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University of Southampton

Faculty of Environmental and Life Sciences

School of Health Sciences

**The experiences of women, birth partners and midwives of a dedicated, midwife-led,
telephone support line for labour: An interpretative phenomenological analysis**

by

Marie Elizabeth Naish

Thesis for the degree of Doctor of Philosophy

December 2024

University of Southampton

Abstract

Faculty of Environmental and Life Sciences

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Doctor of Philosophy

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Women admitted to the birthing environment during the latent, rather than established, phase of labour are significantly more likely to experience interventions. Consequently, women are recommended to remain at or return home until labour is established. In 2013 an NHS Trust in England implemented a dedicated, midwife-led telephone support line for women in labour, known as the '24-hour Labour Line'. This is the first documented telephone triage service located away from the hospital setting, with the midwife situated in the ambulance control centre and whose only role is to provide telephone support to women at home during labour.

In the absence of previous literature this research explores the experience of women, birth partners and midwives of accessing, or working on, the 24-hour labour line, with focus on the decision-making process undertaken. A qualitative design was adopted, using Interpretative Phenomenological Analysis. The sample comprised eleven women, four birth partners and five midwives. Data were collected using semi-structured interviews and a reflective diary. Smith et al's (2022) steps to data analysis were applied. Fourteen 'Group Experiential Themes' were identified from the 'Personal Experiential Themes' of each individual participant.

The dedicated telephone triage line offers virtual support to women and birth partners from trusted professionals during the uncertain period of early labour. The location of the service away from the hospital setting assists midwives to make decisions about care, free from the influence of organisational pressures. Through shared decision-making, women can be empowered to take control of the timing of admission to hospital, enabling their emotional and physical wellbeing to be equally valued during telephone assessment. Through advocating women's choices, midwives experience tension with their hospital counterparts, which may be attributed to a lack of understanding of the scope of the role and a lack of visibility of the work undertaken by 24-hour labour line midwives. Midwives have found a sense of belonging through working in the ambulance control centre and value working collaboratively with other professional groups, to the perceived advantage of both the public and professionals.

The findings of this study offer support for the implementation of dedicated telephone support lines for early labour to facilitate shared decision-making and increase women's control over their care during this phase of labour. This study is the first qualitative research to thoroughly explore the experience of women and birth partners of early labour during the COVID-19 pandemic, offering novel understanding of the importance of remote services during this time. New knowledge of the experiences of midwives working in a non-traditional maternity setting and the challenges this brings is provided and recommendations for practice and policy made.

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Research Thesis: Declaration of Authorship

Print name: Marie Elizabeth Naish

Title of thesis: The experiences of women, birth partners and midwives of a dedicated, midwife-led, telephone support line for labour: An interpretative phenomenological analysis

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: Date:.....

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Definitions and Abbreviations

24-hour labour line and labour line (used interchangeably) – 24-hour telephone support line, situated in the ambulance control centre, for women and birth partners to contact on commencement of, or during, labour.

Birth partner – a friend, partner or family relation of a pregnant woman who has been chosen for physical and emotional support during childbirth.

Dilation and dilatation (used interchangeably) – the opening of the internal and external os (opening) of the cervix during labour.

Early labour and latent phase of labour (used interchangeably) – defined as per the National Institute for Health and Care Excellence (2023 pg. 39): *‘Latent first stage of labour is a period of time, not necessarily continuous, when: there are contractions and there is some cervical change, including cervical position, consistency, effacement and dilatation up to 4 cm’*. Early labour in this context is not with reference to premature (less than 37 weeks' gestation) labour.

Established labour and active labour (used interchangeably) – defined as per the National Institute for Health and Care Excellence (2023 pg. 127): *‘Established first stage of labour is when: there are regular contractions and there is progressive cervical dilatation from 4 cm.’*

Midwife – defined as per the International Confederation of Midwives (ICM 2023) core statement; *‘A midwife is a person who has successfully completed a midwifery education programme based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife,’ and who demonstrates competency in the practice of midwifery’*.

NHS Trust and Trust (used interchangeably) – an organisation providing a National Health Service to the general public in the United Kingdom.

Women and woman – it is recognised that not all people that are pregnant identify as a woman and that some prefer to be referred to as a pregnant or birthing person. Throughout this document, in view of the majority of pregnant people identifying as a woman, the term woman or women will be used.

Primiparous – a woman who is giving birth for the first time.

Definitions and Abbreviations

Multiparous – a woman who has birthed more than one child.

The following abbreviations will be referred to throughout the document:

APGAR Appearance, Pulse, Grimace, Activity and Respiration

BBA Born Before Arrival

cm centimetres

COVID-19 Coronavirus disease (SARS-CoV-2 virus)

ELEQ..... Early Labour Experience Questionnaire

IPA..... Interpretative Phenomenological Analysis

MNVP Maternity and Neonatal Voice Partnership

NHS..... National Health Service

NICE National Institute for Health and Care Excellence

NMC Nursing and Midwifery Council

ONS..... Office for National Statistics

PMA..... Professional Midwifery Advocate

RCM Royal College of Midwives

RCOG Royal College of Obstetrics and Gynaecology

RCT..... Randomised Control Trial

REC Research Ethics Committee

R&D Research and Development

SROM Spontaneous rupture of membranes

UK United Kingdom

UoS University of Southampton

VE.....Vaginal examination

Chapter 1 Introduction

1.1 Introduction

Over the last two decades maternity services have explored ways to support women to remain at home for as long as possible during labour, with the aim to reduce rising intervention rates. Despite the good intentions of this approach, literature and anecdotal experience from clinical practice suggests women's experience of this model of care is poor. This research project uses Interpretative Phenomenological Analysis (IPA) to explore the experiences of women, birth partners and midwives accessing, and working on, a service, which at the time of project inception was the first of its kind, namely 'the 24-hour labour line'. The service aimed to better support families during the early part of labour at home, through providing a dedicated, round-the-clock, telephone support line. Triangulating the experiences of women, birth partners and midwives offers new insights into both a unique service, and the perspectives of all those that use it in relation to labour care. In addition, it is the first qualitative exploration of birth partners experiences which focusses on telephone contact with health professionals while at home during labour. Due to the coronavirus disease (SARS-CoV-2 virus) (COVID-19) pandemic occurring midway through the study, it also offers understanding of the experience of early labour during a period of global uncertainty and instability. This chapter provides a background to the study, situating the researcher in the context of the research, and a guide to the structure of the thesis.

1.2 Positioning the researcher and the study

My desire to study Midwifery was driven by the belief that the process of birth is a life-affirming moment for women and their families as they transition to parenthood. From the early part of my training, I developed a passion for advocating that women take control of their care and the decisions that are made about their bodies. I strongly believe that if women are empowered to make informed choices about their body, and the care of their infant in pregnancy and the early postnatal period, then they will be better equipped for doing the same for their child during parenthood. This was reflected in my decision to practice midwifery in a continuity of care team, where I cared for women with social vulnerabilities, as I felt this demographic required the most support in advocating for their choices.

Since qualifying as a registered midwife in 2010 I had been seeking to develop my skills in research, to support me in pursuing a career in academia. In 2013 I was jointly appointed as a

Clinical Academic Doctoral Fellow at University of Southampton (UoS) and a local National Health Service (NHS) Trust. The Clinical Academic Doctoral Fellowship pathway supports early career health professionals to work towards their doctorate, while continuing to work in clinical practice for forty percent of the working week (Westwood 2014).

Having three years full time post-qualifying experience, I was drawn to an advertised project on an early labour triage service due to my observations from clinical practice that women appeared to assume little control over their care in early labour. The project spoke to my interests around control and decision-making during pregnancy and labour and I was inspired to pursue this unique opportunity to gain my PhD. The fellowship appealed to me in view of the balanced portfolio, which enabled me to continue developing my clinical skills, while gaining new research skills through doctoral study. The situation of the researcher within the context of the area of study was also considered beneficial in ensuring the right research questions were asked for the greatest impact on women and their families, and to identify and resolve practicality issues (Rowland and Jones 2013).

On appointment, a project outline was provided by UoS suggesting a mixed method approach to exploring the implementation of a new early labour triage service. My own observations from clinical practice, particularly of the development and implementation of this service, and emersion in the literature shaped the project further. I considered it an integral part of the research process to put this initial suggestion aside and identify key research questions to meet the needs of women and the service without its influence. I was supported by the sponsor of the project, and my doctoral supervisors in doing so. Speaking with women, partners, midwives, and other service providers in clinical practice enabled me to develop clinically relevant questions that would meet the needs of this doctoral study, while also adding value to the clinical setting. This led me to the premise of this research study; to explore the experiences of women, birth partners and midwives of a dedicated, 24-hour telephone support line for labour. There were three primary research questions focused around the experiences of the 24-hour labour line for these three groups of participants. These were:

1. What are the experiences of women and birth partners who access a dedicated, midwife-led, telephone support line for labour?
2. What are the experiences of midwives working on a dedicated, midwife-led, telephone support line for labour?
3. How is telephone interaction between midwives and women intended, experienced, understood and interpreted by each party?

Following a narrative review, in light of a focus within existing literature on decision making in early labour, secondary research questions were derived to capture women, birth partners and midwives experiences in relation to decision making. These were:

1. How involved do women and birth partners feel in the decision to attend the chosen birthing location/have a midwife attend at home?
2. How involved do women want to be in the decision to attend the chosen birthing location/have a midwife attend at home?
3. How able do midwives feel to make decisions regarding the delivery of care to a woman based on the woman's needs, not the workload of the service?

In 2015 I was appointed as a full time Midwifery Lecturer at UoS, and since that time have been undertaking this study on a part time basis, with two interruptions while I took a period of maternity leave. Becoming a parent myself offered me a new insight into the experience of pregnancy and childbirth, an element I now have in common with the participants of the study. In addition, as a pregnant woman in labour, alongside my partner, I had communication part way through this research project with the service I was researching, in part becoming a participant myself. For this reason, careful reflection on my own experience through reflexivity was required to help prevent influence within the data analysis process. This happened in several stages, both during pregnancy, as soon as reasonably practicable post birth and immediately before, and during, data analysis. A clear description of this process is outlined within the methodology chapter (section 4.11).

A consequence of my two pregnancies, coupled with a period of interruption due to workload pressures, and a delay of more than six months as a result of the COVID-19 pandemic, is that submission of this thesis has been ten years in the making. While this is testament to my perseverance and commitment to ensuring the voice of the participants are heard and offers insight into the experiences of participants both before and during a global pandemic, it has understandably had an impact on the project, which I refer to throughout the thesis.

1.3 Structure of thesis

The thesis is composed of ten chapters. Following this introduction, chapter two outlines the context of midwifery services in the United Kingdom (UK) in relation to supporting women and their birth partners during early labour, including the changing landscape over the last decade. The challenges midwives face in fulfilling their support role are critically explored, before the presentation of the 24-hour labour line is made.

Chapter 1

Chapter three outlines a review of the literature in three parts; the experiences of women, birth partners and midwives of telephone contact during early labour. Existing research will be considered critically, before gaps in the knowledge base are identified and the final research questions this study addresses, as outlined above, are presented.

Chapter four presents a detailed account of the methodology and methods adopted, including the amendments required to respond to the COVID-19 pandemic part way through the project. Crucially, it is here that I address my role as woman, mother, midwife and teacher in the research process, through the practice of reflexivity.

Chapters five to seven present the findings from each sub-sample group of women, birth partners and midwives. Each begins with an introduction to and description of the participants before reporting the final themes relevant to answer the research questions. Chapter eight then outlines the final data analysis steps taken to explore how the themes from the three sub-groups can inform each other, to provide final themes to be discussed.

Chapter nine provides a discussion of the study's findings when considered in the context of wider literature, before chapter nine presents the study's conclusions, including the contribution to the knowledge base with consideration to the strengths and limitations of the research. The implications for both clinical practice and policy are explored, before recommendations for future research are provided.

Chapter 2 Background context

2.1 Introduction

This chapter provides the background context and rationale for this doctoral research project, including an overview of the services available to women during the latent phase of labour, drawing on national and international literature. The parameters for the stages and phases of labour will be outlined, before the significance of the latent phase of labour is discussed with reference to the context of birth in the UK. Following critical consideration of the most usual service organisation for early labour within publicly funded NHS maternity services before 2013, an alternative service structure is described, and service evaluation findings outlined, before gaps in the literature are acknowledged and research questions identified.

2.2 Labour trajectory

Labour is divided into three stages: the first, second and third stage of labour. The first stage of labour encompasses the period of time in which the uterus regularly contracts and retracts, and the cervix progressively becomes fully effaced and dilated (Coad and Dunstall 2011), allowing for the passage of the fetus through the birth canal during the second stage of labour. The first stage of labour is divided into two further phases: the latent (or early) and established (or active) phase of labour. The latent phase of labour itself is difficult to define (Greulich and Tarrant 2007; McDonald 2010), however in the UK it is considered that established labour commences when there is an increase in the rate at which labour progresses and from 4cm cervical dilatation. This is based on research by Friedman (1955; 1956), identifying that from 4cm dilatation the rate of cervical dilation increases, thus indicating established labour. More recent research suggests established labour may not begin until between 4-6cm dilatation (Zhang et al 2002; Zhang et al 2010). This literature has influenced a change in the definition of established labour by The American College of Obstetricians and Gynaecologists (2014; 2019) and the World Health Organisation (2018), to begin at 6cm and 5cm cervical dilatation respectively. For this research project, the National Institute for Health and Care Excellence (NICE) (NICE 2023 pg. 39-40) guideline definition will be referred to throughout due to this being the accepted definition applied in clinical practice:

‘Latent first stage of labour is a period of time, not necessarily continuous, when: there are contractions and there is some cervical change, including cervical position, consistency, effacement and dilatation up to 4cm.’

‘Established first stage of labour is when: there are regular contractions and there is progressive cervical dilatation from 4cm.’

Consequently, cervical dilation, assessed by the undertaking of a digital vaginal examination (VE), is the commonly chosen measurement to differentiate between the latent and established phase of labour (Dixon et al 2013). While there are other means of assessing the rate and progress of labour, such as the observation of regular and painful uterine contractions, these methods carry much subjectivity and rely on accurate maternal reporting to diagnose established labour (Greulich and Tarrant 2007). While the measurement of cervical dilation also carries a degree of subjectivity (Buchmann and Libhaber 2007), progress can be measured over time and therefore is a commonly chosen method.

2.3 Complexities in identifying the onset of established labour

Arguably as challenging as differentiating between the latent and established phase of labour is identifying the onset of labour, which has been cited as a significant clinical decision during the childbirth continuum (Hanley et al 2016). This is due to the influence this decision has on the diagnosis of a prolonged latent phase and labour dystocia, where progress in labour is slow, which may be inaccurate if labour onset is diagnosed erroneously (Lauzon and Hodnett 1998). Whilst the importance of this clinical decision is clear, there is no universal definition of the onset of labour (Hanley et al 2016), partly due to the variety of ways women report experiencing labour onset (Gross et al 2009). Based on the definitions provided by NICE (2014; 2023), both the latent and established stages of labour include the presence of painful contractions. Despite this, Gross et al’s (2006) longitudinal study exploring how women experience the onset of labour discerned that 40% of women did not cite contractions as a sign that their labour had commenced, instead citing other signs such as spontaneous rupture of membranes (SROM). More recent research, using focus groups and questionnaires, has highlighted a range of signs of labour onset including: the presence of contractions, SROM, vaginal loss, pain within the back and legs and reduced appetite (Grylka-Baeschlin and Mueller 2023; Gehling et al 2023). Disparity between the definition midwives use to diagnose labour and women’s experience of the onset of labour is therefore a challenge which further complicates the diagnosis of latent or established labour.

It is recognised that the diagnosis of established labour is complex, with an array of physical and psychological cues to assess (Cheyne et al 2006). Indeed, VEs are cited by midwives as being extremely important in making a diagnosis, however other physical signs such as the presence and strength of contractions, the woman's ability to cope with these and evidence of SRM also influence this decision (Cheyne et al 2006). While VEs are reported by midwives as being most commonly undertaken to assess the commencement and progress of labour (Shepherd and Cheyne 2013), VEs can be embarrassing, painful and distressing (Lewin et al 2005; de Klerk et al 2018) and can act as a trigger for previous trauma (de Klerk et al 2018). The process of undertaking a VE is disruptive to the woman, requiring her to get on and off a bed to have a sensitive and invasive procedure, while experiencing painful contractions. While, when the findings are aligned with the woman's expectations, this can be a '*positive and motivating*' (de Klerk et al 2018 pg. 90) experience, the opposite effect can occur when women are not assessed to be progressing as they had hoped, leading them to become disheartened (Cheyne et al 2007).

Dixon et al (2013) propose that emphasis on cervical dilatation is not beneficial in supporting women, or midwives, to assess the phase of labour without the undertaking of a VE. Reliance on the findings of a VE to confirm latent or established labour consequently requires the presence of a midwife to validate a woman's perception of established labour and removes the focus from the lived experience of women (Dixon et al 2013). This could lead to a sense of loss of control for women, who instead of being encouraged to trust their bodies and the physiology of labour, are subjected to an intimate procedure to validate their experience, potentially negatively impacting their experience.

Dividing labour into two phases is also inconsistent with how women experience labour, with Dixon et al (2013) concluding that while women are aware of the phases of labour, they do not experience or refer to labour in this way, instead describing it as a continuous process. This is further supported by Gross et al (2009) who explored the concept of disparity between a woman and midwife's perception of onset, and thus length of labour. Using a sample of 1170 births, median labour length, as calculated by the woman experiencing it and the midwife caring for her upon admission, was compared, finding nulliparous women that identified labour onset by the commencement of contractions reported labour onset on average 2 hours before the midwife caring for them. Previous longitudinal research by Gross et al (2006) concurs, finding that women reported their labours starting several days prior to the birth of the baby. This is consistent with reflections from clinical practice whereby the recorded length of labour, as calculated by the midwife, is reflected as a much shorter period than the woman reports.

NICE (2014) recognise that there may be misalignment between women and midwives' diagnosis of labour, encouraging midwives to recognise that the woman may consider herself in labour without evidence of cervical change. This is presumably an attempt to avoid the latent phase being treated as an invisible period in which limited or no input from midwives is required. The requirement of a VE to confirm or refute established labour can lead to women's experiences not being validated and feelings of negativity for women (Barnett et al 2008). Diagnosis of labour is therefore a complex concept, whereby midwives must carefully balance the findings of their clinical observations, such as cervical dilatation and contraction frequency, with the experience of the woman when making a decision.

2.4 The latent phase of labour

As demonstrated by the definition of established labour, in which progression in cervical dilatation is a definitive feature, the latent phase is considered a longer, loosely defined period of time (Cheyne et al 2006). The latent phase is of great importance to the childbirth process as it is widely accepted that there is a relationship between events during the latent phase and the likelihood of subsequent intervention.

Over the last two decades six retrospective cohort studies have shown that women admitted to the birthing environment during the latent phase are significantly more likely to experience intervention during established labour, such as caesarean section, epidural analgesia and use of oxytocin (Holmes et al 2001; Klein et al 2004; Bailit et al 2005; Lundgren et al 2013; Kauffman et al 2016; Miller et al 2020) compared to those admitted in established labour. Each study compared the outcomes of women presenting during the latent phase to those presenting in established labour, as defined as either ≥ 3 -4cm or ≥ 4 cm dilated. While these studies confirm a relationship between admission during the latent phase and risk of intervention, they do not offer a reason for this relationship. As such, there are limited, unproved hypotheses, such as that women presenting may be at a higher baseline risk of intervention and that simply being exposed to the medical system may increase intervention (Holmes et al 2001; Bailit et al 2005). The latter is supported by research suggesting that intervention is more likely if an obstetrician perceives a longer labour through the inclusion of the latent phase on the partogram (Cartmill and Thornton 1992), an internationally recognised tool for monitoring progress during labour, identifying labour dystocia and therefore triggering intervention. For this reason, the latent phase is not plotted on the partogram, which is only commenced in established labour. A further hypothesis, based on anecdotal observations of midwives, is that women report a decrease in the frequency of contractions upon admission to the hospital setting, thus slowing

down the progress of labour. Walsh (2009) discredited this observation by asking 58 women in one UK hospital to keep a diary of their contractions throughout labour, finding no significant reduction in the frequency of contractions upon admission. Unfortunately researching the link between admission during the latent phase and intervention using a randomised control trial (RCT), or other controlled methods, is challenging due to the number of variables involved in studying this complex phenomenon and associated ethical considerations, however this has long been advised to offer further explanation (Bailit et al 2005).

In addition to the relationship between admittance during the latent stage and higher levels of intervention, a prolonged latent phase is also the focus of much debate. There is no universal definition for prolonged latent phase, with clinicians and researchers working to varying definitions, ranging from more than 12-24 hours of contractions in nulliparous women, and more than 6-16 hours in multiparous women (Chelmow et al 1993; Maghoma and Buchmann 2002; Lundgren et al 2013; Janssen and Weissinger 2014). Variation in the definition of a prolonged latent phase makes it challenging to compare outcomes of research literature. The inconsistency in definition is due to the way in which labour onset occurs, typically at the woman's home (Maghoma and Buchmann 2002). Reliance on women to accurately record the timing of onset of regular contractions questions the reliability of such data and thus some clinicians prefer to record the time of the first assessment (Maghoma and Buchmann 2002), resulting in part of labour not being recorded. Thus, even if a universally agreed definition were available, challenges would remain in applying this to clinical practice to ensure intervention occurs at an appropriate time.

Historically, a prolonged latent phase was considered benign (Chelmow et al 1993), but later thought to be of clinical significance (Maghoma and Buchmann 2002). Although its significance continues to be disputed, cohort studies have shown women experiencing a prolonged latent phase, compared to those experiencing a shorter latent phase, are also at significantly more risk of interventions such as oxytocin augmentation (Lundgren et al 2013; Janssen and Weissinger 2014; Miller et al 2020), caesarean section (Chelmow et al 1993; Maghoma and Buchmann 2002; Lundgren et al 2013; Janssen and Weissinger 2014; Miller et al 2020) and epidural analgesia (Chelmow et al 1993; Lundgren et al 2013; Janssen and Weissinger 2014; Miller et al 2020). Furthermore, neonates are significantly more likely to have an appearance, pulse, grimace, activity, and respiration (APGAR) score of less than seven at five minutes of age (Chelmow et al 1993; Maghoma and Buchmann 2002; Lundgren et al 2013) and be admitted to the neonatal unit for observation or support (Chelmow et al 1993; Maghoma and Buchmann 2002; Miller et al 2020).

Due to the literature identifying the latent phase as a period of time that influences outcomes and rates of intervention, focus has been placed on midwifery care during this phase of labour as a potential means of reducing intervention during childbirth, which remains a global concern (Fox et al 2019; Marshall et al 2015).

2.5 Intervention during childbirth

To examine the literature around intervention during childbirth there must first be a clear definition of what constitutes a normal, or physiological, birth, to identify deviation from the norm. Despite ongoing international debates surrounding the definition of normal birth (Downe and Finlayson 2016), from a UK perspective a consensus agreement was developed in 2007 by the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG) and National Childbirth Trust, which defined normal birth as:

‘without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery’ (Maternity Care Working Party 2007 pg. 1)

Since this time, following the publication of the independent investigations of University Hospitals of Morecambe Bay NHS Foundation Trust (Kirkup 2015), The Shrewsbury and Telford Hospital NHS Trust (The Independent Maternity Review 2022) and East Kent Hospitals University NHS Foundation Trust (Kirkup 2022), there has been pressure to review the term “normal birth” (RCM 2022a). This is due to the findings of such investigations highlighting that the aim to achieve “normal birth” was prioritised above that of ensuring the safety of mothers and their babies (Kirkup 2015), leading to poor outcomes. While it is not a view I hold - that as midwives we must strive for normal birth - I have kept the term normal birth within this thesis, in view of this being in line with both the language and priorities at the time of the project conception.

