13</sup> call for research to explore perceptions in relation to  
14  
15 453 staff provision in maternity units. Furthermore, a diverse sample of SUs was recruited in  
16  
17 454 terms of ethnicity, (anticipated) mode of birth and antenatal and postnatal women. However,  
18  
19 455 all professionals were white females and therefore the views of males and professionals of  
20  
21 456 other ethnicities were not captured in this study. This study also focussed on interviewing  
22  
23 457 midwives and obstetricians because they were primarily affected by the change to 24-7 CP.  
24  
25 458 This approach may have resulted in data saturation being reached prematurely and may limit  
26  
27 459 the transferability of findings. However, the gender mix reflects the female predominance as  
28  
29 460 79% of trainees are women,<sup>17</sup> and midwifery is overwhelmingly female (in 2001 the  
30  
31 461 midwifery workforce in England and Wales was 99% female and 1% male).<sup>18</sup> However,  
32  
33 462 future work should consider sampling a greater range of participants, both in terms of gender  
34  
35 463 and ethnicity, but also members of different professional groups (e.g., anaesthetists,  
36  
37 464 neonatologists and managers), because participants from these groups may hold different  
38  
39 465 views about 24-7 CP.  
40  
41

42  
43 466 Furthermore, the service users were all inpatients at St. Mary's which suggests they had  
44  
45 467 chosen to give birth in a hospital or were required to receive hospital care, this may result in a  
46  
47 468 participation bias. Selection bias was limited as the initial approach about the study was made  
48  
49 469 by the clinical team, independent of the researchers. However, some women in high-income  
50  
51 470 countries are choosing to give birth away from the labour ward setting.<sup>19</sup> Although, these  
52  
53 471 individuals may not be directly affected by the move to 24-7 CP, qualitative researchers  
54  
55

1  
2  
3 472 should approach such individuals in order to obtain more varied views towards consultant  
4  
5 473 presence. Finally, St. Mary's is a large tertiary unit, specialising in complex births and  
6  
7 474 admits women from a large geographical area. Therefore, these findings should be  
8  
9 475 extrapolated to non-tertiary units with caution.  
10

11 476

### 12 13 477 **Interpretation**

14  
15 478 Participants spoke of consultants' ability to rectify intrapartum problems and make decisions  
16  
17 479 quickly, suggesting that an increase in consultant presence would improve patient outcomes.  
18  
19 480 However, the impact of increased consultant presence on outcomes is not fully understood<sup>9-12</sup>  
20  
21 481 and this was highlighted by consultants. Participants also believed that SUs were happy to be  
22  
23 482 seen by any competent member of staff not just a consultant. This view is disputed in the  
24  
25 483 surgical literature, which advocates that the consultant role is a 'quality kite mark' and  
26  
27 484 reduces a patient's concern about whether they are receiving the best quality care as well as  
28  
29 485 worrying about their illness.<sup>20</sup> However, maternity services in the UK are organised  
30  
31 486 differently to other specialities and a normal birth is not a medical procedure. Most women  
32  
33 487 (57%) report just seeing a midwife during pregnancy and birth<sup>21</sup> and consultant intervention  
34  
35 488 is not deemed a necessity in all births. Therefore, the consultant job title alone was not reason  
36  
37 489 enough to implement 24-7 CP. Furthermore, the variability of consultants' behaviour and  
38  
39 490 attributes was seen as an issue that could compromise the impact of 24-7 CP. Attitudes and  
40  
41 491 behaviours of caregivers have been found to influence women's birth experiences more than  
42  
43 492 pain relief and intrapartum interventions.<sup>22</sup>  
44  
45

46  
47  
48 493 As a large, tertiary maternity unit, St. Mary's Hospital cares for a high-risk, complex  
49  
50 494 population. Increasing case complexity is cited as one of the drivers for increasing obstetric  
51  
52 495 consultant presence.<sup>23</sup> However, this rationale is not fully applicable to smaller non-tertiary  
53  
54 496 units. Participants noted the acute and unpredictable nature of complications in pregnancy  
55  
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57  
58  
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60



1  
2  
3 497 and birth. Women were aware that emergencies can happen during birth as described in  
4  
5 498 Larkin et al.'s<sup>24</sup> mixed methods study, which found women preferred not to have a consultant  
6  
7 499 present during the birth but appreciated their presence during an emergency. To attend in  
8  
9 500 such circumstances requires 24-7 CP and this study found that SUs expected 24-7 CP as  
10  
11 501 standard across all maternity units. As 80% of women were not aware of the four possible  
12  
13 502 places to give birth (home, freestanding midwifery unit, alongside midwifery unit, consultant-  
14  
15 503 led unit),<sup>21</sup> the reason all SU respondents felt 24-7 CP should be standard may be due to an  
16  
17 504 inaccurate perception that all maternity units are consultant-led.

18  
19  
20 505 Although participants highlighted that 24-7 CP could strain working relationships, the  
21  
22 506 benefits of consultants' leadership at the top of the hierarchy for the team was highlighted.  
23  
24 507 The Royal College of Obstetricians and Gynaecologists states "the consultant's role starts with  
25  
26 508 demonstrating leadership: teaching and supporting trainees, midwives and nurses at all  
27  
28 509 times".<sup>6</sup> However, midwives describe finding it difficult to facilitate normal births in an  
29  
30 510 obstetric-led unit due to the obstetrician's powerful position at the top of the hierarchy and  
31  
32 511 dominant decision-making.<sup>25</sup> This raises the question of whether more detailed guidance on  
33  
34 512 how consultants should support other professionals is needed to ensure a more cohesive  
35  
36 513 labour ward team within a 24-7 CP model.

37  
38  
39 514 Trainees and consultants highlighted that 24-7 CP should result in more training  
40  
41 515 opportunities out-of-hours. A systematic review of several specialities found enhanced  
42  
43 516 supervision of trainees had a positive impact on patient- and education-related outcomes.<sup>26</sup>  
44  
45 517 Despite this, respondents identified that in practice this increased supervision could also have  
46  
47 518 a negative impact on trainee development; an issue also identified in a debate against 24-7 CP  
48  
49 519 on the labour ward.<sup>27</sup> A more in-depth analysis of confidence, clinical judgement and  
50  
51 520 obstetric ability of trainees trained in hospitals of varying levels of consultant presence  
52  
53 521 should be undertaken to shed light on this important issue for the future.

1  
2  
3 522 Consultants were positive towards the predictability of shift-duration and appreciated  
4  
5 523 uninterrupted rest when at home. However, they also felt they were carrying out more low-  
6  
7 524 grade work, struggled to balance day-time duties when working night-shifts and that absences  
8  
9 525 were not managed adequately. These negative issues highlight the importance of thorough  
10  
11 526 preparation prior to implementing a change to consultant working and future consultations  
12  
13 527 with staff offer a direction to resolve these issues.  
14  
15

16 528

### 17 529 **Conclusion**

18  
19  
20 530 This is the first qualitative study to understand how maternity SUs and professionals view 24-  
21  
22 531 7 CP. The findings raised several major issues that should be considered by practitioners and  
23  
24 532 policy-makers when deciding whether to implement 24-7 CP in maternity units across the  
25  
26 533 UK. These issues were the attributes of the consultants, necessity on non-tertiary units, the  
27  
28 534 team hierarchy, trainee development, consultants' other duties and consultant absences. This  
29  
30 535 study paves the way for more detailed research into each of these issues. Finally, other units  
31  
32 536 who introduce 24-7 CP should consider further evaluation of 24-7 working to further improve  
33  
34 537 maternity services.  
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12  
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17  
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26  
27 558 **Competing interests**

28  
29 559 All authors have completed the ICMJE uniform disclosure form at  
30  
31 560 [www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) and declare: no financial, personal or other relationships  
32  
33 561 with other people or organisations within three years of beginning the submitted work that  
34  
35 562 could inappropriately influence, or be perceived to influence, the submitted work.  
36

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38 563

39  
40 564 **Contributors**

41  
42 565 HR, AW, SV and AH contributed to the study concept and design. HR conducted all  
43  
44 566 interviews. HR, AW and AH contributed to the analysis and interpretation of the data.

45  
46 567 HR developed the first draft of the manuscript and AW, SV and AH revised all manuscript  
47  
48 568 drafts and approved the final version.  
49

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51 569

52  
53 570 **Data sharing statement**

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3 571 No additional data are available from a repository. Anonymised transcripts are available on  
4  
5 572 request.