As evident through this definition, it is not solely the mode of delivery (i.e. vaginal birth) that constitutes normal birth but rather the absence of intervention. In view of a lack of consistency in recording interventions in birth records (Downe and Finlayson 2016) it is most reliable to examine statistics available on mode of delivery, anaesthetic and induction rates, rather than rely on reported normal birth rates. Data suggests that caesarean section rates continued to rise in all European countries, except for Finland and Sweden, between 2004-2010 (Zeitlin et al 2010). Globally, the trend for caesarean birth is steadily increasing (Betran et al 2021). In the UK, the latest report from NHS Digital (2023) cites that in the year ending March 2023 39% of women had a caesarean section, 57% of women required the use of anaesthetics or analgesia and 33%

of women were induced. When considering this data combined, it is evident that few women in the UK experience birth without intervention. Justification for high rates of intervention has been to improve maternal or perinatal outcomes, however neither of these have been improved by the introduction of such interventions (Marshall et al 2015). An example of this is the routine use of continuous cardiotocography (CTG) of the fetal heart during labour which, following its introduction in the 1960's (Jauniaux and Prefumo 2016), was thought to improve perinatal outcomes by detecting fetal compromise in utero (Alfirevic et al 2013). On the contrary, subsequent synthesis of the literature identified no significant difference in perinatal mortality or morbidity, but instead the risk of caesarean section is significantly higher among women with continuous CTG (Alfirevic et al 2013; 2017).

As there are short and long-term risks associated with interventions such as increased rates of maternal mortality, infection, bladder injury and uterine rupture in subsequent pregnancies following caesarean section (RCOG 2022), and severe headaches, infection and nerve damage following epidural analgesia (Obstetric Anaesthetists' Association 2008 and n.d), it is considered that a reduction in intervention rates will improve both maternal and neonatal outcomes, and reduce the financial costs associated with intervention. As a result of the link between admission during the latent phase and risk of intervention, guidelines recommend that women remain at or return home until the established phase of labour (NICE 2014; 2023; White 2012) to reduce this risk.

2.6 The context of birth in the UK

To further explore the recommendation that women remain at home until labour has established, the context of birth in the UK must be outlined to critically consider the practicalities of implementing this recommendation. Maternity services in the UK are predominately delivered by the publicly funded NHS, with as few as 0.4% of women opting to pay for private maternity care (National Audit Office 2013). Between 2001 and 2012 the Office for National Statistics (ONS 2015) reported an increasing trend in the number of live births. Meanwhile, there was no accompanying increase in the number of midwives, and thus a shortage of midwives ensued. Between 2005 and 2010 this shortage was highest, with the RCM (2011) reporting England had an estimated deficit of 5,000 midwives. As the birth rate gradually plateaued, and the number of midwives gradually increased, the disparity between the birth rate and number of midwives reduced. However latest figures (RCM 2023) estimate a shortage of 2,500 full time midwives in England, highlighting a continued strain on the service.

While the increase in birth rate begins to account for the shortage of midwives, staffing numbers are further complicated by an aging demographic of midwives and high numbers of midwives leaving the profession. Although no more recent statistics are available, the percentage of midwives aged over 50 years in the UK ranged between 33-41% across the four countries in 2016 (RCM 2016). The profession faces a challenge in training new midwives and providing opportunities for them to increase their experience before senior, experienced midwives retire. To further complicate this matter, the number of midwives being trained does not negate the number of midwives leaving the profession (RCM 2023), either through retirement or dissatisfaction with their career. Prior to the COVID-19 pandemic this was a recognised concern, with midwives who had recently left the profession citing staffing concerns and dissatisfaction at the level of care they were able to provide as the leading reason for this decision (RCM 2016). Concerningly, no improvement has been observed in more recent years, with a fall of 600 midwives observed in one year alone between April 2021 and April 2022 (RCM 2022b). Further, midwives are among the staff groups with the highest sickness rates within the NHS (NHS England 2023), resulting in additional pressure on the workforce. Trade unions have voiced their concern about the rising numbers of midwives leaving the profession and the strong indications this will continue. An RCM (2021) survey of 1588 midwives established that over half of respondents were considering leaving their role in the next 12 months, again citing displeasure with staffing levels and working conditions. This results in a vicious cycle, whereby poor staffing levels exacerbate a staffing crisis through lower retention of midwives.

More recently, The Independent Review of Maternity Services (2022) highlighted how staffing problems across the maternity workforce contributed negatively to the safety of women and babies, and the demands to deliver increasingly complex care to a changing demographic of women. Average maternal age has increased considerably since 1973 (ONS 2013), now being 30.9 years (ONS 2023) after a year-on-year increase from 30.0 years in 2013 (ONS 2014). Increased maternal age exposes women to increased risk during pregnancy (Cooke et al 2012), including gestational diabetes and caesarean section (Cleary-Goldman et al 2005; Vaughan et al 2013; Fitzpatrick et al 2016). Furthermore, an increasing number of women with complex medical needs or comorbidities are accessing maternity services (RCM 2023). Providing care to women at increased risk requires additional input from midwifery and obstetric teams which is challenging for service providers in the current climate.

In response to staffing concerns exacerbated by the COVID-19 pandemic NHS England (2023) developed the NHS Long Term Workforce plan, detailing the actions required to improve staffing levels across the NHS. The plan focuses on three areas: training more staff, retaining current staff and reforming ways of working. For the midwifery workforce, the target is to increase the

number of student midwives on programme by 13% between 2021/22 and 2024/25, including through increasing the number of students on the apprenticeship route (NHS England 2023). While this plan is ambitious, it is not estimated to achieve full staffing levels until 2027/28 (NHS England 2023) meaning continued strain on the service for the time being.

In view of this, NHS Trusts providing maternity services must carefully consider how to effectively and efficiently organise and deliver services. In the context of early labour, organisation of services differs depending on the available community and hospital-based facilities in NHS Trusts. For some NHS Trusts this includes delivering services across multiple hospital sites, at alongside or standalone midwifery-led units and through home birth services, resulting in several early labour models within one service (Spiby et al 2013). In consideration of the drive to reduce the number of women admitted early to reduce rates of intervention (Flamm et al 1998) there has been substantial change to the organisation of NHS services over the last twenty years. Changes include the introduction of home assessments and telephone proformas, changes to guidelines and to the organisation of the service (Spiby et al 2013). Commonly, women suspecting they are in labour will telephone the maternity service (Spiby et al 2013), typically a busy labour ward, birth centre or day assessment unit, and speak to a midwife, before a decision is made regarding whether a face-to-face assessment is necessary. This conversation is described by midwives as a means of providing reassurance and advice to the woman while gaining an understanding of the woman's situation and the signs of labour she is experiencing, to decide whether the woman should remain at home or have a face-to-face assessment (Eri et al 2011). If the decision has been made for face-to-face assessment, services such as triage areas, home assessment or assessment at a labour ward or midwifery-led unit are offered by NHS Trusts (Spiby et al 2007).

2.7 Local context

An NHS Trust in Southern England, providing maternity care for approximately 5,000 women per annum (NHS Digital 2023), adopted an approach to care in early labour similar as outlined above. With four options for birth location across the Trust, including two hospitals, a standalone midwifery led birth centre and home birth, management of early labour differed across the locality. The usual process when a woman suspected she was in labour was for her to telephone her chosen birthing location, such as the labour ward or birth centre. Here, a midwife would undertake a telephone assessment of the situation, and the woman would either be given advice for remaining at home or be invited to attend for assessment. Consequently, anecdotal evidence suggests midwives faced competing demands, as they attempted to juggle

workload in a busy labour ward or birth centre setting, leaving limited time available to support women on the phone during early labour.

Following a review of early labour services in early 2013 (Kuponiyi 2013) the senior maternity management team at the Trust decided to change early labour service provision across all sites. Changes aligned services following the merge of two NHS organisations and aimed to ensure equitable care for all women accessing maternity services, regardless of their chosen place of birth. Focus was placed on the communication between staff and women and their families in response to 62% of complaints to maternity services being related to poor staff attitude (Kuponiyi 2013).

The service review included feedback from mystery shoppers who telephoned the birthing locations pretending to be in early labour and a survey completed by 54 women, asking them to evaluate their experiences of the care received during early labour. Women were asked to rate the care they experienced on a ten-point Likert scale, with one being labelled as 'not happy' and ten as 'very happy'. The average rating across responses was calculated as 6.63, however seven women, equating to 15.2% of respondents, rated themselves as 'not happy' with their care. Accompanying qualitative comments included a mix of positive and negative experiences, particularly when telephoning the midwife whilst in labour. The language women used to describe their negative experiences, both regarding how they felt during the telephone call and upon face-to-face assessment on arrival in early labour, is consistent with that of previous research, finding women were uncertain (Eri et al 2015) and encouraged to remain at home or return home (Eri et al 2015; Beake et al 2018), even when this was not what they wanted. While ten recommendations were made in the service evaluation, one notable recommendation in light of this was to introduce a 24-hour telephone triage service for early labour, subsequently changing the entire service structure for delivery of care during the latent phase of labour.

2.8 A different way of delivery

While the introduction of a telephone triage service for early labour is not unique, with many NHS Trusts implementing this service between 2008-2013 (Spiby et al 2013), the NHS Trust collaborated with the local ambulance service, to develop an innovative and distinctive service different to those implemented before it. The telephone triage service - the 24-hour labour line - was moved away from the traditional location within a clinical setting, into an ambulance control room, where the role of the midwife in providing telephone support and advice to women in labour 24 hours a day, seven days a week became protected.

Through the development of a specialist team of telephone support midwives, it was proposed that women, regardless of where they had chosen to birth their baby, would receive consistent and evidence-based advice and, due to the 12-hour shift patterns of midwives, would be more likely to experience continuity of the same midwife while at home during labour. This was a stark comparison to existing services where the person answering the telephone would often differ with each call.

The justification for the location of the service was multi-dimensional. Firstly, the ambulance control centre, which also hosted the NHS 111 service, already had the required technological arrangements and service infrastructure to embed the telephone support service with minimal effort and with the benefit of experienced staff available to support the navigation of the telephone system.

Secondly, locating the midwife away from the traditional clinical setting was thought to enable the midwives to focus on their role in providing support and information to women and their birth partners on the phone, without the distraction of other responsibilities on the ward. Furthermore, embedding the service in a location with other staff members available enabled women accessing maternity services within the Trust to phone one dedicated telephone number and not receive an engaged tone. At the time of the launch of the service this was possible through the support of clinical nursing and paramedic staff in the ambulance control centre. If a woman telephoned the service, and the midwife was already on the phone, the call would automatically divert to clinical staff who would take the woman's details and ask the midwife to call back as soon as the call they were on had ended (Mackenzie 2014). More recently, following collaboration with other local NHS Trusts, the call is now diverted to another midwife based in the centre.

Finally, it was hoped that the setting would promote collaborative working between maternity and emergency services. Midwives were a point of contact for paramedics to phone if they had concerns about any patients presenting with an obstetric related problem, and midwives were able to request ambulance support if a woman phoned the service with an obstetric emergency.

The service was the first of this kind documented globally and has since been adopted by numerous NHS Trusts across the UK. Furthermore, during this research project NICE (2014 pg. 24) implemented an additional recommendation in the intrapartum guideline stating:

'Consider an early assessment of labour by telephone triage provided by a dedicated triage midwife for all women'.

This recommendation was included following the submission of evidence to NICE by the NHS Trust, outlining the service evaluation findings which assessed the extent to which the service had achieved its aims and formed a judgement on the care provided to women and their birth partners. This recommendation remained in place until 2023 when the guideline was updated and reference to a dedicated triage midwife for all women was removed. No explanation for this change is available within the supporting documentation, however this could be reflective of current staffing challenges, or a lack of primary research evaluating the service.

2.9 Challenges of the service

While the concept of the 24-hour labour line offers solutions for existing systemic problems within maternity services, and potential for improving experiences for women, birth partners and midwives, there are possible shortcomings to the service requiring consideration. Firstly, it is hard to quantify the cost effectiveness of the service in the absence of a thorough cost-benefit analysis to measure the financial value or cost to both maternity and ambulance services.

Secondly, the midwives staffing the 24-hour labour line are removed from the quota of midwives working clinically on any one shift. The aforementioned shortage of midwives and focus on safe staffing within maternity services, as highlighted by The Independent Review of Maternity Services (2022), leads to questions about the appropriateness of reducing the number of midwives working in the clinical setting to staff the telephone support line. In a local service evaluation undertaken shortly after the launch of the service (Mackenzie 2014), while most staff recognised the advantages of the 24-hour labour line for both women and staff, the removal of experienced midwives from the clinical area was identified by some as a concern, and the requirement for answering the telephone to be a dedicated role questioned. The skill mix of midwives has since been cited by the RCM (2023) as a concern, with the NHS not retaining older, more experienced midwives, leading to a drive to prioritise the retention of midwives, as well as focusing on the training of newly qualified midwives. While fewer midwives working in the birthing environment pose one challenge to the service, an alternative view could be that the 24-hour labour line provision has helped retain staff who may have otherwise left the profession due to work-related burnout.

Thirdly, while the 24-hour labour line offers some continuity of a midwife across a 12-hour shift, it differs from the continuity recommended within the National Maternity Review (2016) which advocates for a small team of midwives caring for women during pregnancy and the childbirth continuum. The 24-hour labour line was initiated before this recommendation and centralises the care and advice women are provided at home during labour. Existing evidence suggests

midwife-led continuity of care models reduce interventions and achieve maternal satisfaction (Sandall et al 2016) and the NHS remains committed to its ambition for this to be the default model of care (NHS England and NHS Improvement 2021), however the roll out of continuity of care models was hindered by the coinciding COVID-19 pandemic and ensuing staff shortages. Following the publication of the Independent Maternity Review (2022), NHS Trusts were instructed to review and suspend existing continuity of care provision and halt further roll out until safe staffing could be demonstrated, resulting in NHS England removing national targets for the rollout of continuity of carer (NHS England 2022). This decision was made in light of the model being resource intensive and therefore unachievable in the context of a depleted workforce (Ockenden 2021). In time, as the NHS strives towards the goal of all women accessing a continuity of care model, a challenge for the 24-hour labour line service is how to integrate the two systems, or if indeed they should be.

A final consideration is the skill set of midwives, both those working in the hospital and community setting, and on the labour line. Directing all women querying the onset of labour to one place creates potential for midwives working elsewhere to lose the skill of undertaking telephone labour assessments which was a standard part of their previous practice. It will be imperative that student midwives are also afforded the opportunity to work within the labour line setting to develop the risk assessment skills required to undertake telephone assessments upon qualification. In addition, if labour line midwives chose to solely work in this setting, rather than in the hospital or community setting providing face-to-face care, their clinical currency in practical skills and confidence in this area may also diminish over time.

2.10 Service evaluation

A service evaluation of the labour line was undertaken by Mackenzie (2014) five months after implementation to evaluate the potential impact of the service on birth outcomes and the experience of women, birth partners and staff. The evaluation was required to consider the longevity of the service and identify areas for further improvements. The evaluation included an analysis of birth outcome data and an online survey of women and birth partners, midwives, obstetricians and ambulance service employees exploring their experience of the service.

Mackenzie (2014) used retrospective audit to compare the outcomes of women telephoning the labour line to those of the women in Kuponiya's (2013) review. This showed a 23% increase in the number of women presenting for face-to-face assessment in established labour when compared to the Kuponiya (2013) review, resulting in fewer women returning home after initial assessment. This increase is viewed positively considering the theory that women remaining at

home until established labour reduces the risk of intervention during labour. Furthermore, Mackenzie's (2014) retrospective audit of 1% of births during 2014 identified that women admitted during the latent phase experienced intervention in the first stage of labour more frequently than those admitted in established labour (57% vs 21%). While there was a lack of control within the analysis of this service evaluation, this data supports existing evidence that supporting women to remain at home during early labour may reduce the risk of intervention.

Alongside analysing the impact of the labour line on birth outcomes, the experience of women, birth partners and staff was also considered an important part of the evaluation of a new service. The opinions of the 82 women and birth partners who responded to the online survey were mostly positive, with 88% reporting that they felt listened to by the midwife, and 89% stating that they would recommend the service to others (Mackenzie 2014). Furthermore, in both the 2013 and 2014 reviews women were asked to rate their experience of the latent phase on a scale of 1-10, with 1 measured as 'not happy' and 10 measured as 'very happy'. As demonstrated in Figure 1, women more highly rated their experience of the latent phase following the introduction of the labour line, with the mean in the 2014 review being 8.38, compared to 6.63 in 2013 (Kuponiya 2013; Mackenzie 2014). Although these data have not sought to establish the statistical significance of this finding, it does suggest that although more women remained at home until established labour, it did not appear to be at the detriment of their experience.

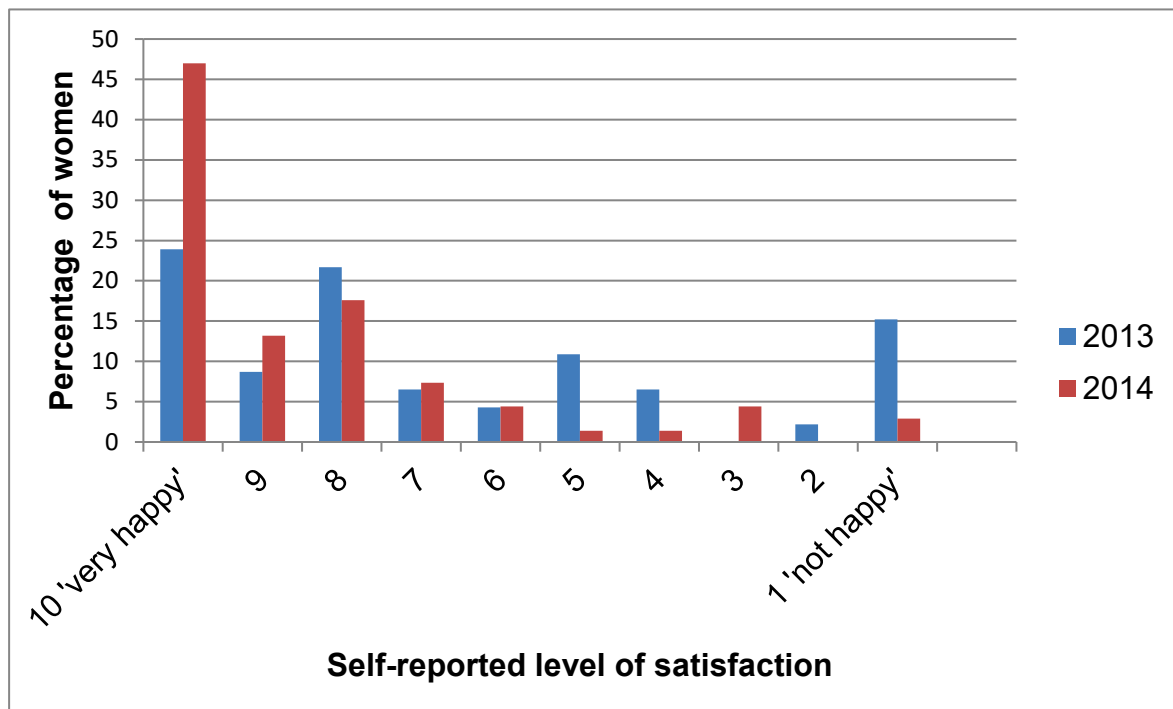


Figure 1 - Comparison of women's satisfaction with early labour care in 2013 with 2014 (Kuponiya 2013; Mackenzie 2014)

The staff survey was completed by ten midwives working on the telephone triage service, seventy clinically active maternity service staff members (including hospital and community midwives and obstetricians) and thirty-five ambulance service employees. Staff across all groups were overwhelmingly positive about the service, as demonstrated in Figure 2. Staff were asked to answer 'yes' or 'no' regarding whether they thought that the service benefitted specific groups. One hundred percent of midwives working on the service agreed that 'yes', the service benefits women, staff and the NHS Trust, and while slightly fewer members of other maternity services staff and emergency operations staff agreed, the majority highly valued the service.

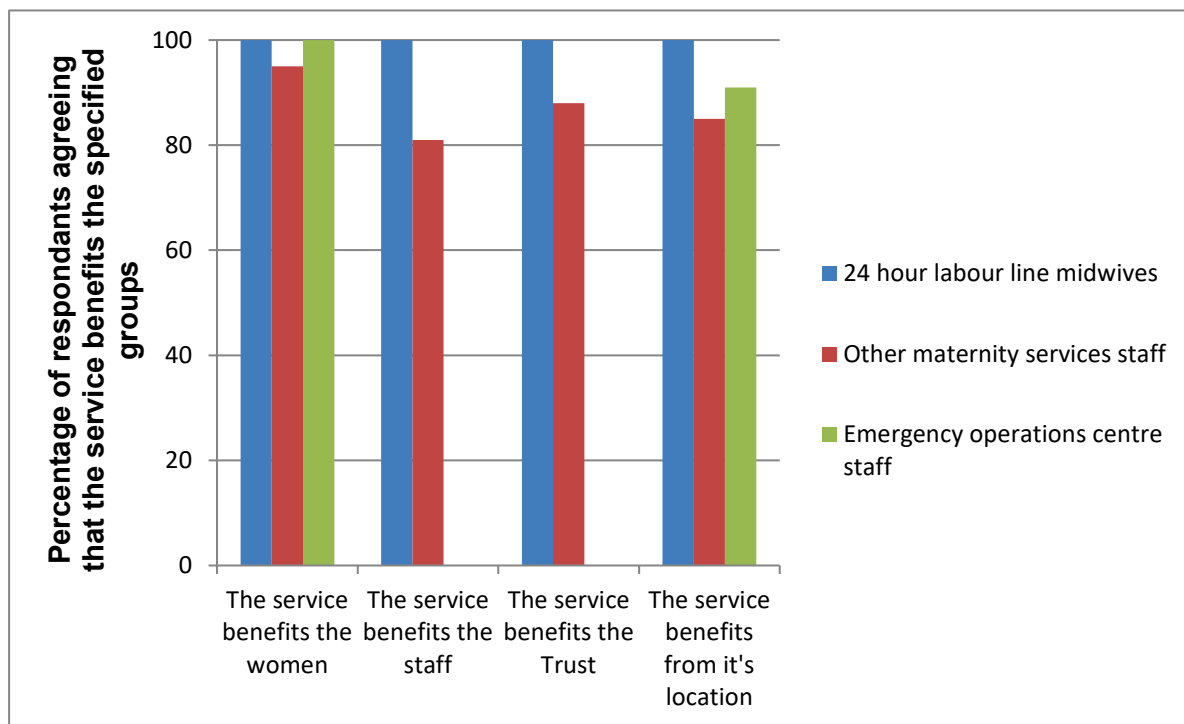


Figure 2 - Staff views of the benefits of the telephone support line (Mackenzie 2014)

2.11 Focus of this research

The latent phase of labour is a complex phenomenon for women and midwives alike to navigate. It is well documented that women admitted during the latent phase are at increased risk of intervention, which in turn increases the risks of maternal and neonatal morbidity and mortality. Consequently, women are advised to remain at home during early labour, and present to their chosen birthing environment once labour is established. To support women to remain at home, changes to early labour service provision, including the introduction of home assessments, telephone assessment tools and triage areas, are commonplace (Spiby et al 2013), however challenges in the management and funding of maternity services hinders the success of such changes, requiring midwives to manage competing demands.

The 24-hour labour line offers a unique service that has not previously been examined as an option for early labour service provision, and in view of the positive findings of the service evaluation, has been implemented permanently across multiple NHS organisations. While the service evaluation suggested the telephone support service is highly rated by women and staff, and may contribute to improving the outcomes of women, it was an online survey with a small sample of women and very limited representation of birth partners' views (2% of participants), as is appropriate for a service evaluation. It was not within the scope of the service evaluation to analyse the lived experiences of women, birth partners or midwives in any depth. Accordingly, further qualitative exploration of the service to fully understand how women, birth partners and midwives make sense of and experience this phenomenon, and the impact this has on their overall labour experience, is required to better inform practice.

Having identified the purpose of the study being to explore the experiences of those using the service, I developed initial research questions, which are the starting point for the research process (Agee 2009; Williamson and Whittaker 2017), before undertaking a literature review. While I was confident that I would be unlikely to locate primary research focused around the 24-hour labour line service, I was unsure if there had been exploration of any other services where the midwife had protected time to provide telephone support to women in labour. As such, the initial research questions focused on the dedicated nature of the telephone support line.

In keeping with qualitative research questions, each started with “what” or “how” to keep focus on the central phenomenon (Creswell and Poth 2018) and were open-ended (Smith et al 2022; Creswell and Creswell 2023). It was accepted that these questions would evolve during the research process, including upon completion of the literature review, but enabled a primary focus of the study to be identified (Agee 2009; Creswell and Poth 2018).

2.11.1 Research questions

- What are the experiences of women and birth partners who access a dedicated, midwife-led, telephone support line for labour?
- What are the experiences of midwives working on a dedicated, midwife-led, telephone support line for labour?
- How was the telephone interaction between midwife and women intended, experienced, understood and interpreted by each party?

2.12 Evolution of the 24-hour labour line

Between 2013-2022 the 24-hour labour line was structured as outlined in section 2.8. In 2022 the service evolved to become “Maternity Triage Line”, with an expanded team of midwives taking calls from pregnant women from 20 weeks' gestation. Since this time the Maternity Triage Line has taken an average of 120 calls per day and, in addition to providing advice and support to women in suspected labour, also triages callers' concerns relating to reduced fetal movements and pregnancy concerns such as abdominal pain. All data exploring the experiences of the 24-hour labour line was collected prior to the adaptation to the service.

2.13 Conclusion

This chapter has provided the background context and rationale for this doctoral research study. Research has identified that women presenting at the birthing environment during the latent phase are at increased risk of intervention, and therefore maternity providers must consider how service provision can be arranged to encourage women to remain at home during this period. An alternative service, the 24-hour labour line, has been described and an initial service evaluation outlined to identify gaps in the literature and research questions. The next chapter provides synthesis and evaluation of the available literature exploring women, birth partners and midwives' experiences of telephone interaction during early labour to identify further gaps in knowledge and refine the research questions.

Chapter 3 Literature Review

3.1 Introduction

This chapter synthesises the available literature exploring the experiences of women and their birth partners at home during the latent phase, with attention paid to telephone interaction with midwives during this phase. Existing literature exploring the experiences of midwives' communication with women via telephone during this phase of labour is also presented. The systematic search strategy, which was derived from the initial research questions, and the inclusion criteria are outlined. A narrative review of the selected literature is provided and gaps in knowledge are identified before the aims, objectives, and final research questions to address these gaps are presented.

3.2 Selection of review process

This study adopted a phenomenological approach (section 4.3), thus in keeping with this philosophy caution was applied to the undertaking of a narrative literature review, to minimise the influence of theories on the researcher and promote an inductive approach. The narrative literature review identifies what is already known about a phenomenon, to minimise repetition, identify gaps in knowledge and help justify the proposed research (Grant and Booth 2009; Smith et al 2022). A scoping review was considered, however this approach does not include analysis of the quality of the research (Arksey and O'Malley 2005). Offering comment on the quality of existing research is considered by Smith et al (2022) to be a key part of the literature review process within IPA and thus a scoping review was rejected. A need to examine the quality of existing work also resulted in consideration of a critical review, however this approach is more theory-driven (Grant and Booth 2009), which is advised to be avoided within IPA studies. A narrative literature review instead provided opportunity to identify strengths and limitations of previous work, to inform future work without being theory-driven, and was therefore the selected approach. This narrative review generated themes outlining what was already known about telephone interaction between women, or birth partners, and midwives during labour, and this knowledge informed the research questions at the beginning of the doctoral research process.

3.2.1 Management of research published after the narrative review

Aligned with IPA, the approach was iterative (Smith et al 2022), with the narrative review undertaken at the start of the research process (2015), and then updated throughout the project (2018, 2023), taking into consideration the publication of new research. This was particularly pertinent in view of the time taken to complete the study being close to ten years and the substantial changes to the professional landscape, particularly in relation to maternity services in the UK, during this time.

Throughout this chapter it is clearly identified which papers were located and selected for consideration after the narrative review had been concluded at the start of the research process. When newly published research was located in 2018 and 2023, the same process of critical appraisal and tabulation, as outlined in section 3.5 and 3.7, was applied. The methodological approach and findings of these studies were considered in order to review any impact on the ongoing research project, particularly in light of the publication of one meta-synthesis (Eri et al 2015) and one systematic review (Beake et al 2018). While narrative reviews can encompass both primary and secondary research (Greenhalgh et al 2018), the publication of these two reviews part way through the project provided opportunity to consider the analysis of these authors, to either support or challenge the findings of the initial narrative review. The inclusion of additional literature did not identify additional themes, or lead to the revision of existing themes, but did provide additional support for the existing themes and the need for further research exploring alternative forms of service provision, such as the 24-hour labour line, and birth partners experiences. For these reasons, these papers were integrated into the narrative review and are presented within this chapter alongside the papers identified in the initial narrative review.

3.3 Focus of review

An initial scope of the literature identified no literature relating to a dedicated telephone support service for early labour. Therefore, to find the literature most relevant to the research questions, the focus was on telephone contact between women, birth partners and midwives during early labour. It is noted that some studies focus specifically on telephone contact, while others explore the experiences of early labour, with reference to telephone contact. For this reason, all studies citing telephone contact during the latent phase were included, to ensure thorough

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consideration of available literature. The main threads of the literature review can be located in Figure 3.

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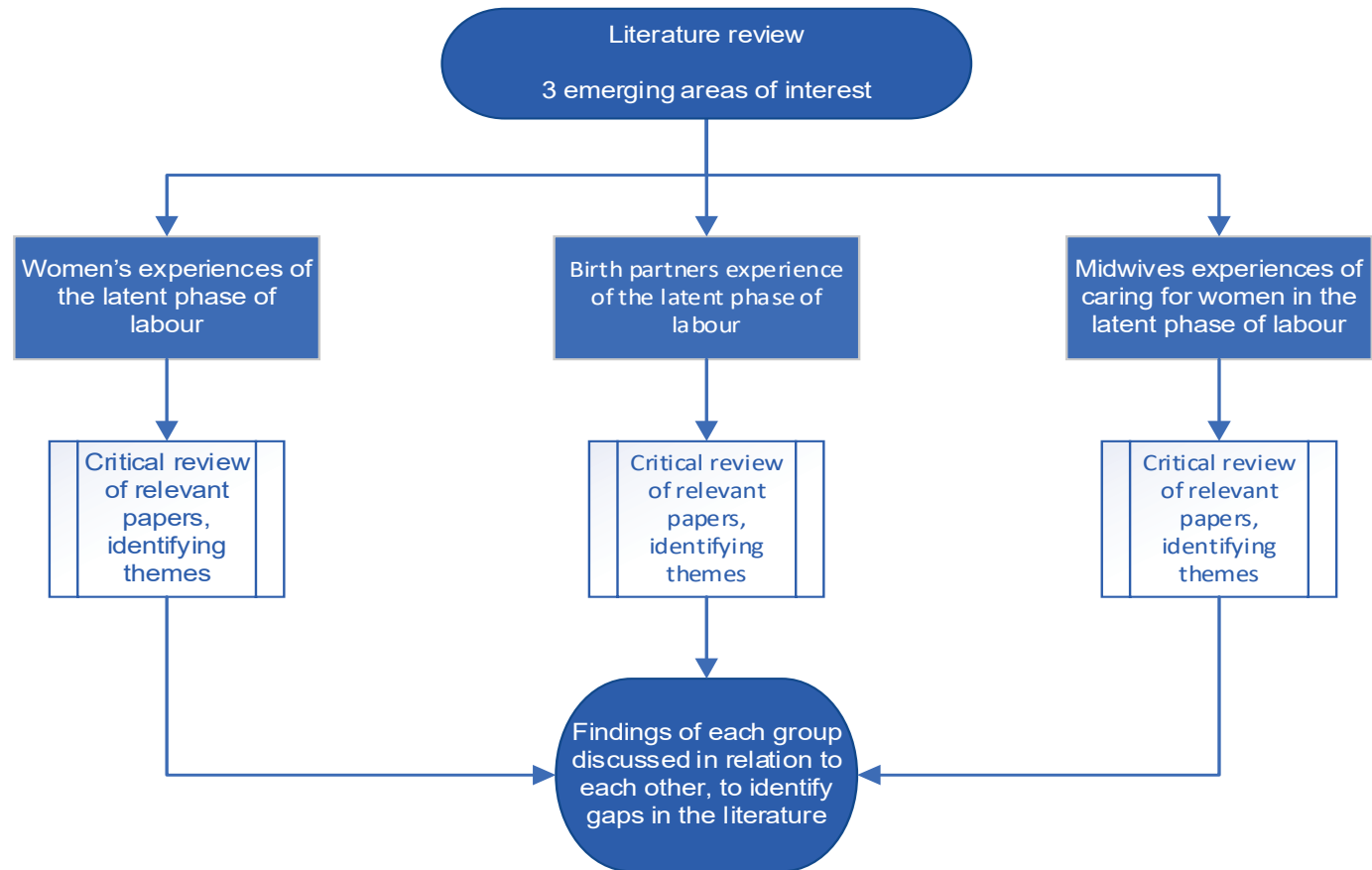


Figure 3 – Overview of literature review

3.4 Detailed Search Strategy

First, the 'Pregnancy and childbirth' section of the Cochrane Database of Systematic Reviews was manually searched to identify existing reviews synthesising the topic area. Any reviews exploring the latent phase or support for women during labour were sought for consideration. One review by Kobayashi et al (2017) was identified, however this was excluded due to its focus on the impact of assessment and support interventions during the latent phase on birth outcomes, rather than experience. No further relevant Cochrane reviews were identified.

Six databases, selected due to the inclusion of relevant health and social care literature, were searched for material. These were: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE), MEDLINE, PsycINFO, Scopus and Web of Science. An overview of these databases is in Appendix A. Grey literature was searched using search engines, such as Google Scholar and NICE Evidence Search, yielding no further literature.

The key search terms, split across two searches, comprised; latent, early, phase, stage, labour, midwives, midwife*, matern*, telephon*, phon*, call*, triag*, contact* and communicat*. Boolean operators 'AND' and 'OR' were used to refine the search further. Appendix B outlines the combination searches undertaken and number of hits.

3.4.1 Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied to the search results (Table 1). In view of several publications in the late 1990's describing the relationship between admission during the latent phase and risk of intervention during labour, the search was restricted to include literature from 1998 onwards. It was considered that this would capture contemporary literature reflective of the change in clinical practice from the millennium; that women are advised to remain at home during the latent phase. Literature published prior to this change in practice would not be reflective of contemporary experiences and therefore has limited scope for informing practice.

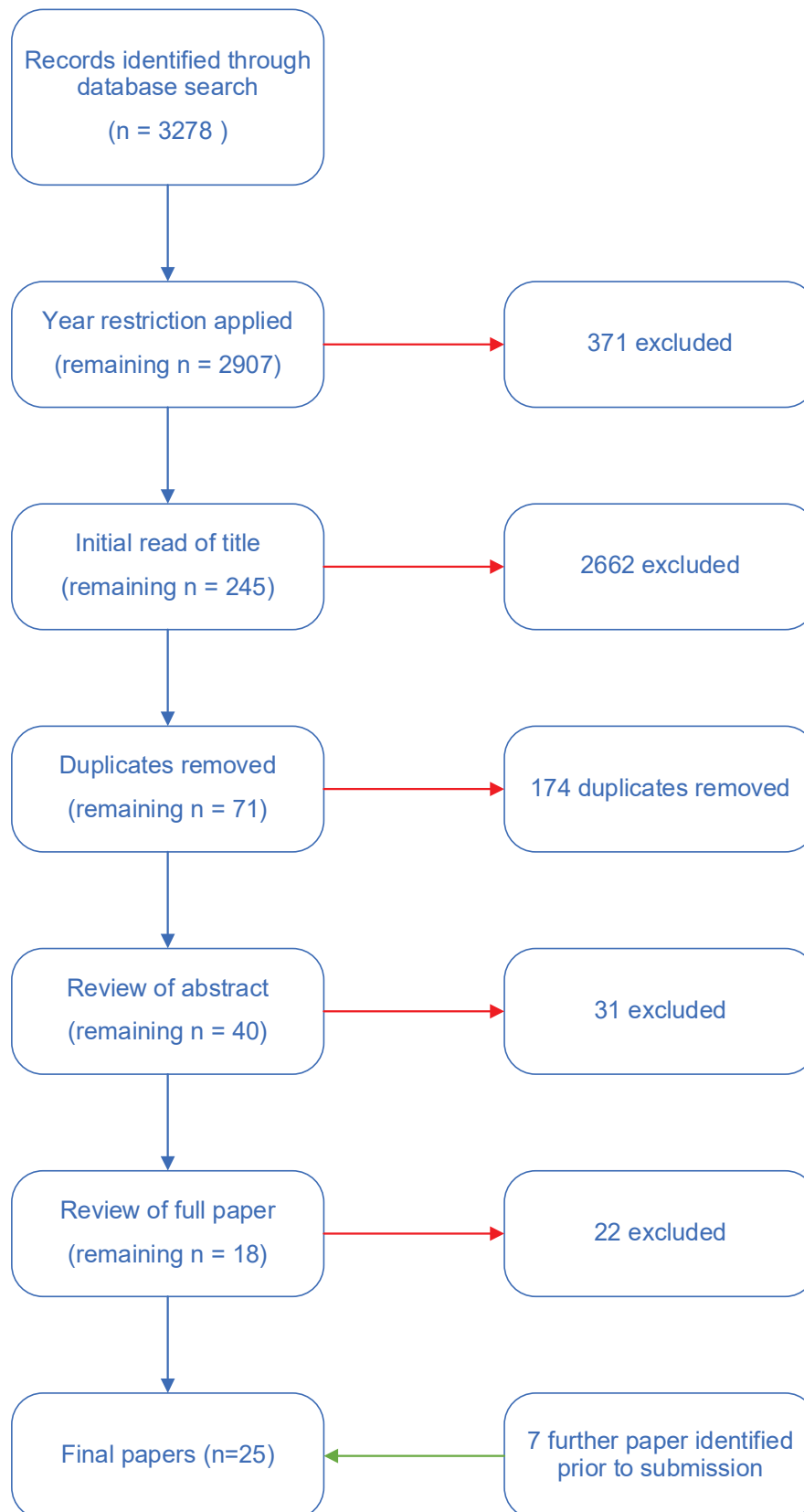
Table 1 – Literature inclusion criteria, with justification

Inclusion	Justification
Papers published between 1998 and 2023.	To reflect a change in practice from 1998.
Written in English language.	Language of researcher and cost of translation.
Research in countries with a similar healthcare standard to that of the UK.	To improve transferability.
Research papers, including meta-analysis/meta-synthesis.	As per Cochrane recommendation (Hannes 2011).
Qualitative, quantitative, mixed-methods research.	To ensure all research exploring the experience of contact between women/birth partners and midwives were included.

Papers were included if the data was collected in countries with a similar healthcare standard to that of the UK. This was defined by the income of the country, with papers from high-income countries being included. Research conducted in low-income or middle-income countries were excluded due to the different outcomes associated with pregnancy and childbirth in these settings, such as higher maternal and neonatal mortality rates (World Health Organisation 2024a, 2024b), and the resulting differences in priorities between these settings and the UK. Focus in low-income and middle-income countries appropriately remains on reducing preventable maternal and neonatal death, which is a current target of the Sustainable Development Goals (United Nations 2015) in view of rates of maternal and neonatal mortality being significantly higher in low-income countries compared to high-income countries (United Nations 2024). Research priorities in low-income and middle-income countries are attentive to exploring and addressing the structural deficiencies that prevent the delivery of effective interventions and the availability of trained healthcare professionals. There is also a difference in the availability of evidence-based guidelines that hinder the transferability of research in these settings to the UK (Miller et al 2016).

In the initial search conducted in 2015, the combination of the two searches outlined in section 3.4, retrieved 3,278 papers and this was reduced to 2,907 when restrictions to the year of publication were applied. The title of each paper was reviewed for relevance, leaving 245 papers, before duplicates (n=174) were removed. The abstract of the remaining 71 papers were

reviewed for relevance, resulting in 40 eligible papers. The full paper was read, resulting in a further 22 being excluded, leaving the final number of papers as 18. In later years the literature search was conducted again to ensure further publications were incorporated into the review identifying two additional papers in 2018 and five additional papers in 2023, bringing the total to 25. The sifting of literature is demonstrated in Figure 4.

**Figure 4 - Reduction in literature**

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Sixteen papers related to women's experience of the latent phase, five related to birth partners experience and five to midwives' experience. Throughout the project no papers exploring a service similar to that of the 24-hour labour line were identified. Table 2 provides an overview of the selected studies.

Table 2 - Overview of selected studies

Study	Country	Aim	Methodology	Participants	Setting
Women only studies					
Cheyne et al (2007)	UK	To explore women's experiences of early labour and factors influencing the decision to attend hospital.	Qualitative study. No overarching methodology identified. Data collected using semi-structured interviews, some in a group setting, and analysed using latent content analysis.	Twenty-one women. Sixteen primiparous and five multiparous women.	No information provided on setting or early labour services offered within this setting.
Barnett et al (2008)	UK	To explore women's experiences of deciding to attend hospital, and subsequently being sent home in early labour.	Qualitative study. No overarching methodology identified. Women completed a diary during early labour and participated in an interview post birth. Data was analysed using latent content analysis.	Five primiparous women.	Women called one of three Scottish hospitals directly in early labour. No information provided on early labour service design within these settings.
Carlsson et al (2009)	Sweden	To explore women's experience of being admitted to hospital during the latent phase of labour.	Qualitative study adopting a grounded theory approach. Data collected using semi-structured interviews. Data analysis occurred simultaneously using initial coding and pooling of themes into categories, which guided	Eighteen women. Eleven primiparous and seven multiparous women.	A hospital with a labour ward providing care to high and low risk women, adopting a medical model of care. A labour admission test is performed on admission. No information

Study	Country	Aim	Methodology	Participants	Setting
			future interviews until data saturation was met.		provided on early labour services available prior to admission.
Nolan et al (2009)	International	To explore how women experience contact with maternity services during early labour.	Quantitative survey, distributed via SurveyMonkey on BabyCentre website. Paper presented data from women that birthed in a labour ward setting and experienced either spontaneous vaginal birth or assisted vaginal birth. The experiences of women from each group was compared using non-parametric tests.	2433 participants, mostly from the UK and Ireland (87.9%). 12.1% of participants were situated outside the UK or Ireland, or did not specify location. The majority of participants (90.9%) were White and primiparous (67.2%).	International study, comparing the experiences of women that birthed their baby in a labour ward setting. Due to participants being recruited from a wide geographical area, no information was provided on the early labour services available prior to admission.
Eri et al (2010)	Norway	To explore first-time mother's experiences of contact with hospital midwives during early labour.	Qualitative study. No overarching methodology identified. Data collected using interviews and diaries kept at home during labour. Data was analysed using reflective and critical examination to identify patterns within participants experiences.	Seventeen primiparous women.	Fifteen women accessed care at a University hospital, one at a medium sized hospital and one at a small hospital. No information provided on early labour services available prior to admission, other than that some

Study	Country	Aim	Methodology	Participants	Setting
					women contacted the hospitals prior to admission.
Nolan and Smith (2010)	UK	To explore women's experiences after telephone advice from a midwife to remain at home during early labour.	Qualitative study. No overarching methodology identified. Data collected using semi-structured telephone interviews and analysed using thematic analysis.	Eight women, seven primiparous women and one multiparous woman.	A hospital with a consultant led maternity unit. Women telephoned the obstetric triage unit for advice in early labour and to arrange admission to the hospital. No detailed description of the organisation of the obstetric triage unit provided.
Carlsson et al (2012)	Sweden	To explore women's experience of staying at home in the latent phase of labour.	Qualitative study adopting a grounded theory approach. Data collected using semi-structured interviews. Data analysis occurred simultaneously using initial, focused and theoretical coding. Codes were compared, concepts constructed and categories formed.	Nineteen primiparous women.	A country hospital. Women were asked to telephone a 24-hour clinic prior to attending the hospital labour ward.

Study	Country	Aim	Methodology	Participants	Setting
Green et al (2012)	UK	To explore women's experiences and satisfaction with the telephone component of the All Wales Pathway for Normal Labour.	A mixed methods study, collecting data using computer assisted telephone interviews with quantitative and qualitative questions. Quantitative and qualitative analysis was performed simultaneously, with the data from one informing the other and vice versa. Data analysis processes were outlined over several key steps.	Forty-six primiparous women.	Six hospitals in Wales. Women were provided telephone advice as per the structured All-Wales Clinical Pathway for Normal Labour.
Larkin et al (2012)	Ireland	To explore the childbirth experiences of women in Ireland.	A descriptive qualitative study, collecting data using five focus groups. Data was analysed using thematic analysis.	Twenty-five women, nine primiparous and 16 multiparous.	Four Irish maternity hospitals, two of rural location and two city hospitals. Due to participants being recruited from across Ireland, and early labour not being the focus of the study, no information was provided on the early labour services available prior to admission.

Study	Country	Aim	Methodology	Participants	Setting
Weavers and Nash (2012)	UK	To evaluate a service improvement project to implement a telephone triage service.	Data was collected using a survey to evaluate women and staff views of the telephone triage service. The survey included quantitative questions which were analysed using descriptive statistics, and qualitative comments which were analysed using thematic analysis.	Eighty-eight women. Parity was unspecified. An unspecified number of midwives and support workers participated.	A hospital in the South of England, with a labour ward and midwifery-led unit. A telephone triage service was implemented for 12 hours a day, 7 days per week in the midwifery-led unit. A telephone proforma was created to ensure consistent advice to women.
Janssen and Desmarais (2013b)	Canada	To compare the experiences of women randomised to receive telephone support only, to those randomised to receive a home visit in early labour.	Multi-site RCT. Women were randomised into usual care (telephone support only), or intervention group (home visit) and asked to complete the ELEQ to evaluate experiences following birth.	630 nulliparous participants - 328 in the intervention (home visit) group and 302 in the usual care (telephone support) group. Questionnaires completed by 246 women in the intervention group and 197 in the usual care group.	Seven hospitals in South-Western area of the province British Columbia, Canada. Women in the usual care group called an obstetric nurse, based in the hospital for support. Women in the intervention group received a home visit and physical assessment.

Study	Country	Aim	Methodology	Participants	Setting
				Comparable socio-demographics across the two groups.	
Eri et al (2015) *returned in 2018 search	Meta-synthesis including papers from Scandinavia, the UK and USA.	To synthesise evidence exploring first-time mother's experiences of early labour.	Meta-synthesis of 11 papers based on interpretive meta-ethnography, resulting in 16 themes.	231 primiparous women across 11 papers.	Selected studies were from three high-resource countries, where hospital based maternity care was provided to women.
Allen et al (2020) *returned in 2023 search	Australia	To explore women's experiences of early labour care in a caseload model.	Analysed survey data collected as part of a multi-site RCT. Women were randomised to the intervention (caseload care) group or usual care group. Women were invited to participate in a survey six weeks postpartum. This paper presents the findings of the early labour category of	Eighty-four women, 44 from the intervention (caseload care) group and 40 from the usual care group. Sixty-four nulliparous women, and 20 multiparous women.	Two hospitals in Australia. Women in the usual care group called the hospital directly for support in early labour and to arrange a physical assessment. Women in the intervention group experienced caseload care from a named midwife and

Study	Country	Aim	Methodology	Participants	Setting
			qualitative content analysis, analysed using critical thematic analysis.		telephoned this midwife directly for support in early labour. If assessed as necessary, the midwife and woman would meet at the hospital for a physical assessment.
Myhre et al (2021) *returned in 2023 search	Norway	To explore women's experience of the information received in early labour and their information needs as reflected postnatally.	Qualitative exploratory and descriptive design adopted. Data collected using focus groups and analysed using systematic text condensation.	Sixteen primiparous women across five focus groups, who had remained at home in early labour.	Four hospitals in Southern-Eastern Norway. No information provided on early labour services available prior to admission.
Vik et al (2022) *returned in 2023 search	Norway	To explore the experiences of Somali women who made contact with health professionals prior to admission.	Qualitative study. No overarching methodology identified. Data was collected using semi-structured interviews and analysed using Systematic Text Condensation.	Ten women, two primiparous and eight multiparous women.	Due to participants being recruited from across Norway, no information was provided on the early labour services available prior to admission.