6  
7 573

8  
9 574 **Ethical approval**

10  
11 575 The study was approved by the ‘South Central – Hampshire A’ Research Ethics Committee

12  
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14  
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648 **Table 1.** Service users' characteristics

<b>Antenatal</b>											
<b>Pseudonym</b>	<b>Age (years)</b>	<b>Ethnicity</b>	<b>Marital status</b>	<b>Occupation</b>	<b>Birth (low/moderate/high) risk</b>	<b>Gestation (weeks)</b>	<b>Anticipated mode of delivery</b>	<b>Number of other children</b>	<b>Age(s) of other child(ren) (years)</b>	<b>Previous mode(s) of delivery</b>	
Amelia	22	White	Cohabiting	Part-time student	High	33	NVD	2	4 / 2	NVD / NVD	
Jessica	27	White	Married	Dental nurse	Moderate	30	EICS	1	4	EmCS	
Natasha	29	Black	Married	Care worker	High	28	NVD	3	9 / 8 / 5	NVD / NVD / NVD	
Lindsey	30	White	Married	Legal PA	High	38	EICS	0	-	-	
Claire	31	White	Cohabiting	Retail manager	Moderate	39	NVD	0	-	-	
<b>Postnatal</b>											
<b>Pseudonym</b>	<b>Age (years)</b>	<b>Ethnicity</b>	<b>Marital status</b>	<b>Occupation</b>	<b>Birth (low/moderate/high) Risk</b>	<b>Age of baby(s) (days)</b>	<b>Mode of delivery</b>	<b>Number of other children</b>	<b>Age(s) of other child(ren) (years)</b>	<b>Previous mode(s) of delivery</b>	
Helen	39	White	Married	Administrator	High	3	EICS	1	15	EmCS	
Sarah	32	White	Married	Nursing assistant	Low	1	NVD	2	4 / 2	NVD / NVD	
Ava	34	Asian	Married	Solicitor	Low	1	Forceps	0	-	-	
Ella	27	White	Cohabiting	Clerical officer	High	5	EmCS	0	-	-	
Katie	35	White	Cohabiting	Caterer	High	6	NVD	1	17	NVD	

649 EICS = elective caesarean section, EmCS = emergency caesarean section, NVD = normal vaginal delivery.



650 **Table 2.** Professionals' characteristics

Pseudonym	Gender	Age (years)	Ethnicity	Marital status	Post	Time in post (years)	651 652
Karen	Female	45	White	Married	Consultant	8.5	653
Carla	Female	35	White	Married	Consultant	0.75	654
Annie	Female	42	White	Married	Consultant	4.5	655
Cathy	Female	45	White	Cohabiting	Consultant	7.5	656
Jocelyn	Female	31	White	Cohabiting	ST1	0.5*	657
Imogen	Female	33	White	Cohabiting	ST6	1.5	658
Erin	Female	32	White	Married	ST4	3	659
Olivia	Female	28	White	Single	Midwife	2	660
Milly	Female	24	White	Cohabiting	Midwife	3	661
Beth	Female	54	White	Married	Midwife	17	661

662 \*not employed at St. Mary's prior to the implementation of 24-7 consultant presence

663 ST = speciality trainee

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665 **Figure 1.** Thematic diagram of service users' and professionals' views of 24-7 obstetric  
666 consultant presence.