Study	Country	Aim	Methodology	Participants	Setting
Mueller and Grylka-Baeschlin (2023) *returned in 2023 search	Switzerland	To explore the self and clinical management sought by women in early labour.	Qualitative study. No overarching methodology identified. Data was collected using four focus groups and analysed using content analysis.	Eighteen primiparous women.	Conducted in the German speaking part of Switzerland. Due to participants being recruited from six hospitals across the geographical area, no information was provided on the early labour services available prior to admission.
Birth partner only studies					
Nolan et al (2011a; 2011b; 2012)	UK	To explore how fathers experience early labour at home.	One study, published across three papers. Conducted using a quantitative survey hosted on SurveyMonkey and advertised on The Fatherhood Institute website and via Children's Centres. No information provided on data analysis processes.	263 fathers. 85.3% of participants were White. 52.4% were first time fathers, and 47.6% second time fathers. 85.2% had babies born in a hospital setting, 9.5% at home and 5.3% in a midwife-led unit.	Due to participants being recruited from a wide geographical area, no information was provided on the early labour services available prior to admission.

Study	Country	Aim	Methodology	Participants	Setting
Roberts and Spiby (2020) *returned in 2023 search	UK	To explore fathers' experiences of early labour.	Qualitative study using an interpretivist approach. Data was collected using semi-structured interviews and analysed using thematic analysis.	Twelve fathers. Ten participants were a first time parent and two had older children.	Due to participants being recruited from across England, no information was provided on the early labour services available prior to admission. Participants experienced care in both hospital obstetric-led units and midwife-led birth centres.
Midwife only studies					
Cheyne et al (2006)	UK	To examine the ways midwives diagnose labour from their own perspective.	Qualitative study with no overarching methodology identified. Two focus groups were used to collect data and analysis was in the form of latent content analysis.	Thirteen midwives. Nine midwives were working in a labour ward setting, two in a postnatal setting and two in a research setting.	A hospital in the North of England. No information provided on early labour services available prior to admission.
Eri et al (2011)	Norway	To explore the priorities and strategies of midwives when communicating with	Qualitative study. No overarching methodology identified. Data was collected using focus groups. Text was coded, before codes were clustered	Eighteen labour ward midwives.	A University hospital in Norway, with two labour wards. One labour ward provided care to only low risk women. The service had no protocol for telephone

Study	Country	Aim	Methodology	Participants	Setting
		women during early labour.	into themes and patterns across participants identified.		communication with women during early labour.
Spiby et al (2014)	UK	To explore midwives' beliefs and concerns relating to telephone conversations with women in early labour.	Qualitative IPA study, using focus groups and semi-structured interviews. Analysed using Smith et al (2009) IPA.	Twenty-three staff members, including labour ward co-ordinators (8), midwives (6), managers (3), matrons (2), obstetricians (2), a lecturer and receptionist.	Two maternity units in the Midlands of England. One unit takes early labour telephone calls in an assessment area during daytime hours, and directed women to labour ward for assessment. Outside of daytime hours early labour telephone calls were directed to labour ward. Early labour telephone calls at the second site are directed to labour ward at all hours.
Papers exploring multiple perspectives					
Beake et al (2018)	Systematic review – including	To explore the experiences of women, birth partners and health	Systematic review of 21 papers, designed using the recommendations of the Joanna Briggs Institute for	Reviewed 21 publications. Fifteen papers focused on women's experiences, four	Selected studies were from six high-income countries, offering

Study	Country	Aim	Methodology	Participants	Setting
*returned in 2018 search	papers from the UK, Ireland, Scandinavia, USA, Italy and New Zealand.	professionals of managing early labour.	systematic reviews of qualitative studies. The systematic review resulted in 18 themes.	on healthcare professional experiences, one on birth partner experiences and one on women and midwives experiences. The total number of participants is unspecified.	maternity care in obstetric or midwife-led facilities.
Shallow et al (2018) *returned in 2018 search	UK	To explore the interactions of women and midwives at the start of labour.	Participatory action research. Data was collected using focus groups and semi-structured interviews. Data was analysed using coding and a process identified as 'The Listening Guide'.	Seventy-two participants – the total number of women and midwives is unspecified. Characteristics of participants unspecified.	A maternity service in the North of England, with an obstetric unit and two midwifery-led units. No information provided on early labour services available prior to admission.

3.5 Critical appraisal of published work

To critique the literature the Critical Appraisal Skills Programme (CASP 2013) tools were used, due to the availability of a range of tools for different methodologies. An example critique of one study is provided in Appendix C, and a CASP checklist summary table provided in Appendix D. Critical appraisal was undertaken for each paper before the twenty-five papers were tabulated in three categories: women, birth partners' and midwives' experience. Each table provided an overview of; full reference, justification for study, methodology, recruitment, sampling/sample size, key findings, conclusions, critique and application to literature review.

3.6 Patterns in the literature

3.6.1 Country of origin

The studies ranged in their country of origin, with over 48% (n=12) of studies conducted in the UK and a further 32% from Europe (Norway (n=4), Sweden (n=2), Ireland (n=1), Switzerland (n=1). One study was from Canada and one from Australia. One presented the findings of an international survey and the final two were a meta-synthesis surmising the findings of 11 international papers and a systematic review surmising the findings of 21 publications. These studies were included in view of cultural similarities with the UK or the availability of public healthcare and the consistent recommendation to remain at home during early labour, improving the transferability of the findings.

3.6.2 Service provision

To assess the transferability of the findings, the service outlined was considered to determine similarities and differences to the 24-hour labour line. Of the 23 primary research papers 14 did not specify the service provided to women, hindering the ability to assess the transferability of findings. Five papers required women to telephone the labour ward or midwifery-led-unit directly, while two provided a telephone triage service and obstetric triage unit for part of the day, with women required to telephone the labour ward out of hours. More definition regarding the set up and running of the obstetric triage unit would have been beneficial in establishing how similar the service is to other maternity hospitals. For example, there was no information provided regarding whether the obstetric triage unit was dedicated to triaging women in the latent phase or if the midwives have other roles, such as running a day assessment unit, potentially impacting women's experiences. One paper explored the experiences of women that

either called their caseload midwife, or the hospital directly. The final paper was a RCT comparing home visits to telephone support provided by a hospital based obstetric nurse. The lack of research into a dedicated telephone support service such as the 24-hour labour line identifies a clear gap in the literature, which my project aims to address.

3.6.3 Methodology and methods

Ten studies used a qualitative approach, which is appropriate in exploring the experiences of women, birth partners and midwives. Five qualitative papers did not specify an underpinning methodology, making it difficult to assess the philosophical stance of the researcher. Two studies used a grounded theory approach, one IPA and the final paper adopted participatory action research; all appropriate methodology to address the research aims. Six papers adopted a quantitative approach, while one used a mixed-method approach. The two remaining papers were a meta-synthesis of 11 qualitative research papers (Eri et al 2015) and a systematic review of 21 qualitative research papers (Beake et al 2018). Seven papers from Eri et al (2015) and 12 papers from Beake et al (2018) were also selected for this review and there was overlap of seven papers between these two reviews. The remaining papers selected for analysis were not considered relevant for this literature review due to a lack of reference to telephone interactions during labour.

3.7 Key themes

Following critical appraisal of the selected literature each study was tabulated into a group; research exploring women, birth partners' and midwives' experience. Papers that presented the perspectives of more than one group were tabulated in all appropriate groups, with the findings pertinent to that group outlined. Organising the information in this way made initial synthesis of the findings from each group easier in the first instance.

Key findings were extracted from each paper. The themes that the authors of papers presented as their findings was the information used, rather than raw data as offered through verbatim quotes. This was to acknowledge that verbatim quotes are usually presented to support the credibility of an interpreted theme, rather than as themes themselves. When extracting findings only information applicable to the focus of the narrative review was included. Focus was placed on findings relating to telephone interaction between women or birth partners and midwives during the labour. In some cases, such as Larkin et al (2012), this was not the main focus of the study, which instead explored women's experiences of birth, with contact between women and

midwives during early labour featured as part of that wider exploration. Extracting only these aspects helped ensure only relevant information formed part of the narrative review.

Within each group, patterns were searched for across the key findings. This was done initially by highlighting similar findings across papers, before identifying the most recurring topics and grouping them within a new document to form themes. After each group had been considered individually, patterns were searched for across the group themes to identify relationships between them. This led either to further support for a particular theme, or offered an alternative perspective within the themes to be considered as subthemes to an overarching theme. Finally, the themes were reviewed and categorised into one of three overarching themes; stay at home as long as possible, decision-making is not woman centred and interaction with midwife can positively or negatively influence experience. Subthemes were identified within each overarching theme, as outlined in Figure 5.

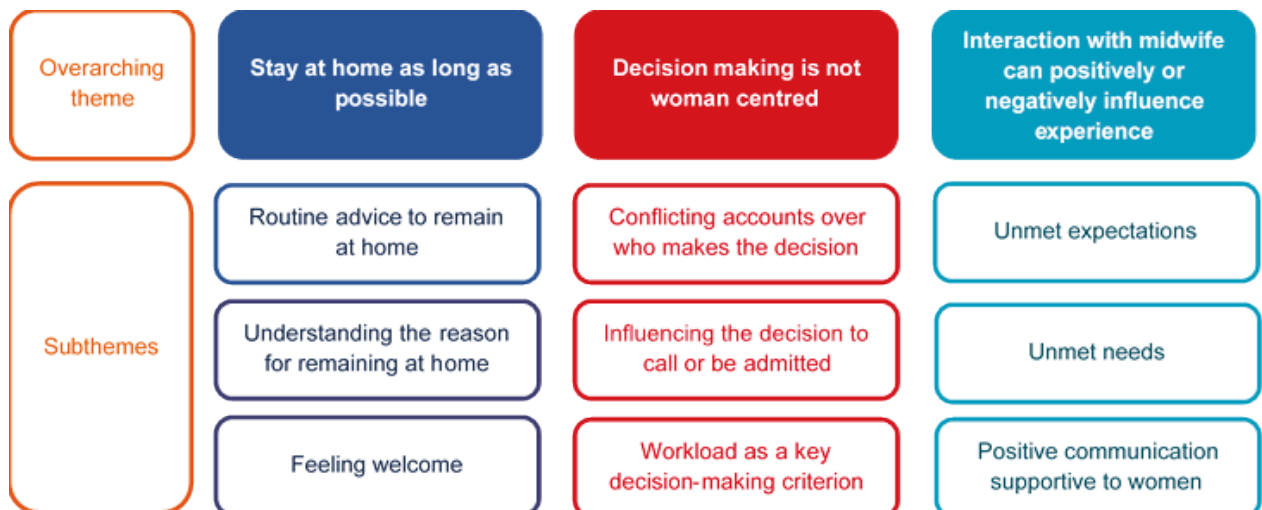


Figure 5 - Overarching themes and subthemes

3.7.1 Stay at home as long as possible

Stay at home as long as possible was an overarching theme, with three subthemes supporting this theme: routine advice to remain at home, understanding the reason for remaining at home and feeling welcome.

3.7.1.1 Routine advice to remain at home

Ten papers referred to the advice from the midwife being to stay at home for as long as possible (Cheyne et al 2007; Eri et al 2010; Nolan and Smith 2010; Eri et al 2011; Green et al 2012; Larkin et al 2012; Spiby et al 2014; Eri et al 2015; Shallow et al 2018; Mueller and Grylka-Baesclin 2023). Findings from studies exploring midwives' and women's experience of early labour were

congruent in this theme; women were aware the advice was to remain at home and midwives acknowledged that they gave this advice. This is perhaps unsurprising as the advice is in line with the guidelines of NICE (2014; 2023) and the RCM (White 2012), to reduce the intervention associated with admission during early labour. One study recognised that women have different experiences with regards to advice to remain at home, with some women perceiving the hospital as having an open-door policy, and others feeling they were being asked to stay at home too long (Myhre et al 2021). Three studies quantified the number of participants advised to remain at home. Green et al (2012) identified that 32 of 46 women were advised to stay at home, while Nolan and Smith (2010) discerned that all eight women were advised to stay at home, though for the latter study this formed part of the inclusion criteria. Of note, Shallow et al's (2018) participatory action research identified that of seven participants experiencing unexpected birth outside of the hospital, four spoke with a midwife and were advised to remain at home, despite informing them that they wanted to attend for assessment.

Qualitative studies, Cheyne et al (2007) and Nolan and Smith (2010) explored the experiences of women during labour, finding that women were advised to remain at home as long as possible, or until pain relief was required. Women in these studies generally wanted to be at home (Cheyne et al 2007) and most would opt to remain at home in early labour if they were to be in labour again (Nolan and Smith 2010), though there were some women in these studies who had concerns about remaining at home and risks to their baby. This was echoed by studies involving birth partners (Nolan et al 2011b; Roberts and Spiby 2020) and women in wider studies (Vik et al 2022). Nolan and Smith (2010) surmise this by suggesting that, due to the portrayal of birth in the media and the amount of screening offered during pregnancy, women expect monitoring in labour to be required. Instead, in early labour they are expected to monitor things themselves, which they find challenging. Consequently, they seek physical examination from a midwife to provide reassurance (Mueller and Grylka-Baeschlin 2023) and had this been provided would have been happy to return home (Cheyne et al 2007).

While Cheyne et al (2007) and Nolan and Smith (2010) provide insight into the experience of women receiving this advice, there is very limited context provided by the authors in terms of the services women accessed during early labour. A thick description of the research setting is required in qualitative research to enable readers to assess the transferability of findings to their context (Lincoln and Guba 1985). Thus, it is difficult to transfer the findings to the context of the 24-hour labour line, as it is not clear where or who women contacted, or if the midwives they contacted had other roles to undertake at the same time as fielding telephone calls.

In Nolan and Smith's (2010) study the recruitment of women also raised some ethical concerns. Women were recruited during labour by the midwife assessing them over the telephone. There are ethical issues arising from recruiting women during labour, in view of their physical and emotional vulnerability, and participation in the study may have impacted the behaviour of both the midwife and the woman. Furthermore, it is not clear at what stage of the telephone call women were recruited or if reassurance was given that their response would not impact their upcoming care, all factors that affect the credibility of the study.

Studies by Eri et al (2011) and Spiby et al (2014) adopted a qualitative approach, using focus groups, to explore the experience of midwives in communicating with women during early labour. Both studies identified that routine advice was for women to remain at home until labour was established to reduce the risk of intervention. Interestingly, midwives in Eri et al's (2011) study showed awareness of the concerns women have regarding this recommendation and cited often offering women to attend for assessment and reassurance before returning home, something not experienced by women in the studies identified or referred to by midwives in Spiby et al (2014). This may be explained by the recruitment strategy adopted by Eri et al (2011). Purposive sampling was used to recruit participants by emailing the target population, and although this is an appropriate and relatively usual way to recruit for focus groups (Goodman and Evans 2010), it can result in an unrepresentative sample, depending on the participants that volunteer. Eri et al (2011) recruited midwives at a hospital in which 75% of women delivered on labour ward, however the hospital also had a midwifery-led unit, and recruitment resulted in most midwives working on the midwifery-led unit, rather than a representative sample of midwives from the labour ward setting. It is difficult to establish to what extent this impacted the findings, but from my own clinical experience the midwifery-led unit may have more capacity to invite women for assessment and reassurance, prior to sending them home again, than the labour ward setting. This is supported by Ball et al (2018) identifying significant volumes of activity on labour wards, contributed to by the admission of women not in labour but requiring attention. In view of the admission criteria for midwifery-led units, there is generally less work of this nature in this environment. In comparison, Spiby et al (2014) recruited midwives from a labour ward setting only, possibly explaining the difference in findings.

The 24-hour labour line does not offer routine advice to remain at home, but instead aims to assess each woman holistically and as an individual, taking into consideration the woman's choice regarding ongoing management. It may be that the availability of a dedicated midwife to women and birth partners empowers them to remain at home with the reassurance that the fetus is not at risk. It is therefore important to explore the experiences of women, birth partners and midwives using the 24-hour labour line with regards to advice to remain at home.

3.7.1.2 Understanding the reason for remaining at home

There were conflicting findings regarding whether women, partners or midwives were comfortable with the concept of women remaining at home. Women in Nolan and Smith's (2010) study were unsurprised at the advice that they should remain at home, as this is what they expected. Green et al (2012) further supports this, reporting that comments women made about advice to stay at home insinuated they were happy about this, as it was in line with their expectations. However, it is not specified how many participants felt this way, and as 46% of women stated they were not informed they would be expected to remain at home, it is questionable how many women were truly satisfied with this aspect of care.

Midwives articulate a clear understanding of the benefits to women remaining at home, and consequently were concerned about admitting women too early (Eri et al 2011), viewing the labour ward as an inappropriate setting for women in early labour (Spiby et al 2014). This understanding was not conveyed to women and their birth partners, who scarcely identified the benefits of remaining at home. Multiple studies identified that women did not fully understand the reasons for remaining at home (Cheyne et al 2007; Nolan and Smith 2010; Nolan et al 2012), leading to a lack of confidence and feeling of uncertainty (Cheyne et al 2007; Nolan and Smith 2010), an inability to relax (Nolan and Smith 2010; Nolan et al 2012), and feelings of fear (Nolan and Smith 2010) and frustration (Nolan et al 2012).

Similar findings were observed for birth partners. Roberts and Spiby's (2020) qualitative study adopting an interpretivist approach was the first to explore the early labour experiences of fathers. Using semi-structured interviews with 12 fathers it appeared that while fathers were aware that the advice was to remain at home as long as possible, there was little understanding among participants about the benefits of staying at home during early labour, with only one father making reference to this (Roberts and Spiby 2020). The fathers were not reassured by this advice, with some questioning the need to do nothing in the early stages of labour (Roberts and Spiby 2020).

Women wanted the midwife to explain the rationale for remaining at home to them, so they could understand and be reassured by this advice (Cheyne et al 2007). When women did understand the rationale, it supported them to maintain control over the situation and they were empowered to remain at home (Carlsson et al 2012). In contrast, those women who lacked such understanding, were more likely to experience multiple admissions for assessment (Nolan and Smith 2010), presumably because they considered the hospital the safest place to be.

While midwives recognise the importance of women remaining at home, the literature does not indicate whether they explain the reasons for this to women and birth partners. In view of the negative impact that not understanding advice to remain at home has on women and birth partners experiences, it is important this aspect of care is explored. The service design of the 24-hour labour line should provide midwives with time to explain the rationale to women and thus differences in the lived experiences could be expected within this study.

3.7.1.3 Feeling welcome

Another way of assessing women's experience is through exploring how welcome they felt they were to attend, or return to, the hospital. Green et al's (2012) study used telephone interviews with both qualitative and quantitative data collection tools to explore women's satisfaction with the telephone aspect of the 'All-Wales Clinical Pathway for Normal Labour', a pathway to provide evidence-based advice to low-risk women at home in early labour. Women were asked to rate their satisfaction using a simple Likert scale, which was piloted but not an approved tool for measuring childbirth satisfaction, affecting the validity of findings. While some women specifically noted that they felt they could have attended the birthing environment if they had wanted, women who rated themselves as 'dissatisfied' with their experience frequently mentioned feeling unwelcome (Green et al 2012), though the number of women experiencing this was not provided, affecting the reliability of the results. Women interviewed in Eri et al (2010) and Allen et al (2020) studies also described that it was important to feel welcome, but this had not been their experience.

How welcome women felt to attend was further influenced by being assessed in the hospital and sent home again as they were not in established labour. Women in both Green et al (2012) and Eri et al's (2010) study revealed that the embarrassment of being sent home, the lack of follow up and feeling unwelcome on admission negatively impacted their experience and discouraged them from making contact or attending again. On the contrary, Spiby et al (2014) found that midwives expressed how important it was that women felt they could phone back or attend the hospital, with midwives explaining that they informed women that they could attend before ceasing the call. Despite this, midwives in both Eri et al (2011) and Spiby et al (2014) stated that they always prepared women to be sent home if they were not in established labour. This finding may be explained by the decision of both studies to use focus groups to collect data. Using focus groups was appropriate for the aim of the studies, which explored midwives' experiences of communicating with women in the latent phase prior to admission, however the challenges associated with using focus groups were not recognised. There is potential that interactions during the focus groups were influenced by other participants, as they were

interacting with colleagues, and thus midwives may be inclined to say what is expected of them, rather than reflect their true experience. This may explain the disparity between the experiences of women, who feel unwelcome, and the intention of midwives, who want women to feel welcome. It may be that midwives have good intentions in preparing women, so that they are not surprised when they are advised to return home, but that in doing so they make women feel unwelcome to attend.

The reasons for feeling unwelcome have not been explored as part of these studies, identifying a gap in the literature. The 24-hour labour line has a clear philosophy that decisions for face-to-face assessment should be made collaboratively with women, and once this decision is made there should be good communication between the 24-hour labour line midwife and the co-ordinators at the hospital sites to ensure the women are expected and welcomed on arrival (Mackenzie 2014). The absent description within the studies of the process that occurred once a woman is invited into hospital makes it challenging to apply the findings to the 24-hour labour line setting. Moreover, the conflicting findings between women and midwives requires further exploration, as the studies were undertaken in different countries, at different times, with different services available in each. Further insight into the intentions of midwives and experiences of women can be gained by examining in this study the experiences of women and midwives using the same service.

3.7.2 Decision-making is not woman centred

Nine studies referred to the decision to attend the chosen birthing location during the latent phase (Cheyne et al 2007; Barnett et al 2008; Carlsson et al 2009; Nolan et al 2009; Eri et al 2010; Nolan and Smith 2010; Eri et al 2011; Eri et al 2015; Shallow et al 2018), with conflicting findings about who made the decision and how it was influenced.

3.7.2.1 Conflicting accounts over who makes the decision

There were conflicting accounts across the literature regarding who made the decision to either call the midwife or attend for assessment. Women recalled their partners and/or mothers (Cheyne et al 2007; Barnett et al 2008; Carlsson et al 2009; Eri et al 2010; Nolan and Smith 2010) being involved in the decision, with it not always being the woman's decision, or desire, to attend. In some instances, women wanted to delay contact as they felt they were coping at home (Cheyne et al 2007) but were pressured by their partners to attend for assessment (Eri et al 2010; Nolan and Smith 2010), increasing the anxiety felt by women (Nolan and Smith 2010).

The only study initially available to explore fathers' experiences of early labour, published across three papers (Nolan et al 2011a; 2011b; 2012), supports this, discerning that fathers identified themselves as either solely making the decision to call or attend, or making a joint decision with the woman in almost 50% of cases. Fathers desired to be in the hospital setting and described being at home as something they had to endure before admission. Nolan et al (2011a) conducted a questionnaire which asked fathers questions about their experience of early labour in relation to their most recent birth. Although 263 fathers responded to the survey, cited by the authors as a satisfactory sample size, no justification for this sample size was provided, and no statistical significance outlined. The survey included mostly closed questions, with a few open-ended questions enabling fathers to provide qualitative comment at the end. Despite this, there was no qualitative comments to explore the involvement in the decision-making process further, providing very limited literature on the role and experience of birth partners in relation to this theme at the time of initial review.

These studies highlight how influential birth partners can be with regards to decision-making in the latent phase, and that this influence must not be undervalued or ignored. In contrast, qualitative research published since the initial literature review and exploring fathers' experience of early labour identified that fathers did not feel involved in decision-making in early labour, instead relying on their partner in labour to make this decision (Roberts and Spiby 2020). The current paucity of research exploring the experiences of birth partners needs addressing, with focus not solely on fathers, but any birth partner that may be influential to the woman's childbirth journey.

Research exploring women's experiences (Carlsson et al 2009; Eri et al 2010; Nolan and Smith 2010; Eri et al 2015; Allen et al 2020) concluded that it was often the midwife that made the ultimate decision regarding whether to attend, acting as a gatekeeper to admission to hospital. Women described having to negotiate (Eri et al 2010) with midwives, or phone to ask if they could attend several times (Nolan and Smith 2010) before this was agreed. Some women used more extreme measures, such as turning up at the hospital, or lying about the frequency of contractions to gain admission (Myhre et al 2021) in order to navigate the system. Midwives were described as having an agenda (Nolan and Smith 2010) to keep women out of the hospital causing much anguish, anger and distress for women. It is plausible that this is the reality, with Eri et al (2011 pg. e290) suggesting women should stay at home '*for their own good*', as midwives attempt to protect women from the increased risk of intervention associated with admission.

Midwives expressed a different account with regards to who makes the decision to go into the birthing environment. Eri et al (2011) found that midwives wanted the woman to agree with their decision, or make it themselves, but only if it aligned with what the midwife thought was the right decision. This is supported by Shallow et al (2018), who concludes that interaction is not personalised, and decisions are not made collaboratively, finding that four of seven women were advised to stay at home when their wish had been to attend for face-to-face assessment. The Nursing and Midwifery Council (NMC) code clearly outlines midwives' responsibility in ensuring women are actively involved in decisions about their care, stating midwives must:

'Encourage and empower people to share decisions about their treatment and care'

'Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care' NMC (2015 pg. 5)

Involving service users in decisions about their care is also heavily integrated into NHS policy, for example the 'No decision about me, without me' publication by the Department of Health (2012), and more recent maternity recommendations which state that women should participate in all decision-making processes related to their care (The Independent Maternity Review 2022). It is therefore surprising that women are not heavily involved in decisions surrounding early labour. Decision-making is cited by midwives as being influenced by knowledge that risks increase if women are admitted to hospital in the latent phase (Spiby et al 2014; Eri et al 2011) and therefore women are advised to stay at home to protect them from intervention. It could be suggested that midwives are torn between two roles; protecting women from intervention, while also trying to empower women and work in partnership with joint decision-making. Early labour may be an example of when these two roles are in direct conflict, particularly if a woman is requesting something that may increase the risk of intervention, challenging the fundamentals of midwifery practice.

Exploration of the experiences of midwives and women in decision-making for assessment when using the 24-hour labour line is therefore important, due to fundamental differences in the approach to decision-making the service takes. According to Mackenzie (2014), a discussion with both the woman and partner regarding the next step should be a precursor to the end of the telephone call, with the three parties agreeing on whether the woman should attend for face-to-face assessment or remain at home. In the case of the latter, the midwife also agrees with the woman when she would like to call back, or if she would prefer the midwife to call her back. The situation of the midwife away from the busy hospital setting may provide time to explore the options available to women. This philosophy underpins shared decision-making and therefore exploring women and midwives' experiences around decision-making in relation to the 24-hour

labour line is important to bridge the gap in knowledge of experiences when a dedicated telephone support service is in place.

3.7.2.2 Influencing the decision to call or be admitted

Interestingly, how women and midwives made the decision regarding when to attend hospital also differed considerably. Women and fathers described fearing seeking care too soon (Eri et al 2015) and were unsure of the right time to attend (Nolan and Smith 2010; Roberts and Spiby 2020) as they were informed by midwives that women often arrived too early (Eri et al 2010). This made women concerned about making contact, as they feared embarrassment if they did not present at the right time (Eri et al 2010). On the contrary, women also identified that they wanted to be admitted, enabling them to hand over the responsibility to a midwife and making them feel safe (Carlsson et al 2009). Women are therefore required to balance these two factors, possibly explaining some of the uncertainty described during early labour (Cheyne et al 2007; Carlsson et al 2009; Nolan and Smith 2010; Eri et al 2015). While this research offers insight into the experiences of women in early labour generally, it does not address the experiences of women with telephone access to a dedicated midwife. Awareness of this service, where women can call at any time, may reduce these anxieties, as they work in collaboration with the midwife to decide the best time, for their physical and emotional wellbeing, to attend for assessment.

Women overwhelmingly reported that pain was the main factor for deciding when to go in, or if previously admitted, return to hospital (Cheyne et al 2007; Barnett et al 2008; Carlsson et al 2009; Eri et al 2015), and this was often the reason birth partners encouraged women to make contact (Carlsson 2009). Other factors influencing the decision included being concerned (Barnett et al 2008) and requiring reassurance (Cheyne et al 2007; Nolan and Smith 2010; Carlsson et al 2012) and a need to share the experience with a health professional to have this validated (Carlsson et al 2009; Nolan and Smith 2010; Carlsson et al 2012). While Eri et al (2010) identified that the frequency and length of contractions reaching two contractions in ten minutes, lasting for approximately a minute, was a trigger to call for admission, less emphasis was placed on this by women in comparison to midwives.

For midwives, telephone decision-making was heavily influenced by physical descriptors provided by women, such as contraction frequency and length, whether SROM had occurred (Eri et al 2011; Spiby et al 2014) and set criteria, for example if the woman had telephoned three or more times (Spiby et al 2014). Focus on these two aspects was evident regardless of whether the woman was coping and simply required reassurance (Spiby et al 2014). Reasons for inviting women for assessment based on these criteria were not explored, however midwives may be influenced by prior experience of caring for women in labour or alternatively are trying to reduce

risk by not advising women to remain at home for too long without assessment. While these criteria were key factors in deciding whether to invite a woman for face-to-face assessment, midwives in Spiby et al's (2014) study stated that they wanted to speak with the woman themselves, rather than confer with a birth partner, to hear the woman experience a contraction. This finding is aligned with the experience of fathers who recalled making the initial call before being asked to hand the telephone over to the woman in labour (Roberts and Spiby 2020). The fact that midwives wanted to listen directly to the frequency and duration of the contraction, rather than rely on what women or birth partners are reporting on the frequency and length of contractions, is an interesting approach. It suggests that midwives may perceive they can judge the strength of contraction and a woman's ability to cope using this method. One example of this may be to assess whether a woman is able to talk through a contraction or needs to pause the conversation. Regardless, the literature highlights that the criterion to gain admission differs for women and midwives.

Although studies offer insight into the criteria women and midwives use to make decisions about admission, the studies were conducted at different times and places, limiting the extent to which conclusions can be drawn about the way women and midwives do or do not make decisions together. Exploring the perspectives of women and midwives using the same service would enable better understanding of the decision-making process and address this gap in the literature. Exploration of the experiences of women, birth partners and midwives, who are all cited as involved in making this decision provides opportunity to do this, while also providing a contemporary study of experiences.

3.7.2.3 Workload as a key decision-making criterion

Midwives across all primary research studies identified workload as an issue when caring for women during early labour (Cheyne et al 2006; Eri et al 2011; Spiby et al 2014; Shallow et al 2018). Within Spiby et al's (2014) study, workload was shown to influence decision-making, with midwives citing that it was important that one person, with knowledge of the workload, controlled who was invited in. Midwives acknowledged that women are not listened to when workload is increased but calls were still considered successful by some midwives if the woman remained at home (Spiby et al 2014).

It is recognised that midwives wanted to provide empathetic care and do what was right for the woman (Shallow et al 2018) however they were restricted by multiple factors, for example: the judgement of other staff (Cheyne et al 2006; Spiby et al 2014) within a culture of delaying admission (Shallow et al 2018), workload through limited physical space within the unit and a lack of available staff to care for women (Eri et al 2011; Spiby et al 2014; Shallow et al 2018) and

the necessity to prioritise the care of women in established labour (Eri et al 2011; Spiby et al 2014; Shallow et al 2018) who require one-to-one care (NICE 2014; 2023). Midwives talked of the conveyor belt on labour ward (Shallow et al 2018) where they are encouraged to clear beds, with little room for niceties. Multiple demands were placed on midwives as they assumed the role of managers, carers, advocates, and co-ordinators while experiencing pressure from women, family, colleagues and managers. In addition to this, midwives were fielding calls, undertaking assessments and caring for women in labour, while also facing pressure to complete the paperwork associated with juggling these demands (Shallow et al 2018).

Midwives showed concern about the requirement to care for women in both established and the latent phase of labour, with them prioritising care for the former (Spiby et al 2014) and consequently, women telephoning in the latent phase being described as a '*burden*' (Eri et al 2011). Midwives voiced that admitting women in early labour to the birthing environment was viewed by some as assuming responsibility for women (Shallow et al 2018). This is an interesting concept, suggesting that midwives are not responsible for the wellbeing of women until they are admitted to the birthing environment and this school of thought potentially puts midwives in a vulnerable position in relation to their code of conduct with the NMC (2015). Furthermore, midwives spoke of the difficulties of trying to protect women from intervention if they are admitted during the latent phase in view of guidelines regarding expected progress in labour (Cheyne et al 2006; Spiby et al 2014). Midwives are encouraged to promote evidence-based practice and adhere to guidelines (NMC 2015), which both involve women remaining at home during the latent phase to prevent intervention. This could explain why midwives in Eri et al's (2011 pg. e290) study suggested women should stay at home '*for their own good*', a seemingly unsupportive attitude in the perception of the mother, but one which is well intentioned advice based on experience and available evidence.

While midwives working on the 24-hour labour line remain aware of the increased risks of intervention to women admitted during the latent phase, they are not competing with the workload demands described by these studies. Instead, the midwives only role is to provide support and advice to women, meaning they have dedicated time to fulfil this role, without causing detriment to other women. Furthermore, their physical location away from the birthing environment may influence the decisions they make collaboratively with women, as they are not privy to workload pressures. Together these differences in approach may impact their ability to make shared decisions based on the woman's need, rather than external factors. Exploration of women and midwives' experiences of the 24-hour labour line will therefore provide new knowledge in this area.

3.7.3 Interaction with midwives can positively or negatively influence experience

Interaction with midwives positively or negatively influencing experience was an overarching theme and was supported by three subthemes: unmet expectations, positive communication is supportive to women and unmet needs.

3.7.3.1 Unmet expectations

Women in some studies had expectations of early labour that were not met and found this distressing. They talked of the preparation they had completed for labour, but that their own experience regarding the onset of labour and labour trajectory did not match their expectations (Cheyne et al 2007; Eri et al 2010). This led to uncertainty about whether labour had commenced (Cheyne et al 2007) and frustration and disappointment that the ‘textbook’ labours they had been taught did not align with their experience (Cheyne et al 2007; Nolan and Smith 2010), with early labour lasting much longer than they had expected (Carlsson et al 2009).

Women, and birth partners, across multiple studies were of the understanding that admission would occur when contractions were five minutes apart, lasting one minute (Eri et al 2010; Green et al 2012; Nolan et al 2012; Eri et al 2015). Women reported being asked about this during telephone calls with midwives (Eri et al 2010), but that they were still advised to remain at home when this criterion had been met (Eri et al 2010; Green et al 2012; Nolan et al 2012; Eri et al 2015). This was distressing for women and birth partners alike, inducing panic about their ability to cope for the remainder of the labour. These findings raise questions about how maternity services support women during pregnancy to understand labour in all its forms; a challenging task due to the multitude of ways women experience the onset and progress of labour (Grylka-Baeschlin and Mueller 2023; Gehling et al 2023; Gross et al 2009; Gross et al 2006).

Women were also negatively impacted by being diagnosed as ‘not in labour’ (Barnett et al 2008), feeling their experience was not being validated by professionals. Barnett et al (2008) used a qualitative approach to explore the experiences of women that had been assessed in the unit and sent home. The approach adopted was strengthened by the triangulation of data collection methods, with women being asked to complete a diary of their experience which could later be used as a prompt for interview. Unfortunately, despite providing some insight into women’s experiences, the study acknowledges problems with recruitment. Researchers aimed to recruit 40 women from four hospitals in Scotland, however just five women participated, impacting the credibility of the research. Furthermore, the paper provides no description of the service women accessed, limiting the transferability of the findings to the 24-hour labour line setting. This may

be due to a lack of available service; with Barnett et al (2008) concluding that further research should focus on evaluating ways to better support women, such as the 24-hour labour line.

There is very limited exploration of birth partners' expectations for early labour. While Nolan et al (2011a) identified that only 41.6% of fathers experienced early labour as expected, the study failed to explore this further in view of the chosen methodology of an online questionnaire.

Roberts and Spiby (2020) offers further insight using a qualitative approach, finding that fathers did not experience early labour and the progression of contractions as they had expected following attendance at antenatal education classes. As indicated previously, birth partners influence the experience of women during early labour, yet there has been very limited exploration of their own experience and expectations, requiring further exploration.

While the 24-hour labour line cannot prevent women and birth partners from forming antenatal expectations about how they will experience labour, the time available to the midwife to explore expectations once labour has commenced may provide a new opportunity to help them manage these expectations in labour. Therefore, exploring the experiences of women and birth partners with access to this service will be valuable in evaluating the service.

3.7.3.2 Positive communication supportive to women

Communication with health professionals was important to women (Beake et al 2018), and when this communication was good it could improve their experience (Eri et al 2015). Women sought midwives that were compassionate, provided reassurance, encouragement, support and information (Carlsson et al 2009; Eri et al 2010; Nolan and Smith 2010; Green et al 2012). Women sought validation of their experiences from professionals (Nolan and Smith 2010) to give them strength and confidence during early labour (Carlsson et al 2012; Weavers and Nash 2012) and appreciated those that alleviated their concerns about arriving at the hospital at the right time (Eri et al 2010).

The importance to women of being provided information and advice during the latent phase is acknowledged by women and midwives alike (Eri et al 2011; Beake et al 2018). Contact provided women with information, advice, and support (Green et al 2012) which Carlsson et al (2009) in turn, observed helped them manage their uncertainty during the latent phase. Encouragingly, Weavers and Nash's (2012) audit of a telephone triage line for early labour in one NHS Trust established that of 88 women participants 100% considered the information given by the midwife helpful, and 92% reported that advice was provided on coping strategies. The service was predominately evaluated as excellent (69%) or good (29%), demonstrating that women value the service, however in a hospital unit with almost 6,000 deliveries per year (Royal

Berkshire NHS Foundation Trust 2014), the 88 women that responded are unlikely to be representative.

Weavers and Nash (2012) was the only paper that specifically explored a telephone triage service for women in the latent phase, though key differences between the service and the 24-hour labour line are evident. The service ran for just 12 hours per day and the telephone triage midwife's role included undertaking physical assessment of women when they presented in labour, thus rendering them unavailable for telephone triage during this time. While the transferability of the findings from this paper to the experiences of women telephoning the 24-hour labour line is limited, it offers insight to some of the benefits of telephone triage services. Methodologically, it would have been beneficial for Weavers and Nash (2012) to undertake a larger questionnaire using a validated tool, such as the Early Labour Experience Questionnaire (ELEQ) (Janssen and Desmarais 2013a), to enhance the reliability and validity of the study, but as a service evaluation project the methods adopted were appropriate. The lack of further evaluation of a telephone triage service for women and birth partners in labour identifies a gross gap in the literature, particularly in view of research by Spiby et al (2013) explaining that the implementation of telephone triage services is a practice change within maternity services. In-depth, qualitative exploration of women's experiences will therefore address this gap and further inform practice.

The experience of fathers was also improved when advice was received during telephone contact (Nolan et al 2012), though this was not quantified and based on limited qualitative comments at the end of a Survey Monkey survey. The use of Survey Monkey hindered the control the researchers had over sampling and recruitment. A convenience sample was chosen and participants were recruited to the survey via advertisement and a link on popular websites. Despite participants responding from across the UK, the majority (85.3%) were white, and employed (Nolan et al 2011a), resulting in the experiences of fathers of other ethnicities and sociodemographic status not being represented. Furthermore, the authors acknowledge disproportionate representation of fathers whose partners had a home birth, consisting of 9% of respondents when the home birth rate at the time of data collection was just 2.7% (ONS 2014), further affecting the generalisability of findings. As the survey was publicly available, it is unknown if participants were genuine, took the survey more than once or how long ago they experienced labour, influencing their ability to recall the event. In view of this, the results of the study must be applied cautiously. Finally, while qualitative commenting was offered, a survey is not the most appropriate way to explore experience, and therefore an in depth, qualitative study will provide further insight into the experiences of birth partners.

3.7.3.3 Unmet needs

When communication between women and health professionals was not good and women felt their needs were not met, it negatively impacted on their experience. Women became frustrated when they could not get firm answers from staff (Carlsson et al 2009), advice did not help them with the pain (Barnett et al 2008) and advice was not individualised (Eri et al 2015). Women in Allen et al (2020) highlighted telephone triage in early labour as a particularly negative aspect of their labour, emphasising the importance of better support in this area.

Most papers concluded that women had not received, what was considered by their own definition, 'adequate' information or advice (Barnett et al 2008; Carlsson et al 2009; Green et al 2012). Green et al (2012), who used a scale of 0-5 to measure satisfaction with the telephone aspect of the 'All Wales Clinical Pathway for Normal Birth', identified a lack of advice. Green et al (2012) not only identified that women who rated their satisfaction as three or less considered that they had received inadequate advice, but also that the differences in experience of women rating four and five demonstrated insufficient advice as a deciding scoring factor. The pathway includes a paper telephone proforma for midwives to complete, with cues for giving appropriate advice. In view of this, all women should receive consistent advice, therefore it is surprising that differences were acknowledged regarding the amount of advice given. There is, however, a lack of control, as it is not known if the midwives followed the proforma, or the women's expectations of advice prior to the call. It is therefore difficult to evaluate the extent to which women were satisfied with this aspect of the pathway, as the degree to which midwives complied with the proforma is unknown. Furthermore, the target sample size was 100 women, which Green et al (2012) justified through it being appropriate for both quantitative and qualitative data analysis with the resources available. The target sample size was not calculated to establish a minimum number of participants to achieve statistically significant results and furthermore the actual sample size following recruitment was 46 women, significantly less than the target size. Although Green et al (2012) acknowledge the problems relating to sample size, it is difficult to apply the quantitative results with confidence in reliability or validity.

Further support that information and advice from telephone interactions with midwives was inadequate is established in Nolan et al's (2009) study which explored the experiences of 2,433 women during early labour using a questionnaire. Nolan et al (2009) identified that more than 50% of women were given no information regarding how to cope better at home and thus no difference in the anxiety levels of women following telephone contact with a midwife. Nolan et al (2009) was the only study to explicitly explore whether women from ethnic minorities had the same experiences as white women, observing that significantly more white women reported

suggestions of how to cope than women from ethnic minorities, showing a difference in experience based on ethnicity. While this was a large study, no justification for the sample size to achieve statistical significance is provided. Furthermore, the questionnaire was completed using free online software Survey Monkey, which hinders the control the researchers had when recruiting participants. The study used convenience sampling to recruit, with the participants accessing the survey via advertisement and a link on popular websites. When exploring telephone interactions in early labour collecting data on the number of women that have English as a first language is arguably more insightful than collecting data on ethnicity. Although Nolan et al (2009) have tried to account for potential problems in accessing a representative sample, by comparing the ethnicities with the latest census and confirming a spread of representation across UK cities, with such limited control and information about the sample the findings are not generalizable and provide little understanding of potential communication barriers faced during early labour telephone care.

In Nolan et al's (2011a; 2011b; 2012) study of fathers' experiences almost half of participants spoke to the midwife on the telephone at home during labour. First time fathers whose partner was having their first baby and who spoke to the midwife were significantly less excited, more anxious and worried about calling for help than those who did not. Thirty-three percent said deciding whether to call the midwife induced anxiety. Labour and birth are found to be life-changing and transformative experiences for fathers (Howarth et al 2017; Ledenfors and Berterö 2016) and midwives recognise that, while it is not their main focus, they do have a role in supporting fathers wellbeing during the childbirth continuum (Wynter et al 2021). As such, reports of anxiety, worry and a lack of excitement from fathers are not what is sought when they are considering contacting maternity services. That said, the survey did not explore how fathers felt before and after speaking to a midwife, therefore it cannot be concluded whether it was speaking with the midwife that induced this response, or if fathers that were inclined to telephone the midwife felt more anxious, worried about calling and less excited regardless. This is a limitation to gathering data on experience using a survey, rather than in depth qualitative research. Further research is therefore required to explore birth partners' experiences in more depth and can be achieved through exploration of the 24-hour labour line service.

Midwives recognised the importance of providing women with clear and specific advice and checking women had understood this advice and agreed with it before ending the telephone call (Eri et al 2011; Spiby et al 2014). However, the conflicting findings regarding the information and advice given to women could be explained by peaks and troughs of workload or the competencies of the specific midwife the woman spoke to. Spiby et al (2013) found that although midwives considered that ensuring women received individualised advice during the

latent phase was essential, on busy shifts women on the labour ward take precedence over this, leading to times that women are not receiving this information and thus impacting on their experience. Furthermore, some midwives in Eri et al's (2011) study had concerns that their colleagues were not always explicit in the advice they were giving, suggesting the experience women receive is dependent upon which member of staff answers the phone. Midwives also admitted that they did not ask women about coping strategies and while the reason for this was not explored, it was suggested by the authors that midwives may be constricted by time or feel inadequately prepared to provide this advice (Spiby et al 2014).

These factors are not necessarily relevant to the 24-hour labour line, in view of the specific training the midwives have received to advise women during early labour, and the protected role of the midwife. It is therefore imperative that the experience of women, birth partners and midwives working in this alternative service is explored.

3.8 Discussion

The key themes identified highlight the challenges women, midwives and birth partners experience when communicating during the latent phase of labour. Despite NHS Trusts identifying significant changes to early labour service provision, such as those identified by Spiby et al (2013), the review identified little research evaluating the impact of changes to early labour service organisation on women, birth partners and midwives experience. Janssen and Desmarais (2013b) were the only authors to compare the satisfaction of women randomised to two different care packages available to women during early labour. Women, when contacting the hospital during the latent phase, were recruited to the study and randomly allocated to receive telephone support only, or telephone support with home visits. Women then rated their satisfaction with aspects of their care using the validated ELEQ. While this study identified that women in the home visit group rated their experience significantly higher than those receiving only telephone support, it does not provide any explanation as to why, or that women in the telephone support group were dissatisfied, thus telling us a limited amount about women's experiences.

As demonstrated within the literature review, there has been no research exploring a dedicated, 24-hour telephone support line for labour that is situated away from the busy birthing environment, where midwives can focus solely on providing information and advice to women and their birth partners, limiting the transferability of existing research to this setting. At the time of the project conception the 24-hour labour line was an innovative and unique service that warranted further exploration. Since this time this model of early labour care has been

implemented by several NHS Trusts across England despite the absence of evidence to support this service change. Evaluating the impact of the 24-hour labour line on women, birth partners' and midwives' experiences will inform hospital Trusts of the strengths and limitations of this service, allowing them to consider current or future changes to their service with further evidence.

There is conflicting opinion between women, birth partners and midwives with regards to who makes the decision to enter the hospital, the level of support and advice available to women while at home and the understood motives for the suggestion that women stay at home. This suggests that communication between women, birth partners and midwives is flawed, both during the antenatal period and early labour. Unfortunately, these findings do not support the woman-centred, personalised approach strived for within the NHS and specifically maternity services (National Maternity Review 2016), and could impact on the future psychological health and family planning of parents (Gottvall and Waldenstrom 2002). This could be a product of the health system, and thus the experiences of those accessing the 24-hour labour line may differ from those outlined in existing studies, warranting research into this area and adding to the currently limited contemporary evidence base around early labour experience.

The conflicting accounts of women, birth partners and midwives require further exploration as no studies explored the experiences of women and midwives following the same episode of contact, arguably explaining some of the differences outlined in relation to decision-making, support and advice. It is therefore recommended that the same episode of contact is explored from the perspective of women and midwives, to enable better understanding of how interactions are intended, experienced, understood and interpreted by each party.

The literature identifies a struggle for midwives, who describe wanting to provide support and advice, but not at the expense of women in established labour. Papers (Eri et al 2011; Spiby et al 2014; Shallow et al 2018) explored the pull of resources on labour wards, with midwives needing to satisfy both woman and managerial demands. This is emphasised by Spiby et al (2014), who refers to labour wards needing to be utilised for '*genuine need*', posing questions regarding whether midwives are appropriately placed, with the additional stresses of the labour ward, to be assessing who qualifies as being at genuine need. Spiby et al (2014) questions whether, if midwives can have telephone conversations with women privately, with no other staff or management observing advice given or the amount of time consumed on the call, this would allow them to be at liberty in advising, supporting and making shared decisions with the woman. This supports the rationale of the 24-hour labour line but as there is limited research on midwives' experience of telephone contact (Spiby et al 2014), all of which has been undertaken

in the labour ward setting, there is a gap in the literature to explore midwives' experiences of a dedicated telephone support service.