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For peer review only

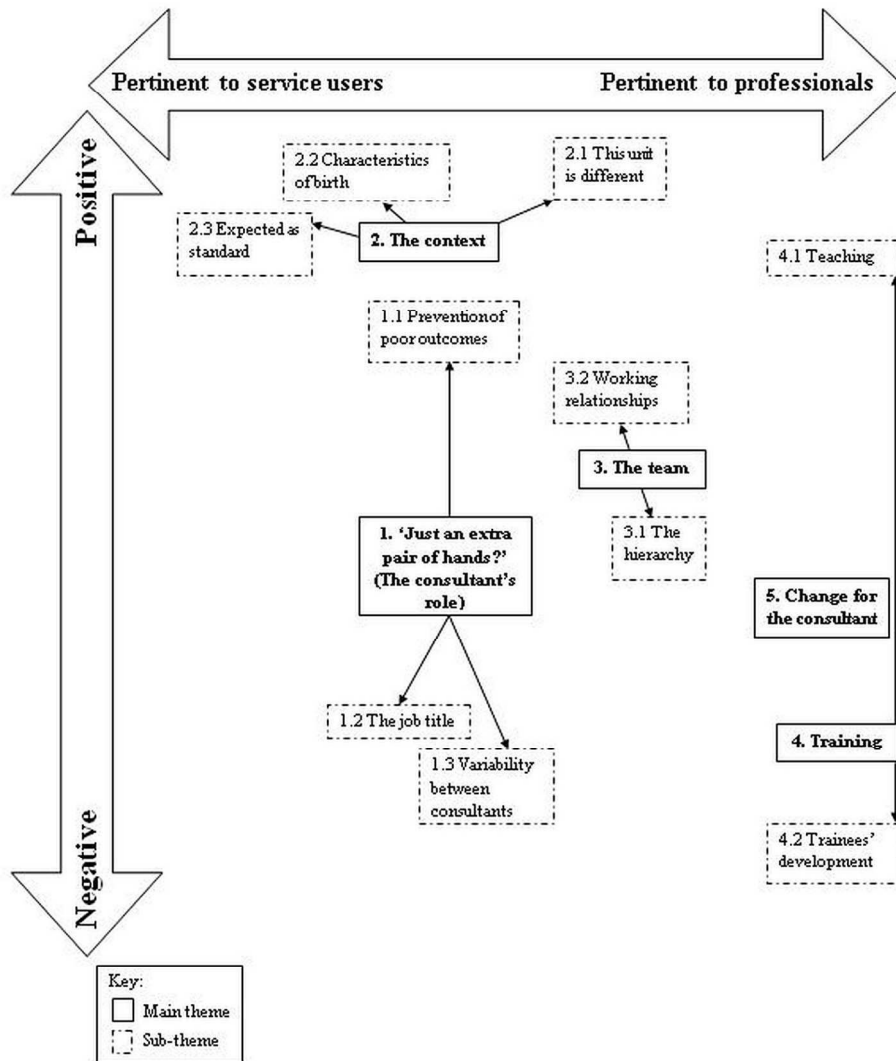


Figure 1. Thematic diagram of service users' and professionals' views of 24-7 obstetric consultant presence.

Figure 1. Thematic diagram of service users' and professionals' views of 24-7 obstetric consultant presence.

125x160mm (300 x 300 DPI)

## Appendix S1. Semi-structured interview schedule for service users

### Opening Statement:

**Thank you for participating in this research study investigating service user views towards 24-7 consultant presence at St. Mary's Hospital. My name is Holly Reid and I am a research assistant at the University of Manchester. Through this research we aim to describe the effect that 24-7 consultant presence has on patient care and birthing experiences. Do you have any questions?**

1. Why did you choose to give birth at St. Mary's?
  - Did you look at other units? If so, what made you choose St. Mary's?
2. How aware are you of 24-7 consultant presence on the maternity unit?
  - If they are not aware: **24-7 consultant presence was introduced to St. Mary's Hospital on 1<sup>st</sup> September 2014 and ensures that a consultant is available 24 hours a day 7 days a week.**
  - When/where did you hear about it?
3. What are your thoughts on consultants?
  - In general?
  - On a maternity unit?
4. What are your views on consultants being present at the unit?
5. Could you tell me about your experiences of St Mary's during your pregnancy/birth?
6. Could you tell me about how your family have experienced St Mary's during your pregnancy/birth (if involved)?
7. Was a consultant involved in the care of you/your baby at any point?
  - If so, how did you experience their involvement?
8. How do you feel about 24-7 consultant presence on the unit?
  - Why?
  - Have you ever felt differently? Why?

## Appendix S2. Semi-structured interview schedule for professionals

### Opening Statement:

**Thank you for participating in this research study investigating staff views towards 24-7 consultant presence at St. Mary's Hospital. My name is Holly Reid and I am a research assistant at the University of Manchester. Through this research we aim to describe the effect that 24-7 consultant presence has on staff's clinical work. Do you have any questions?**

1. How long have you been in your current role?
2. Could you tell me about how consultants are involved in your work?  
or  
Could you tell me about your duties as a consultant?
3. How aware are you of 24-7 consultant presence on the maternity unit?
  - If they are not aware: **24-7 consultant presence was introduced to St. Mary's Hospital on 1<sup>st</sup> September 2014 and ensures that a consultant is available 24 hours a day 7 days a week on the maternity unit.**
  - When/where did you hear about it?
4. How do you feel about 24-7 consultant presence on the unit?
  - Why?
  - Have you ever felt differently? Why?
5. Has 24-7 consultant presence changed your work in any way?
  - How has your work changed?
6. Could you tell me about any aspects of others' work that may have changed as a result of 24-7 consultant presence?
  - Work/life balance?
  - Dynamics of multidisciplinary team?
7. Could you tell me about any aspects of patient care that may have changed as a result of 24-7 consultant presence?
  - Mother and baby?
  - Family of mother and baby?
  - Antenatal vs. postnatal?

For peer review only

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