Finally, this literature review has demonstrated a paucity of research relating to birth partners' experiences of the latent phase. At the time of the initial literature review, which led to the crafting of the final research questions, just one, poor quality quantitative study explored this. During the project, a high-quality paper exploring the experiences of fathers during early labour was published (Roberts and Spiby 2020), though did not focus on the telephone interaction with midwives but rather on the experiences of fathers more broadly in early labour. Furthermore, there is no literature on the experiences of wider birth partners, such as partners who are not men, or the mothers, siblings or friends of the woman, who are cited by women as being an important support provider during labour (Lunda et al 2018), including the latent phase (Carlsson et al 2009; Carlsson 2012), and are commonly observed attending labour within the clinical setting. Birth partners have also been identified by women as being influential in the decision to call the midwife and seek admission during labour (Barnett et al 2008; Cheyne et al 2008; Carlsson et al 2009; Eri et al 2010; Nolan and Smith 2010) and as a source of anxiety for women (Nolan et al 2009) and therefore further exploration and understanding of birth partners' experience is vital for midwives to appreciate their role in supporting birth partners during early labour.

3.9 Refined research questions, aims and objectives

3.9.1 Research questions

Agee (2009) proposes that good qualitative research questions are developed and refined throughout the research process. Consequently, following the conclusion of the literature review, the research questions were reconsidered to assess their pertinence in light of the identified gaps in knowledge described in 3.8. Due to the absence of research exploring the experiences of women, birth partners and midwives of a dedicated telephone support service for labour, and the need to better understand telephone interactions between midwives and women, the initial research questions proposed in 2.11.1 were retained and are restated below:

1. What are the experiences of women and birth partners who access a dedicated, midwife-led, telephone support line for labour?
2. What are the experiences of midwives working on a dedicated, midwife-led, telephone support line for labour?

3. How is telephone interaction between midwives and women intended, experienced, understood and interpreted by each party?

As appropriate in IPA studies, secondary research questions were then derived from the findings of the literature review (Smith et al 2009; Smith et al 2022) to explore the decision-making processes undertaken on the 24-hour labour line. These questions enabled me to narrow the broader focus of the initial research questions (Creswell and Creswell 2023) and ensure the exploration of decision-making from the perspectives of women, birth partners and midwives. It was considered that two of the overarching themes from the literature review - “Stay at home as long possible” and “Decision-making is not woman-centred” - aligned with the concept of decision-making and warranted further exploration in relation to the 24-hour labour line. In comparison, the final theme - “Interaction with midwives can positively or negatively influence experience” – was captured within the primary research questions and therefore did not require the addition of further secondary research questions. The secondary research questions are:

1. How involved do women and birth partners feel in the decision to attend the chosen birthing location/have a midwife attend at home?
2. How involved do women want to be in the decision to attend the chosen birthing location/have a midwife attend at home?
3. How able do midwives feel to make decisions regarding the delivery of care to a woman based on the woman’s needs, not the workload of the service?

3.9.2 Research aims and objectives

The aims of the research are:

- to understand the lived experiences of women, birth partners and midwives of accessing a dedicated, midwife-led, telephone support line for labour.
- to understand how, and by whom, decisions are made regarding care, particularly around the timing of a face-to-face assessment, from the perspective of women, birth partners and midwives.

The research objectives are:

- To explore the experiences of women and birth partners who access a dedicated, midwife-led, telephone support line for labour.
- To explore the experiences of midwives working on a dedicated, midwife-led, telephone support line for labour.

- To identify factors that influence women, birth partners' and midwives' decision-making around when a woman attends the birthing environment.
- To determine who makes the decision regarding the timing of attendance at the birthing environment for a face-to-face labour assessment.
- To explore the extent to which midwives feel able to make decisions regarding the delivery of care based on the woman's need as opposed to organisational demands.
- To explore the extent to which women want to be involved in decision-making around care in early labour.

3.10 Conclusion

This chapter has outlined the systematic search undertaken to identify literature exploring the experience of women, birth partners and midwives of telephone contact during early labour. Twenty-five studies were critically appraised, and findings synthesised to discuss the available evidence under three overarching themes, each of which was supported by subthemes. The findings were then discussed to identify gaps in the literature.

While the available research provides insight into the experiences of women telephoning traditional telephone triage services, or a labour ward, and the experience of midwives communicating with women via telephone from a labour ward setting, no studies explore the experience of those accessing, or working on, a dedicated telephone support line for women in labour. The location of the midwife away from the clinical setting aims to provide time to support and advise women and their birth partners during early labour, potentially addressing the issues identified by women and midwives in existing research and thus warranting further exploration.

Furthermore, conflicting accounts from women and midwives regarding who makes the decision to attend the birth environment for assessment, and the information and support provided, needs addressing. Previous studies have not explored the perspective of women and midwives following the same episode of contact to understand how interactions are intended, experienced, understood and interpreted by each party. Further, at the time of the design of this research project one study, published across three papers (Nolan et al 2011a; Nolan et al 2011b; Nolan et al 2012), explored the experiences of fathers. This study was methodologically flawed and focussed solely on fathers' experiences, rather than broader birth partners, warranting further research. While further research has since been published exploring the experiences of fathers during early labour (Roberts and Spiby 2020) there remains a gap in exploring the experiences of birth partners accessing a dedicated telephone support service.

Chapter 3

This study therefore provides opportunity to add to the sparse evidence-base of birth partners' experiences of telephone interactions with midwives during early labour.

In view of the findings of the literature review, the research aim and primary research questions were reviewed, and secondary research questions developed. Chapter four will next outline the methodology and methods adopted to answer these research questions.

Chapter 4 Methodology

4.1 Introduction

This chapter presents the chosen research methodology and methods designed to address the research questions. In qualitative research it is recognised that the prior assumptions and worldviews of the researcher, i.e. their ontological and epistemological stance, influence the choices made during the research design process (Ormston et al 2014), and as such these assumptions must be made clear (Creswell 2007). Thus, to begin, the chosen paradigm and related ontological, epistemological and methodological perspectives are debated, and the chosen approach of IPA justified as being most appropriate to answer the research questions. Next the methods of the research are presented and justified including sections on recruitment, sampling, data collection, analysis and ethical considerations. Necessary amendments to the research methods in order to respond to the COVID-19 pandemic are outlined, including the prevention of phase II of the study.

4.2 Research paradigm

Based on the conclusions from the literature review, the identified gaps in knowledge and observations from clinical practice, it was evident that exploration of the experiences of women, birth partners and midwives of the 24-hour labour line was required, lending itself to a qualitative approach. Qualitative enquiry traditionally addresses research questions that seek to explore human behaviour, interactions and experiences (Topping 2010 in Gerrish and Lacey). By the definition of what it seeks to explore, qualitative research is subjective (Harvey and Land 2017) and relies on the interpretation of the researcher to translate experiences and interactions into theory.

This is in stark contrast to a quantitative, or positivist, approach which argues there is one truth that can be objectively measured, independently of human interpretation (Crossan 2003). This stance was widely accepted until the 1900's, when post positivism was developed; arguing that while there may be one phenomenon, there will be different viewpoints of this phenomenon, and as such it is not possible to identify one truth using objective means (Parahoo 2014). Instead post positivists are concerned by correlation, to account for the different viewpoints of any particular phenomenon (Creswell 2007). Importantly, both positivists and post positivists hold the belief that one truth exists but dispute how possible it is to get close to this truth.

Conversely, interpretivism opposes the belief that there is one truth, with focus placed instead on individual human interpretation of experience, that is how we feel and think about experiences to understand them (Ormston et al 2014). In recognising that there is no one truth, the researchers own interpretation and understanding of a phenomenon, and the influence of this on the research process, can also be acknowledged (Ormston et al 2014; Parahoo 2014).

The interpretivist approach fits most comfortably, both with the research questions presented, and my philosophical perspective. First, the research is concerned with the lived experience of the participants, as experienced through their senses. It is considered that not only have the participants had an experience of contacting the 24-hour labour line, but they have also reflected on and interpreted this experience in the context of their social, cultural and psychological understanding (Ormston et al 2014). For that reason, the lived experience of the phenomenon is individual, and more fitting to qualitative exploration, than a quantitative approach with an overarching aim to generalise findings.

Second, within the discipline of midwifery, the use of qualitative research has become an increasingly popular approach in answering practice focused research questions (Miles et al 2013). This may have been triggered by the focus on seeking the client voice within all areas of the NHS (NHS England 2014), and thus the acknowledgement of the insight this can provide practitioners and service providers alike. As Pope et al (2002) argued, it is no longer accepted that the quality of NHS services is measured purely by quantitative means. Instead, the perspective of those involved in new services, in a range of capacities (working with new services, being treated by new services, managing new services or supporting those accessing new services) all form part of the overall assessment of quality (Pope et al 2002; Kingdon 2004).

Qualitative exploration in maternity services is further supported by Kingdon (2004) who concludes that negative experiences of maternity services are not solely based on outcomes, but instead on the extent to which women feel prepared for and in control of the childbirth process. This was an interesting consideration with regards to the dedicated telephone support line. While, as suggested by the initial service evaluation (Mackenzie 2014), it might reduce the number of women being admitted during the latent phase, this is not necessarily the most important factor for women and birth partners if their experience is poor. As a midwife the importance of caring for each woman and family holistically, and individually, is central to the role (Miles et al 2013). It is my personal belief that no two women will experience pregnancy, birth and the puerperium in the same way, regardless of how closely their physical, social, cultural or spiritual demographic align. It is therefore perhaps unsurprising that a paradigm

focussing on individual experience and rejecting the philosophy that research findings can be generalised, has particular resonance with me.

4.3 Interpretative Phenomenological Analysis

The chosen qualitative approach is interpretative phenomenological analysis (IPA). IPA is a relatively new form of phenomenology which integrates a phenomenological, hermeneutic and idiographic approach (Smith et al 2009). While IPA encourages the researcher to get as close as possible to the participants' world, it also appreciates the barriers of the researcher's preconceptions and own experiences on directly accessing this world (Smith and Osborn 2008). As a result, IPA is concerned with how participants make sense of their experience and is referred to as a double hermeneutic method, involving the researcher making sense of the participant making sense of their experience (Smith and Osborn 2008). Next, the three methodological influences of IPA will be explored.

4.3.1 Phenomenology

Phenomenology, with underpinnings in philosophy (Dowling 2007), was established as an alternative approach to the positivist paradigm during the early 1900's, with its foundations built by philosopher Edmund Husserl. The ability of researchers to study reality using objective methods is questioned in phenomenology, due to the complexity of human interaction and experience, and the personal interpretation of reality making it an individual phenomenon (Reiners 2012). Consequently, phenomenology as an overarching principle aims to:

'understand, describe and interpret human behaviour and the meaning individuals make of their experience' (Carpenter 2010 pg. 125).

There are two leading schools of thought within phenomenology; descriptive and interpretative phenomenology, with IPA influenced by both.

Husserl's approach proposed studying things as they appear, before they have been reflected on and '*as free as possible from cultural context*' (Dowling 2007 pg. 132). Husserl argued it is possible to study the experiences of others, without bias from your own experience, beliefs, values or preconceptions about the phenomenon. Husserl referred to this approach as epoché, or 'bracketing'; the concept that judgment can be suspended, and the researcher can examine the phenomenon authentically (Smith et al 2009; Carpenter 2010). In this context,

phenomenology is descriptive. Heidegger, a philosopher working with Husserl, began challenging this approach and developed the form of phenomenology now referred to as interpretative phenomenology. Heidegger questioned the ability of one to successfully 'bracket', as researchers cannot remove themselves from the world in which we also engage in and live (Charlick et al 2016), and so the interpretative process was integrated into phenomenology. In this form it is accepted that it is not possible to completely bracket, and instead the impact that researchers' presuppositions can have on the research is valued (Carpenter 2010).

Other philosophers who have influenced this interpretative nature of IPA include Merleau-Ponty and Sartre. Both are concerned with the position of one's 'self' in the world in which we live. Merleau-Ponty postulates that humans view themselves as different to the other things they see in the world, suggesting that the "self" is involved in observing the world, as opposed to the "self" being subsumed within it (Smith et al 2022). Smith et al (2022 pg. 14) conclude that Merleau-Ponty's stance is that:

'while we can observe and experience empathy for another, ultimately we can never share entirely the other's experience, because their experience belongs to their own embodied position in the world'.

From a research perspective, this means that it is impossible to entirely capture the experiences of others, and so focussing on uncovering these experiences and meanings within data analysis is crucial to ensuring they are not overlooked (Smith et al 2022). In view of not having experienced the exact experience, from the exact same position in the world as the participant, IPA relies on an interpretative lens to assess the meaning-making of the participant.

Finally, Sartre highlights the ongoing process and developing nature of finding oneself, with Smith et al (2022, pg. 15) explaining:

"The self is not a pre-existing unity to be discovered, but rather an ongoing project to be unfurled"

In relation to research, the view that engagement with the world is an iterative process means that as both the participant and researcher engage in this process the meaning they attach is unfolding. The participant and the researcher are both interpreting the phenomenon simultaneously and the story is being developed during the research process (Smith et al 2022).

4.3.2 Hermeneutics

Hermeneutics is the theory of interpretation, and within IPA is influenced by three key scholars: Schleiermacher, Heidegger and Gadamer (Smith et al 2022). Schleiermacher was a pioneer in the concept of hermeneutics, initially proposing that interpretation involves both grammatical and psychological interpretation (Schleiermacher 1998). That is, a text will have an objective meaning (grammatical interpretation), but the reader may also intuit a psychological meaning which has been influenced by the individuality of the speaker. This would not be explicitly described grammatically by the speaker themselves (Smith et al 2022). Schleiermacher proposed that interpretation is an art involving a range of skills including intuition. As such, if a researcher engages in detailed analysis, they can offer meaningful insights that include the explicit claims of the participants while also exceeding them, by offering interpretation through a different lens.

Heidegger's perspective on hermeneutics is neatly summarised in the quote by Smith et al (2022, pg. 28):

'There is a phenomenon ready to shine forth, but detective work is required by the researcher to facilitate the coming forth, and then to make sense of it once it has happened'.

This suggests the role of the researcher in IPA is to be the detective, encouraging the lived experience of the participant in relation to the phenomenon to emerge from the data, and then to analyse it with an interpretative lens to make sense of it. Concurrently, Heidegger considers that researchers bring with them their own preconceptions and despite attempts at bracketing, cannot prevent looking at a phenomenon in light of their own experience (Smith et al 2022). Thus reflective practices are an important element of hermeneutics within IPA, to bring these preconceptions to the fore and into the consciousness of the researcher, throughout the research process.

Gadamer furthers this idea, by suggesting that researchers may only identify preconceptions once analysis and interpretation are underway (Smith et al 2022). Gadamer (2004) refers to the "fusion of horizons", meaning that the researcher and the researched cannot be considered separately due to the changes that occur as a result of engaging with the phenomenon. This can be explained by considering the participant having a view of the phenomenon from one horizon and the researcher from another; by drawing on their own experience of the phenomenon, preconceptions and engagement with the literature and data. Therefore, the phenomenon itself influences the interpretation, which influences the researcher, which then again influences the

interpretation (Smith et al 2022) as the view from the researcher's horizon changes. This is a particularly important concept for me, as the view from my horizon was initially shaped by my clinical experience as a midwife, but later my view shifted to include my experiences as a pregnant woman in labour and my experiences from engaging in the data. It was therefore vital that within the interpretative data analysis process that I recognised similar views to my own horizon in the participants account, acknowledging this within the transcript.

This can be captured by the concept of the hermeneutic cycle in which the iterative process of the IPA analysis process is recognised. Through engaging in this cycle, I adopt different ways to think about the data (Smith et al 2022). Within the cycle, it is postulated that to understand any given part the researcher must look to the whole, and to understand the whole, the researcher must look to the parts (Smith et al 2022). Consequently, the analysis process, influenced by Schleiermacher, involves looking at the particulars of the participants chosen terminology, the wider sentences and paragraphs, and the whole transcript. IPA researchers want to be able to see what the lived experience is like from the participant's perspective, by considering how it would be to stand in their shoes, while also standing next to the participant to consider it from a different angle and question the simple descriptive view held (Smith et al 2022). The double hermeneutic approach facilitates this examination of the phenomenon.

4.3.3 Idiography

IPA is also idiographic in nature, meaning it is concerned with understanding how particular people experience and make sense of a phenomenon at a particular time (Smith et al 2009). For this reason, IPA involves extremely detailed and in-depth analysis of individual cases. This study was concerned with the experiences of women/birth partners (particular people), telephoning one support line (a particular phenomenon), during labour (a particular time), lending itself to an idiographic approach.

4.3.4 Selecting the methodology

When selecting a methodology, I felt strongly that as a midwife, with tacit understanding of the latent phase, and my own experience of speaking with women during this time, I would struggle to entirely bracket all assumptions and preconceptions, despite adopting strategies to minimise bias. For this reason, it was clear that a form of interpretative phenomenology would be most aligned with my own beliefs about how we experience, see and interpret the world. Of particular importance was that part way through the research I experienced labour and birth for the first

time personally, during which I contacted the 24-hour labour line myself as part of the process for admission to the birthing environment. This experience confirmed my decision in a methodology that allowed for and encouraged reflexivity and consideration of my personal influence on the findings.

Smith et al's (2009) IPA acknowledges and accounts for this understanding, in view of the double hermeneutic approach, by referring to the researcher getting close to how the participant themselves perceives the phenomenon through their lens, while also exploring it considering the researcher's own knowledge, values and experience. I was excited by the concept of getting as close as possible to the participants own lived experience and trying to stand in their shoes, while also approaching the analysis by standing next to them and viewing things differently, taking into account my own background and experience. The influence of Merleau-Ponty and Gadamer also resonated with me, as it supported my personal view that experiencing the same phenomenon as another person does not mean the same lived experience. This was important as while I have had experience of the same phenomenon from both a personal and professional perspective, I am viewing it from my own embodied position in the world. As such while there may be similarities in individual cases, the lens in which we, me and the participants, are viewing and interpreting the experience will be different.

The idiographic nature of IPA also neatly fit the research study for several reasons. Firstly, I believe that the birth journey is a unique experience for women and while aspects of their experience may be comparable, each woman has her own story and thus this story should be respected by considering each participant on an individual basis. Secondly, while midwives work within the governance structures of the NHS, drawing on guidelines in their work, they are autonomous practitioners who will approach care with a unique perspective, dependant on their prior experiences and influences. Midwives are also required by the NMC (2015) Code of Conduct, to ensure that they treat people as individuals, meaning the experience of women and birth partners will not be the same based on the midwives' assessment of their needs.

4.3.5 Consideration of other approaches

Narrative research was carefully considered as a potential methodology. Focussed around storytelling by the participant, narrative research is described as '*a re-creation of experiences and events in people's lives either by themselves or others*' (Freshwater and Holloway 2015 pg. 225). Researchers gather data using interviews, observation or diaries (Creswell 2007) to

explore detailed stories and the interpretation a participant attaches to life events and interactions. As Creswell (2007) explains, narrative research focusses on exploring the story of a participant within the context of their wider life. This is reflected in narrative research within the midwifery discipline, which explore the life of participants over time, for example Montgomery et al (2015) studied the maternity care experiences of women who have a history of childhood sexual abuse, with the storytelling element of this study naturally spanning to life outside of labour and birth. I felt strongly that this research study is focused around a particular phenomenon, and the participants lived experience of this phenomenon. Consequently, this is where I wanted the focus to be, rather than risk it becoming lost in a broader story about the childbirth continuum. For this reason, a form of phenomenology, which focusses on the essence of experience (Creswell 2007) was considered most appropriate. Despite this, narrative principles of broad opening questions (Freshwater and Holloway 2015) were adopted, to enable the participant to initially tell their story and provide context to their experience, before focussing further exploration around the phenomenon itself.

Grounded theory, first developed by Glaser and Strauss in 1967, is an inductive qualitative approach which aims to generate theories from data (Creswell 2007). Researchers use a variety of data collection methods, such as interviews, observations and documents to generate data, which is then coded and categorised to identify concepts that can be followed up with either the same, or different participants (Holloway and Galvin 2015). As such, researchers adopt theoretical sampling, with data collection and analysis occurring concurrently (Holloway and Galvin 2015), enabling theories to be tested as they emerge. Grounded theory is generally used when there is little known about a phenomenon or topic area, or to explore questions focussing on process (Holloway and Galvin 2015). For these reasons, it was an unsuitable approach for this research study in view of existing understanding of telephone contact between women and midwives during the latent phase of labour, and the lack of a process driven phenomenon being studied.

4.4 Research design

The research design was split into two phases. Due to restrictions related to the COVID-19 pandemic I was unable to undertake phase II of the study. Each phase is briefly outlined here to provide context in each section of the research design.

4.4.1 Phase I

During phase I of the design women, birth partners and midwives were interviewed about their experience of accessing or working on the 24-hour labour line. While IPA focusses on individual experiences, similarities and differences between participant experiences can be explored (Smith et al 2009) and it can be useful to identify a purposive sample that provides an understanding of the phenomenon from multiple perspectives as a form of triangulation (Reid et al 2005; Smith et al 2009). Exploring multiple perspectives is an advanced design of IPA (Smith et al 2022), with each sub-sample, in this case women, birth partners and midwives, providing insight into a homogenous group, before searching for experiential themes for the whole sample (Smith et al 2022) to allow the consideration of relational and intersubjective aspects of the phenomenon (Larkin et al 2019).

Multi-perspectival IPA can be challenging to manage due to the requirement to synthesise between samples, as well as within them (Larkin et al 2019), but can offer broader meaning to the evaluation of a service. In this case, three key sub-samples have experience of the phenomenon – the 24-hour labour line – each with their own perspective of it. To fully understand the phenomenon, it is necessary to explore the areas of congruence and difference of those who use it. Larkin (2019 pg. 194) states: *‘meaning is “in between” us, but it is rarely studied that way in phenomenological inquiry’*, and so the multi-perspective design allows the meaning between the three sub-groups to be considered.

4.4.2 Phase II

Conversations between health care professionals and patients are recognised as determinants in how patients interact with, and their satisfaction with, the health care services they are provided (Drew et al 2001). Due to the challenges of analysing naturally occurring interactions between midwives and women, this area has been minimally researched. As the literature review demonstrates, there has been no research examining the interaction between women and midwives on the telephone from both perspectives of the same episode of contact. At the time of writing the research proposal, the recordings of all telephone conversations could be accessed with consent from participants, and therefore opportunity to analyse this aspect of care from both the perspective of the woman and the midwife she spoke to. It was proposed that once a midwife and woman had participated in phase I and were identified as a match, i.e. they spoke to each other via the 24-hour labour line, and both participants consented to the

researcher accessing and transcribing the telephone recording, a second, individual semi-structured interview with the woman and midwife would be undertaken.

It was proposed that the transcript of the conversation between the woman and midwife would be taken to the second interview with the woman and the second interview with the midwife, as a trigger for discussion. I planned to explore with the midwife: how they interpreted the dialogue from the woman, how they used this information to inform their decision-making, what they intended in their dialogue to the woman, and how they think this was interpreted by the woman. I intended to explore with the woman what they intended in their dialogue, how they wanted this to be interpreted by the midwife, how they interpreted dialogue from the midwife and how they think this influenced their experience. For the benefit of the midwife, to encourage their ability to recall the scenario and decisions made during the telephone discussion, a bullet point overview of the clinical presentation at the time of the phone call would be provided.

While ethical approval was gained for this phase of the study, unfortunately the method of matching participating women and midwives involved using paper records stored at the ambulance control centre. Due to the COVID-19 pandemic access to this environment was restricted and for this reason I was unable to complete phase II of the study.

4.5 Sample

Consistent with the qualitative paradigm, and in view of the absence of a complete and current list of the sample population to derive a sample from (Procter et al 2010 in Gerrish and Lacey), non-probability sampling was used. Participants were initially sampled using purposive sampling, whereby women, birth partners and midwives that had experience of the 24-hour labour line were signposted to the study. Purposive sampling is adopted when the sample can offer a particular insight into a phenomenon (Smith et al 2009). As only a select number of midwives who work on the service, and only women and birth partners who contacted the service, can offer insight into this phenomenon, purposive sampling was an appropriate sampling strategy.

As is usual for IPA, women and birth partners were initially referred to the study via gatekeepers (Smith et al 2022), in this case midwives working on the postnatal ward. I was interested in gathering a range of experiences from women and birth partners that had experience of the phenomenon, therefore those that had contacted the 24-hour labour line were signposted to the study, regardless of parity, mode of birth or socio-demographic characteristics in the first

instance. The key consideration was experience of the 24-hour labour line, as this ensured that the phenomena could be explored in depth and from the perspective of those that had experienced it. Therefore, initial emphasis was placed more on what the participants could contribute, as opposed to representation, as is expected within qualitative research (Parahoo et al 2014).

Prior to the COVID-19 pandemic, the research proposal planned for the demographic data of participants to be reviewed during data collection. It was proposed that socio-demographic characteristics, parity and clinical outcomes of participants would be considered, and similarities between participants identified. If patterns were identified, signposting midwives could then be instructed to approach women and birth partners offering potentially different perspectives – such as a different mode of delivery, parity or wider socio-demographics. At this point I would have purposively selected participants with different characteristics, parities or birth outcomes, to ensure broader demographics and greater transferability of the findings. Due to slow recruitment and low interest in participation at this stage of the study, ultimately the selection of women and birth partners was led by the inclusion and exclusion criteria. If either a woman or birth partner had experience to share of the 24-hour labour line, they met the inclusion criteria and they consented to participate, they were selected to participate in the study.

All midwives working on the 24-hour labour line were purposively selected and invited to participate in the research study, regardless of the amount of clinical experience they had, time spent working within the service or length of time qualified. This was due to them being best placed to provide insight into the phenomena of working on the 24-hour labour line service.

Part way through the research, due to restrictions to access in NHS hospitals and workforce issues related to the COVID-19 pandemic, the sampling of women and birth partners was required to change to convenience sampling. While the recruitment strategy was amended, the inclusion and exclusion criteria remained the same throughout the study, as outlined next.

This change was characterised by moving away from purposively approaching specific women and birth partners that had experience of the phenomena and instead advertising the research study to the general public and providing opportunity for them to identify themselves as being interested in participating in the study. Convenience sampling is characterised by the idea that participants who are easy to access and willing to participate are recruited (Parahoo et al 2014). While information about the study was shared on maternity focussed social media pages, it is

unlikely that all those viewing the post were from the target population. This differs to the purposive sampling applied earlier in the study, prior to the pandemic, where women and birth partners were approached specifically due to their experience of the phenomena.

4.5.1 Inclusion and exclusion criteria

Within IPA methodology it is advised that a relatively homogenous sample is used to ensure the research question is addressed by those to whom it is meaningful (Smith et al 2009; Smith and Osborn 2015). The phenomenon explored in this study was the experience of women and/or birth partners and midwives working on a dedicated telephone support line and the inclusion of the three groups of participants allows this to be understood from more than one perspective (Smith et al 2009; Smith and Osborn 2015). While the ways in which the sample is homogenous are outlined within the inclusion criteria, the decision was made not to focus the study on one demographic group but to maintain the homogeneity of the phenomenon studied, by only exploring one service and focussing on communication in labour only. Instead, any differences in demographic, for example, education level or parity, would be explored in relation to the phenomenon at the data analysis stage, as recommended by Smith et al (2009).

While there were differing inclusion and exclusion criteria across the three sample groups there were also common criteria for women, birth partners and midwives (Table 3).

Table 3 - Inclusion criteria for study

Inclusion Criteria		
Women	Birth Partners	Midwives
Contacted a 24-hour labour line in the South of England during what they perceived to be labour	Contacted a 24-hour labour line in the South of England during what they perceived to be labour	Midwives working on a 24-hour labour line in the South of England
Within 12 weeks of birth	Within 12 weeks of birth	Within 12 weeks of working on the service
Fluent in English language	Fluent in English language	
Aged 18 years or over	Aged 18 years or over	
Feel able to talk about their experiences of the 24-hour labour line	Feel able to talk about their experiences of the 24-hour labour line	

As outlined by the United Nations General Assembly (1989) in the Convention of the Rights of the Child, 18 years of age is the legal age of adults in the UK and for this reason birth partners and women aged less than 18 years were excluded from the study. While the experiences of younger women and birth partners are of equal importance, it was decided that their experiences may differ somewhat to over 18's, and therefore to promote a homogenous sample they would be excluded.

Fluency in the English language was a requirement for participation due to the practical and financial constraints of using an interpreter during interview and to work towards a homogenous sample. It was considered that the lived experience of women and birth partners with limited ability to communicate in spoken English would be substantially different to those able to speak freely in the English language. The ability to communicate on the telephone is central to the telephone support service, and thus it was considered the challenges faced by women and birth partners in this area would best be considered separately to this exploration. Fluency was assessed by the potential participants ability to converse with me during an initial telephone discussion once they had expressed interest in the research. Nobody was excluded from the study based on these criteria and there was only one participant for whom English was not their first language.

There is no consensus on the amount of time after the experience of a phenomenon to collect data to reduce recall bias. As a guide, I examined a series of papers examining women's experience in the latent phase. Data, mostly interviews, were collected between one week and nine months after birth. The decision was made for recruitment to take place between birth and six weeks, with participants able to identify a time that was suitable for them for data collection, within 12 weeks of delivery. This was considered a reasonable amount of time for the participants to have reflected on their experience, and to have started to adapt to life with a new baby. It was also recognised that midwives may not work consistently on the telephone support service, therefore midwives were required to have worked on the service within 12 weeks of participation. The decision to include midwives no longer working on the telephone support service was based on the assumption that their decision to discontinue this role may be associated with their experience, and therefore their perspective should still be sought. All participating midwives were still working on the service at the time of recruitment and interview.

Women and birth partners were required to have contacted the 24-hour labour line during what they perceived to be labour. Due to the guaranteed contact with a midwife on telephoning the service it was acknowledged that pregnant/postpartum women telephone with common complaints, queries or routine questions about their care. As this research study is focussed on experience during labour, women and their birth partners were excluded unless they had telephoned during what they perceived to be labour.

4.5.2 Sample size

There is no agreed optimal or minimum sample size for qualitative research, with studies sampling between one and 325 participants (Creswell 2013). Generally, in qualitative research focus is placed more heavily on data saturation, and therefore it is ideal for recruitment to continue until this is achieved (Polit and Beck 2022). In view of the approach of IPA being idiographic, with focus on individuals' understanding of a particular phenomenon, sample size is often very small, with Smith et al (2022) recommending around ten interviews for doctoral studies. It is acknowledged that when seeking in-depth exploration of experience, a sample consisting of too many participants is more complex to manage than too few (Smith et al 2009). The guideline of four to ten interviews therefore allows the researcher to draw on congruence and differences between the sample while still providing an appropriate amount of data to manage (Smith et al 2009). The target sample size was a minimum of five women, five birth partners and five midwives. While this total target sample size exceeds that recommended by

Smith et al (2009), it was chosen with aim of having enough data within each participant group for meaningful findings to emerge. In total eleven women, four birth partners and five midwives were recruited to the study.

4.6 Recruitment

4.6.1 Recruitment of women and birth partners

Women and birth partners were recruited to the study after labour and birth had occurred. Previous studies, such as Nolan and Smith (2010), recruited women when they telephoned the midwife in early labour. This option was considered, however was rejected in view of the potential biases this may introduce, for example the woman's experience may be influenced by the knowledge that she is participating in the study, leading her perhaps to be more aware of the interactions between herself and the midwife, and the midwife's behaviour may also change with knowledge the woman would be interviewed about her experience.

Each participant group was recruited in parallel, with the launch of recruitment occurring simultaneously. This was initially necessary in order to match women and midwife participants for phase II of the study, but also enabled me to facilitate the request of any women and birth partners that wanted to participate and be interviewed together. Parallel recruitment offered the benefit of examining experiences of each group within the same time period, which ensured their experience of the same service at a particular time was considered. For this reason, later in the thesis participants will be identified as those interviewed before or during the pandemic, to acknowledge the change in context.

4.6.1.1 Pre-pandemic recruitment process

In view of the NHS Trust process that all women suspecting spontaneous labour telephone the 24-hour labour line prior to presenting at their chosen birthing location, the sample population for women was large in view of a birth rate of over 5,000 per year (NHS Digital 2017). Considering my responsibility to safeguard the public and it being the most likely way to reach the target sample group, midwives working on the postnatal wards at the participating Trusts initially signposted women to the study. Written guidance was provided to midwives regarding their role to ensure clarity (Appendix E), and I met with the lead midwives on the postnatal wards to talk this through further. Midwives gave potential participants written information about the study, including a leaflet and the participant information sheet (Appendix F, G, H and I). Once midwives

had given the information about the study to potential participants, they documented this in the woman's notes, using a sticker, to ensure the woman, and her birth partners were not given this information multiple times.

Potential participants were provided with the option of registering an interest by contacting me directly, or by completing a form to hand back to the midwife, which included their contact details, for me to collect (Appendix I).

Four women and two birth partners contacted the 24-hour labour line before the COVID-19 pandemic and were recruited using this strategy.

4.6.1.2 Pandemic recruitment strategy

Part way through the study amendments to the recruitment strategy were required. These amendments were two-fold; firstly, the strain on NHS maternity services, including staffing challenges around redeployment, resulted in non-covid related research being paused, and secondly due to restricted access to the hospitals I was unable to attend the postnatal wards and provide support and information to signposting midwives who had not yet been briefed. It was considered most appropriate to lessen the burden on clinical midwives and remove the need for their input into the recruitment process.

For this reason, the recruitment strategy was amended to make use of social media to advertise the study to the woman and birth partner population. As located in Appendix K a social media post advertising the study was created and shared by the maternity specific Facebook pages of the NHS Trusts and local Maternity and Neonatal Voices Partnership (MNVP) organisations. The post provided interested people who wanted to hear more about the study with two options:

1. Contact me directly, using the email or telephone number provided on the social media post
2. Follow a link from the post to a survey hosted by the University's iSurvey website. The website explained that if they would like me to contact them, they could complete the online form and submit it to me. The website informed potential participants that completion of the form did not mean they had agreed to participate and further discussion between us would ensue before they made this decision. The data collected via the iSurvey is located in Appendix L.

Seven women and two birth partners contacted the 24-hour labour line during the COVID-19 pandemic and were recruited using this strategy.

4.6.1.3 Comparison of two recruitment strategies

The two recruitment strategies adopted offered different strengths and limitations. Despite the briefing provided to midwives on the postnatal ward, the original strategy had potential to introduce selection bias, whereby only certain women and birth partners were signposted to the study by the midwife. The online advertisement of the study resolved this bias, meaning the research was more widely known about without reliance or influence of midwives on the postnatal ward. Instead it came with the limitation that only those with access to the social media platforms on which it was advertised would be informed of the study, potentially excluding some of the target population from the opportunity to participate. This may explain the lack of diversity within the sample, which is explored further in section 10.5.2. To reduce selection bias, I contacted all those that expressed interest in the study. Due to the constraints of the pandemic, there was limited opportunity to resolve this challenge, however reflections on alternative recruitment strategies to engage more birth partners are explored within section 10.5.2.

4.6.2 Contact with potential participants

When telephone contact was made with the potential participant it was ensured that: they met the inclusion and exclusion criteria; the participant information sheet, which had been revised (Appendix M and N) was discussed; and the participant was able to ask any questions before deciding to proceed. Once the participant had agreed to take part, an interview would be arranged on a date and time convenient to them. If the potential participant had not yet read the participant information sheet a copy was sent via email and revisited immediately prior to the interview and the consent form being completed.

4.6.3 Recruitment of midwives

Eligible midwives were invited to participate in the research study using posters displayed in their place of work at the ambulance control centre (Appendix O). A participant information sheet (Appendix P and Q) was attached to the poster, enabling midwives to read about the study before contacting me. This recruitment strategy alone only resulted in one participant, and therefore was followed up by an email (Appendix R) from senior management signposting midwives to the research. The recruitment strategy for midwives remained unchanged during the COVID-19 pandemic, with one midwife recruited prior to the COVID-19 pandemic, and the remaining four recruited during the pandemic.

4.6.4 Service-user consultation

The recruitment materials were co-produced with input from the former Maternity Services Liaison Committee, now MNVP, before consideration by the relevant ethics committees. The MNVP is a local group of service users and health professionals seeking to ensure that the service user voice is at the centre of service review and improvement (NHS England 2023). Service users were able to provide feedback on draft materials to ensure they were attractive, accessible and understood by the demographic of women at which they were aimed. This was considered integral to the gathering of informed consent to participate in the study, which is discussed later. Participant information sheets are required to provide the necessary information to enable informed consent to be gained, while simultaneously being simple enough for potential participants to comprehend this information (Ennis and Wykes 2016). Trialling the readability of recruitment material with the MNVP enabled assessment of the comprehension of the content with lay people who had previously been part of the target population and led to minor changes of the materials, such as changing terminology to include my name rather than “the researcher” to be more personable.

4.7 Data collection

4.7.1 Semi-structured interviews

The chosen data collection method was semi-structured interviews, with a narrative approach to the first part of the interview. Interviews are defined as ‘*an interchange of views between two persons conversing about a theme of common interest*’ (Kvale 2007 pg. 5) to gain understanding of the participant’s experience through their description. As the research aimed to gain rich insight into the experiences of women, birth partners and midwives of the phenomenon, semi-structured interviews were an appropriate choice, facilitating the participants to describe their experience using their own words, tone and body language (Kvale 2007). The advantage of this is that participants can expand beyond the factual evidence of telling their story and discuss how the experience made them feel and the meaning of the experience to them (Smith et al 2009). Although it is noted that the interviewer structures the interview to achieve a purpose (Kvale 2007), through using semi-structured interviews the researcher encourages the participant to first identify the aspects they consider particularly important, modifying their questions in view of the responses provided. The participant is the ‘*experiential expert*’ on the phenomenon of interest and as such a loose interview schedule was utilised to enable the participant to guide

the interview in the direction of their choosing (Smith et al 2009). To encourage this, the opening questions I asked were purposefully broad and more in keeping with a narrative approach, to get the story flowing. It was considered important for the participants to be able to tell their story, to generate rich data with a focus on the individual meaning they attach to their experience. The opening statements can be found for the interviews with women, birth partners and midwives in Box 1.

Researchers opening statement:

Woman = 'Tell me about your experience at home during labour'.

Birth partner = 'Tell me about your experience supporting your partner/daughter/friend at home during labour'

Midwife = 'Tell me about your experience working on the 24-hour labour line'

Box 1 - Opening interview statements

As hoped, the structure of the statement led most women and birth partner participants to respond by storytelling; describing the process of labour from onset to birth that they or their partner experienced. This was helpful in gathering a timeline of events and being able to situate the calls made to the labour line in the broader narrative around their birth experience. In some instances, participants would also draw on particularly pertinent experiences during the pregnancy or previous childbirth experiences, allowing me to see connections between the antenatal experiences, previous birth experiences and subsequent experience of birth.

As the research was concerned with exploring the phenomenon of contacting or working on the dedicated 24-hour telephone support line, it was appropriate to trigger the participants onto this aspect of their experience, if it was not discussed in response to the opening statement. To achieve this, where applicable, it was asked:

Researchers prompt questions:

Woman = ‘Tell me about your experience contacting the 24-hour labour line at home during labour’

Birth partner = ‘Tell me about your experience contacting the 24-hour labour line while supporting your partner/daughter/friend at home during labour’

Midwife = ‘Tell me about your experience while working on the 24-hour labour line of speaking to women and birth partners who are at home during labour’

Box 2 - Interview prompt statements

As the interviews progressed, prompts were used to gather further information and depth from the participant to gain insight into the emotive responses experienced during the time they were describing. Prompts included phrases such as ‘you mentioned...can you tell me a little more about that?’ and ‘can you tell me about how that made you feel?’, alongside questions focussed on the secondary research questions, regarding the decision-making processes (Appendix S).

As a novice researcher, initially my confidence in undertaking interviews was low, and this contributed to some of the earlier interviews being shorter than the intended 30-60 minutes. Despite being confident in talking to people from a range of diverse backgrounds throughout my midwifery and education career, I was nervous about getting the interviews right. I felt I was in a privileged position to have participants sharing their stories, experiences, and feelings with me, and I was keen to do them justice. As time progressed, my confidence grew, however undertaking initial transcription and data analysis of four scripts part way through the project provided further insight into my interviewing style and identified areas where further questioning may have resulted in more depth to the transcript and ability to interpret the phenomenon. This reflection supported future interviews to achieve a richer data set and resulted in a greater level of analysis in the later transcripts. The final sample of interviews ranged from 15.5 minutes to 74 minutes in length, with the average interview lasting 46 minutes. The interviews with midwife participants were longest, lasting an average of 62 minutes. This was unsurprising due to having more than one case experience to explore, and my further experience of interviewing by the time most midwives were recruited.

4.7.2 Location of interview

Initially, interviews were undertaken at the participants home, providing a comfortable, quiet environment for the participants. Being together in person enabled me to build rapport in a physical space and observe the body language of participants, providing additional comment within the analysis. Seven participants were interviewed in this environment before, due to the COVID-19 pandemic, I had to amend the study to undertake remote, videocall interviews. This decision reduced the risk of COVID-19 transmission and ensured compliance with the evolving social distancing laws and guidelines present at the time.

Understandably, this changed the dynamic of the interview, and led to a dip in confidence while I adapted to this new way of interviewing participants. While interviewing online presented some challenges, such as occasional delay or disconnection making the interview feel disjointed, and the inability to assess all body language due to the presentation of only the upper half the participants body, it also offered opportunity. Being in my own surrounding helped me feel more comfortable than when I was entering participants' personal space at home, while still offering the same comforting physical environment to the participants. It also provided further flexibility to me and the participants in scheduling the interview, including the removal of travel time and lone working considerations.

Overall, despite the change in the way the interviews were conducted, the process for all participants was the same. Using the interview schedule (Appendix S) the participants were welcomed and reassured, and the process of the interview was discussed prior to consent being gained and the interview commencing.

For most of the interviews with women the infants were present and so with both face-to-face and video interviews distractions did occur when the infant needed nursing. This was an expected event in view of the chosen participant group, and I simply paused the interview until such time as the baby had settled, reminding the participant of the last topic of discussion.

4.7.3 Recording and note taking

All interviews were recorded, either on a recording device, or later using the Microsoft Teams™ function. After the interview the recordings were downloaded and stored on a password protected, encrypted, University computer. During the interview I also took field notes such as a timeline of events, things of interest that the participant had said that I wanted to explore further

later and observations from the interview, such as the chosen terminology or body language of the participant. Paper hard copies were transported back to the University in sealed envelopes with 'Private and Confidential' written on them and digital notes stored on University computers.

4.8 Ethical considerations and permissions

All researchers have a responsibility to consider the ethical dilemmas associated with the chosen methods, regardless of the chosen paradigm. In qualitative research this is particularly poignant due to the guaranteed involvement of human subjects in data collection methods. Consequently, there is a focus on ensuring subjects voluntarily participate in research, having received full and transparent information about the research aims and methods adopted (Christians 2011).

It is necessary for research involving human subjects to be presented before an ethics committee for scrutiny both at the UoS and the NHS. Processes within the University require ethical approval by the UoS Research Governance Office prior to application to the local NHS Research Ethics Committee (REC). Approval from these committees was gained in March 2015, before application and approval were granted by the NHS REC in July 2015 (Appendix T). NHS Research and Development (R&D) approval and permission were also gained from the NHS Trust prior to the research commencing.

After initial approval was gained, a non-substantial amendment was required in view of the challenges faced during recruitment. Initially, the protocol outlined that main data collection would not commence until one birth partner, midwife, woman and a pair of a midwife and woman had been interviewed and data analysed. It became apparent that there was interest from potential participants who I was unable to contact as the protocol prevented moving forward with further interviews. The non-substantial amendment therefore changed this part of the protocol so that the recruitment, data collection and data analysis processes were reviewed by me and my supervisory team alongside main data collection to prevent a loss of participants, enabling recruitment to continue despite the pilot not being complete. Further substantial amendments were required relating to the temporary suspension of the research study for several reasons across the course of the study, including workload issues, two episodes of maternity leave and the COVID-19 pandemic. The timeline of these suspensions can be located in Appendix U.

Between March 2019 and 23rd March 2020, I had a first period of maternity leave. The same day I returned to study, the UK entered a period of national lockdown due to the COVID-19 pandemic and strict access criteria to NHS Trusts was in place. Following discussion with my supervisors, the decision was made to extend the suspension of the study for a further six months, until there was more clarity about the longevity and severity of the situation. At the end of this period in September 2020, it had become apparent that the recruitment and data collection strategy was no longer viable, due to its reliance on access to NHS settings and face-to-face interviews. Consequently, I submitted substantial amendments to University, NHS and R&D ethics to make changes to these processes.

While the study was scrutinized throughout these processes, the ethical considerations most relevant to the research are presented in more depth below.

4.8.1 Consent

As outlined by Silverman (2010), key ethical principles in qualitative research include the voluntary participation of subjects, which encompasses the right to withdraw, and the gaining of informed consent. Written consent was gained from participants prior to interview (Appendix V, W and X). It was ensured that all potential participants had the opportunity to read the participant information sheet, which included information about the purpose and process of the research (Brinkmann and Kvale 2015), and gave opportunity for questions to be raised both during initial contact and immediately prior to interview. The participant information sheet was talked through with participants both during initial telephone contact, and prior to interview, during which time participants were again informed that their participation was voluntary. Participants were also informed verbally and via the written consent form that they could withdraw from the study at any stage, without providing a reason, and that any data they provided would be withdrawn from the study.

Following the move to online video interviews participants were required to provide the consent form via email. Due to the complexities of including a written signature on this consent form, many participants returned it with their name simply typed into this section. Following discussion with my supervisors it was agreed that in these instances the consent form should be read out, and the participant confirm agreement, at the start of the interview once the recording had commenced.

4.8.2 Confidentiality

Confidentiality in relation to qualitative research refers to identifiable participant information not being disclosed in verbal or written presentation and the commitment of the researcher to anonymise information as far as possible to reduce the likelihood of the identification of participants (Wiles 2012). Confidentiality was maintained through the removal of potentially identifying information (Wiles 2012) such as names, places and timings from transcripts and the allocation of a pseudonym by the researcher.

While the inclusion of verbatim quotes in publications is considered to enhance the credibility of qualitative research, it also provides opportunity for identification of participants to occur if not handled sensitively. As such, participants were informed about, and provided written consent for, verbatim quotes from their interview to be included in reports generated by the research, and that while they may be able to recognise themselves others would not be able to identify them.

Finally, all collected demographic data is aggregated to ensure the confidentiality of participants. While demographic data was collected from midwives, minimal publication of these demographics has occurred within this thesis. This decision is grounded in the assurances provided to participants that their confidentiality would be protected. In view of the small target sample size, and subsequent small sample size, publication of this information jeopardises participants' confidentiality and would therefore be unethical.

Further considerations were required in maintaining the confidentiality of the midwife participants, in view of the small target sample and subsequent small sample size. As explained by Saunders et al (2015), qualitative researchers must balance the demand of maintaining the anonymity of their participants with providing enough detail to preserve the integrity of the data. Further, in the findings section of the thesis I do not refer to specific stories told by midwife participants, for example related to poor outcomes, obstetric or neonatal emergencies or safeguarding issues. While this removes some of the richness and contextualisation of the findings, it was a conscious decision to ensure participants would not be identified by other colleagues within the same team or NHS Trust, as well as ensuring anonymity further afield, a concept coined by Tolich (2004) as "internal confidentiality". This decision was discussed with my supervisors to establish the extent of data exclusion required.

4.8.3 Incentives for participants

Initially, no financial incentive was offered to any participant groups. Potential participants were informed within the participant information sheet that there was no direct benefit to them in taking part in the research. Recruitment stagnated for midwives after the participation of just one member of staff. The midwives working on the labour line had applied to work there, suggesting they had an interest in supporting women and birth partners during the early stages of labour, so I began to question why they appeared reluctant to share their experience of working on the service.

There are clear differences between new parents and midwives; storytelling and talking through the experience of birth can be cathartic for women (Johnson et al 2020) and the excitement and joy of welcoming a new baby into their world is something parents are keen to share. In comparison, midwives are employed to undertake a job and so participating in the research in their own time offers them no substantial personal reward. Agreeing with the Trust that they could claim the time for participation was not considered to be an option as this compromised their confidentiality.

After discussion with my links at the Trusts, including midwives working on the labour line, it was considered that providing some compensation for their time, in view of it being related to their employment, may encourage them to look more favourably on participating. The review of recruitment processes was also undertaken during the COVID-19 pandemic. Prior to the pandemic, clinical midwifery staff in the UK were experiencing high levels of burnout (Hunter et al 2019) which was likely exacerbated by challenges the pandemic posed (Hunter et al 2020), such as reduced staffing due to shielding and self-isolation requirements. It was therefore considered even more critical to ensure the time midwives offered to the study was accounted for, through the provision of a £30 voucher.

Incentives to participate in research have long been a contentious issue (Bentley and Thacker 2004) with most of the literature exploring the ethical implications of offering inducements for quantitative, intervention-based research where the risk to participants tends to be more likely than in qualitative research. Using a questionnaire to assess participants willingness to participate in research, Bentley and Thacker (2004) confirmed that payment does increase willingness to participate, regardless of the level of risk a study poses. Thus, the key consideration is whether people agree to participate voluntarily, or because of the incentive (Grant and Sugarman 2004) which hinders their ability to give true informed consent. On the

contrary, Head (2009) argues that financial incentives would not be the lone reason a person agrees to participate. In this instance, midwives are registered professionals, with very good understanding of informed consent due to their professional responsibility to gain it during their daily work activities (NMC 2015). This reduces the likelihood that they would participate because they need the voucher for financial reasons, which is a further concern when offering an incentive to the public. One can postulate that it is right to acknowledge the contribution participants make (Draper et al 2009) and this can be appropriate through monetary means. Consequently, an amendment was approved by the HRA and R&D to offer the £30 voucher to participating midwives.

4.8.4 Participant support

Wiles (2012) states that all research activities have the potential for risk, be it physical or psychological, and thus researchers have a responsibility to minimise that risk. While the risk of physical harm was negligible, the potential risk of psychological harm through revisiting emotional and life changing events was considered, and an area of the protocol scrutinized heavily by the ethic committees. While it was not required for any of the interviews, a clear process was established in preparation for participants becoming upset or distressed during the interview. The process for all participants included offering to stop the interview and signposting participants to health professionals, such as the GP, for additional support. For the women participants this included the recommendation that they access the NHS Trust service for patients to talk through their birth experience, and have any unanswered questions addressed by a midwife. Women and birth partner participants were also provided with a letter (Appendix Y and Z) to confirm their participation in the study, at request of the NHS R&D department. The letter provided participants with the opportunity to inform their healthcare providers that they had participated, should they wish to and where they felt it was relevant to their healthcare. This provided a further avenue for support, should participants need it later.

4.8.5 Researcher's professional responsibility

As I am a midwife registered with the NMC I have a duty to respond promptly if there is risk to patient or public safety (NMC 2015). This leads to complex ethical dilemmas for a midwife researcher who may become conflicted between their ethical obligation to maintain confidentiality and their professional responsibility to escalate concerns (Rogers 2008; Ryan et al 2011). In the absence of guidelines for midwife researchers (Ryan et al 2011) discussing any

arising concerns with midwife participants at the time of interview and directing them to an appropriate individual to discuss such concerns, is considered appropriate for researchers holding a professional registration (Rogers 2008). This enables them to uphold their professional responsibility, while also committing to maintain the confidentiality of participants (Rogers 2008). As stated in the participant information sheet and discussed verbally with midwife participants, had the researcher been concerned about the clinical care recalled by midwives during interview they would have encouraged the midwife to contact their Supervisor of Midwives personally, and supported them to do so. At the time of writing the research protocol the role of the Supervisor of Midwives had been embedded in the NMC's regulatory legislation since 1902 (NHS England 2017) to provide professional support to midwifery colleagues and carry out investigations related to fitness to practice. Since changes to legislation were implemented in 2017, each country of the UK has considered how positive elements of midwifery supervision can be continued within NHS Trusts. In England the Supervisor of Midwives has been replaced by the Professional Midwifery Advocate (PMA) (NHS England 2017). The role of the PMA is to support midwives in building resilience, improve the quality of the care they offer to women and families and support them in professional revalidation (NHS England 2017). Thus, it was appropriate following the removal of Supervisor of Midwives to encourage contact between the midwife and PMA. This was not required following interviews with any of the midwife participants.

4.8.6 Data management

A thorough data management plan (Appendix AA) was developed in collaboration with the UoS Faculty Business Relationship Manager and Information Governance Manager at the host NHS Trust. All data recorded on paper was transferred directly from the collection site to UoS in sealed envelopes marked as 'Private and Confidential' and then converted into digital data (apart from signed consent forms). All digital data is stored on UoS, password protected, encrypted computers. Digital recordings and transcripts will be stored and destroyed after a minimum of 10 years from last access, as per the UoS Research Data Management policy (UoS 2014).

4.9 Data analysis

The chosen approach for data analysis is IPA. While other data analysis tools, such as thematic analysis were considered, IPA had been selected as the underpinning methodology, providing a

framework for the research project, due to the idiographic focus previously explored. It was therefore optimal to select IPA as the data analysis method, rather than a standalone data analysis method, to remain in keeping with the idiographic focus. The data of each participant was analysed individually in full before moving on to the next case. Once data in each group of participants (women, birth partners, midwives) had been analysed, patterns were looked for across cases within these groups.

The seven data analysis steps of IPA were followed, using Smith et al's (2022) process description as guidance for the novice analyst. These steps are outlined in Figure 6, and in detail in section 4.9.1 – 4.9.8.

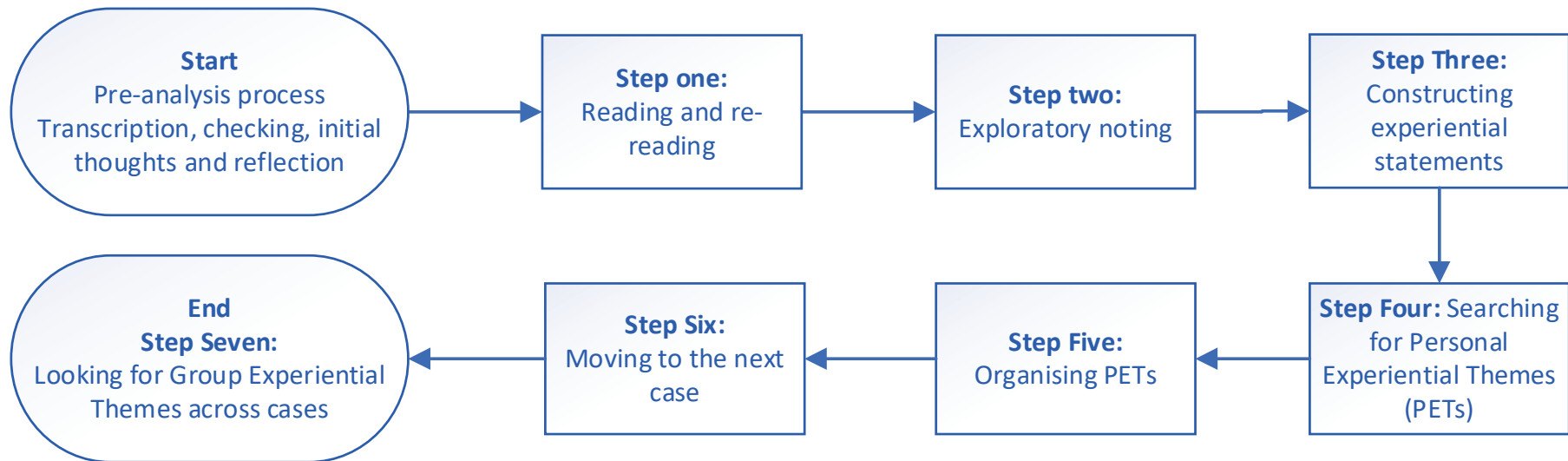


Figure 6 - Overview of Smith et al's (2022) data analysis steps

4.9.1 Transcription, checking, initial thoughts and reflection

While there are only seven steps outlined by Smith et al (2022), it is also recognised that this guide is not a strict process and should be adapted for individual research projects. For this reason, prior to outlining the approach to the seven steps, it is important to describe the process that was undertaken between the interview and step one of the formal data analysis process.

Despite being a time-consuming process, I transcribed each interview myself. This was considered the initial stage of the data analysis process, as it provided opportunity to begin familiarisation with the data (Brinkmann and Kvale 2015). Transcription was aided using a foot pedal and my ability to touch type, though as predicted by Smith et al (2009) transcription of each interview took between three and seven hours, depending on the quality of the recording and interruptions experienced during interview. The benefits of undertaking transcription myself was worth the time consumed, allowing me to feel close to the data and hear important nuances that may have been missed by a transcribing service.

Next, the quality and accuracy of the transcription was checked. While Smith et al (2009) notes that IPA does not necessitate the same level of detail and accuracy required for other forms of analysis, for example conversational analysis, it was important to check that the terminology chosen by participants was correct, to identify pauses and include any non-verbal actions noted within the field notes. To do this, each transcript was printed with wide margins and double-spaced lines, as recommended by Saldaña (2013), and the audio of the interview was listened to again, while reading the transcript (Smith et al 2022). Upon commencing this quality check, it was noted that it was not possible to prevent thoughts about the data during a read through, and therefore the decision was made to make initial analytical comments in the margin. Smith et al (2009) advocates capturing these initial thoughts, before putting them aside and returning to them later in the analysis process.

As a novice researcher, it was important to reflect on the process of interviewing, and as such my own thoughts on the interview were also recorded. This formed, in most cases, a written reflective account, whereby strengths and weaknesses of the questioning and commenting were identified, and assumptions made during the interview acknowledged. An example can be located in Appendix BB. Observations about my role within the interview were also noted on the transcript during quality checking, as recommended by Pietkiewicz and Smith (2012).

4.9.2 Step One: Reading and re-reading

The first step in Smith et al's (2022) data analysis process involved reading the script multiple times. Each transcript was printed again, following the initial edit for accuracy, and read frequently. Initially, this happened over a week however later in the data analysis process a script was read multiple times within a day. Transcripts were read at least five times, including the first read through described above. The aim of this was to familiarise myself with the data and begin immersion in the participant's world so that they are at the forefront of the analysis.

In view of the amount of data I had collected it became helpful to produce a timeline of the labour, and in some cases pregnancy, as described by the women and birth partner participants themselves. Smith et al (2022 pg. 79) explains:

“embedded within these ‘life stories’ there may be a pattern of shifting from generic explanations to the specificities of particular events”

Within this analysis it was the birth stories of the women and their partners that structured the interview. Their contact with the 24-hour labour line was a specific event or events within a broader story of labour and birth, events in pregnancy or previous pregnancies, and in some cases their fertility journey. Each story betrothed a strong sense of transition to parenthood, with labour symbolising a major event after which time their life would not be the same again. This was all considered important data for understanding the meaning they attached to the phenomenon of contacting the 24-hour labour line, a small part of a greater journey. Creating a timeline of the labour and birth from their storytelling encouraged me to keep that broader journey in the forethought of the analysis.

4.9.3 Step Two: Exploratory noting

Exploratory noting required me to engage deeply with the data to begin to analyse the way in which the participant themselves understand their experience, in relation to the world they live (Smith et al 2009). Smith et al (2009) note three types of comments being critical to this process, as outlined in Table 4.

Table 4 - Smith et al's (2009 pg. 84) description of comment type

Comment type	Key features
Descriptive comments	<i>'focused on describing the content of what the participant has said'</i>
Linguistic comments	<i>'focused upon exploring the specific use of language by the participant'</i>
Conceptual comments	<i>'focused on engaging at a more interrogative and conceptual level'</i>

This step produced a comprehensive set of exploratory notes within the left-hand margin of the script. The first review of the script included all three types of comment being noted, to prevent any thoughts being lost by reviewing the script for each type of comment separately. Once this was complete the script was reviewed again, seeking out any additional comments. The transcript was read in reverse, as suggested by Smith et al (2009), to deconstruct the transcript and enable the analyst to get close to the language the participant had chosen.

As expected, when analysing the transcripts I experienced flashbacks to my own experiences of labour, birth and contact with the 24-hour labour line. To be transparent and to capture how the participants account of their experience resonates with me, I documented these thoughts on the script in purple.

As shown in the abstract presented in Table 5, a different coloured pen was used to identify each type of comment on the script.

Table 5 - Example of step two – exploratory noting – Camilla

Exploratory noting	Transcript
Descriptive = blue Linguistic = green Conceptual = red appreciation central hub seamless transition communication of information valuing being on the radar stressed okay to call very clear to call back whenever no criteria to call could call for questions or pain relief comfort of open call policy additional concerns in labour wanting to avoid wasting people's time suggests some idea uncertainty of progress perception busy NHS aware of busy clinical setting additional concerns in labour avoiding an identity clear open call policy reassurance comfort of being able to call permission to call comfort of shared experience with others reassurance comfort	it was great to be able to have that central hub and know that they knew they could tell the hospital and that there was sort of then it was kind of on the radar that at some point I might be going in erm and they also they were very very clear that it didn't matter how quickly I phoned them back erm whether I phoned them back in two minutes literally put the phone down and picked it back up again and said I need pain relief or I've got more questions or anything like that or whether it was another two three days before they heard from me again erm and that was really comforting because I I didn't want to feel like I was wasting people's time especially where I didn't really know how far along I would be or anything like that and obviously everybody's busy so I didn't I didn't want to feel like I was wasting people's time and if I did need to phone them back but they were really really clear that it did not matter how many times I called when I called or how often I called so yeah that was it was just nice they said and but they didn't pose as you know you can they posed it as people do um and it yeah it just it was very reassuring right from the outset so that was good

4.9.4 Step Three: Constructing experiential statements

This step requires the analyst to reduce what had become a larger set of data during step two; forming concise statements (themes) to capture the most important elements from the transcript and exploratory noting (Smith et al 2022). Using the exploratory noting from step two, the themes reflect both the participants experience and the interpretation of the analyst. It is acknowledged that this step draws the analyst further away from the participant, as the hermeneutic element of IPA begins to emerge (Smith et al 2009).

The transcript was reviewed in sections, as recommended by Smith et al (2022), and experiential statements were recorded in the right-hand margin, as demonstrated in Table 6.

Table 6 - Example of step three - developing experiential statements – Camilla

Exploratory noting	Transcript	Experiential statements
Descriptive = blue Linguistic = green Conceptual = red		
appreciation central hub seamless transition communication of information valuing being on the radar stressed okay to call very clear to call back whenever no criteria to call could call for questions or pain relief comfort of open call policy additional concerns in labour wanting to avoid wasting people's time suggests some idea uncertainty of progress perception busy NHS aware of busy clinical setting additional concerns in labour avoiding an identity clear open call policy reassurance comfort of being able to call permission to call comfort of shared experience with others reassurance comfort	it was great to be able to have that central hub and know that they knew they could tell the hospital and that there was sort of then it was kind of on the radar that at some point I might be going in erm and they also they were very very clear that it didn't matter how quickly I phoned them back erm whether I phoned them back in two minutes literally put the phone down and picked it back up again and said I need pain relief or I've got more questions or anything like that or whether it was another two three days before they heard from me again erm and that was really comforting because I I didn't want to feel like I was wasting people's time especially where I didn't really know how far along I would be or anything like that and obviously everybody's busy so I didn't I didn't want to feel like I was wasting people's time and if I did need to phone them back but they were really really clear that it did not matter how many times I called when I called or how often I called so yeah that was it was just nice they said and but they didn't pose as you know you can they posed it as people do um and it yeah it just it was very reassuring right from the outset so that was good	Helicopter view Being on the radar Taking comfort in an open call policy Alleviating concerns of being a hinderance Reassurance of labour line

4.9.5 Step Four: Searching for connections across experiential statements

This step required the analyst to move from a chronological list of experiential statements to Personal Experiential Themes, encompassing all relevant experiential statements; essentially considering how they link together and drawing out the most important and interesting aspects of the data (Smith et al 2022). This was done by printing a list of experiential statements, cutting them up and organising them into groups using two methods:

1. Abstraction – grouping of themes with likeness to each other, and creating a Personal Experiential Themes to umbrella them.
2. Numeration – the number of times an experiential statement occurred to suggest the importance of themes to the participant (Smith et al 2009).

To be able to link back to the participant, each experiential statement included an indication of which script it was born from and a transcript line number.

4.9.6 Step Five: Naming and organising the Personal Experiential Themes

Once I was satisfied with the final groups they were converted into tables, with the linked experiential statements underneath, page/line number and participant quotes, as recommended by Smith et al (2022) to aid identification of supporting information for future reference. An extract of this is demonstrated in Table 7.

Table 7 – Example of naming and organising the Personal Experiential Themes - Camilla

Personal Experiential Theme	Experiential statements	Line number	Quotes associated with experiential statement
Finding reassurance in the 24-hour labour line	Reassurance x 4	536	“they were there to support in those early stages and I could contact them whenever I whenever I needed to so yeah it was it was a real reassurance and it's a service that I'm I'm really pleased exists”
		110	“the team were really really comforting and reassuring erm they put me at ease straight away”
		129	“it just it was very reassuring right from the outset so that was good”
	Comfort in an open call policy x 2	118	“they also they were very very clear that it didn't matter how quickly I phoned them back erm whether I phoned them back in two minutes literally put the phone down and picked it back up again and said I need pain relief or I've got more questions or anything like that or whether it was another two three days before they heard from me again erm and that was really comforting”
		545	“it took any anxiety of whether to call or not away if I thought I'm going to call them I just called them I didn't think oh should I? shouldn't I? should I just wait a bit? so yeah it just took any questioning away”
	Virtual support	226	“even though I'm at home there's still support so it felt like there was sort of a link then between the home space and the hospital that didn't matter that I wasn't there I could still get support from here”
	Being on the radar x 2	182	“that's probably one of the key things for me and just starting the process just so that people knew something was happening cause yeah the last thing I wanted was to get too far along and then be like oh no sorry no probably probably should have told us like two hours ago [laughs]”
		16	“I decided to phone the labour line uh just to give them a heads up”

Personal Experiential Theme	Experiential statements	Line number	Quotes associated with experiential statement
	Comfort of a Helicopter view x 2	116	“it was great to be able to have that central hub and know that they knew they could tell the hospital and that there was sort of then it was kind of on the radar that at some point I might be going in”
		177	“my midwife had said to me all the time that they had like almost like air traffic control screens around them and they could see where all the whether there was space in sort of the [birth centre name] the maternity suite the labour ward the [birth centre name] erm so that they’d know whether there was enough space so what I was conscious of was I didn't want to leave it too late and then not be able to get a bed in my preferred place”

4.9.7 Step Six: Moving onto the next case

This step is self-explanatory; the next script was analysed using the same 1-5 steps outlined. In view of the idiographic nature of IPA, the analyst is encouraged to bracket ideas from the previous case, to enable the next script to be analysed in such a way that its individuality is embraced. The process of reading and re-reading facilitated this; by spending time immersing myself in the next participants world, the themes from the previous case became distant. To further separate myself from the participant I had just analysed, I alternated the participant group that I was analysing where possible, to consider the phenomenon from a different angle.

4.9.8 Step Seven: Looking for Group Experiential Themes across cases

This step looked to identify recurring Personal Experiential Themes across the individually analysed cases, enabling me to identify the most powerful themes through the frequency by which they occur and consider how one case informs another within each participant group. While similarities and shared themes were of note, any differences between participant Personal Experiential Themes were also important to the analysis process. Once clustered, these Personal Experiential Themes formed Group Experiential Themes within each participant group. The process was completed by printing the table of Personal Experiential Themes for each case and browsing for patterns across them. The final Group Experiential Themes, and the supporting Personal Experiential Themes from individual participants, are provided in Table 8. As advised by Smith et al (2022), Group Experiential Themes were present for a minimum of half the participants of each sub-group to be considered plausible. Once the Group Experiential Themes were confirmed, a table was developed to show how the Group Experiential Themes were supported by the Personal Experiential Themes of each participant. This table included key quotes to support the theme and is demonstrated in Table 9.

Table 8 - Example of step seven, part one – development of Group Experiential Themes

		Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
Personal Experiential Themes	Eliza	Managing expectations in the uncertainty of labour	Taking comfort in easy access to reassurance and advice	Balancing risk with comfort during early labour	Respecting professional expertise and guidance	Feeling empowered to take control of the decision
	Lucy	The journey into parenthood that is impossible to prepare for	Space to be calmly heard and reassured	Seeking safety and security		Being empowered by others to make decisions
	Julia	Processing the shock of labour	- Reassurance of midwives - Virtual presence of midwives at a point in time	Managing fear and anxiety about safety of fetus	Handing over responsibility to trusted experts	Authentication by midwives
	Nora	Balancing expectations	A sense of reassurance	Prioritising reducing risk	Putting trust in experts	Happily complying with midwives advice

		Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
	Camilla	Managing broken expectations among the uncertainty	Finding reassurance in the comfort of the 24-hour labour line	Balancing the comfort of home with the safety of hospital	Putting faith in professionals	Being in control of the decision to attend
	Mabel	The uncertainty of unmet expectations	Reassurance of 24-hour labour line		Trust in professionals alleviated underlying fear	Seeking to hand over control
	Annabel	The need to know amid the uncertainty	Keep calm and leave as soon as possible		Confidence in self-diagnosis of labour	Appreciating verification of the decision to attend
	Francesca	Seeking reassurance among the uncertainty	Seeking reassurance among the uncertainty	Prioritising safety	Dismissal derailed the experience	Midwives as gatekeepers to control
	Dorothy	Managing the uncertainty of labour		Timing it right in murky waters	- Confidence in self - Being believed	Navigating varied approaches to decision-making

		Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
	Scarlett	Navigating chartered waters		Safety first	- Power of trust in mind and body of self and from others - Intuition	Autonomy to be in control
	Sara			Being in a safe place	- Following intuition - Importance of not labouring alone	- Midwife holds the key to admission - Transient control

Table 9 - Example of step seven, part two – tabulating Group Experiential Themes with supporting Personal Experiential Theme quotes

Group Experiential Theme: Finding reassurance in the 24-hour labour line		Line number and key quote
Personal Experiential themes leading to Group Experiential Theme	Scarlett	
	Sara	
	Julia - Reassurance of midwives - Virtual presence of midwives at a point in time	181 - that reassurance it meant it meant yeah it did mean a lot to us both of us 108 - and she said well they might there's lots of options and you'll just have to discuss with them it might not be giving birth but if it is there's this don't worry and erm yeah it was all it was just it was nice to know that there were options
	Nora - A sense of reassurance	76 - they were like 'no you'd be able to feel it so you you don't need to worry' and that was really reassuring to hear' 234 - so just the fact that rather than having to resort to Google or whatever you can erm or even ring 111 you can talk to someone and um and get the kind of the reassurance that it's it's all OK and what you should be doing um I found that really really invaluable
	Dorothy	
	Eliza - Taking comfort in easy access to reassurance and advice	115 - that's where actually having the line to phone to to speak to some you know speak to someone about was really was really helpful because um yeah I I think it gave you a bit more reassurance

Group Experiential Theme: Finding reassurance in the 24-hour labour line		Line number and key quote
		285 - it just adds to that feeling that someone cares and that um there's someone there to help
	Mabel - Reassurance of labour line	400 - I mean I was never scared I was never scared erm and talking to them definitely reaffirmed that I thought you know I felt like I knew what I was doing 774 - it was just very calming the way that they spoke the language that they used there was no rush no panic and and therefore you didn't feel like there was anything to worry about either 768 - nobody panicked I think in your mind I know it's really it's such a silly thing but in your mind you're going excuse my my language shit shit shit shit shit shit you know like oh my god oh my god there's a baby coming like a duck you know the legs are going underneath and inside you're going ok you're already ten hours ahead or a day ahead erm whereas when you ring the labour line and you say ok this is what's happening I think it was just that [brightly] ok alright well let's have a you know have you tried this? have you tried that? there was no panic from their side there was none of this oh gosh well you need to get to the hospital then 913 - that is very clear when you say labour line what's it for? It's a ok well it's your midwives before you go to hospital it's the people looking after you before you get there so it is it's an extension of the care that you get at the hospital
	Annabel - Keep calm and leave as soon as possible	45 - they recommended that we come in as soon as possible erm but it wasn't it didn't feel like it was like it was important to come in as soon as possible but it didn't feel like it was like panicked or like anything like that it was just like you know don't waste any time just make sure you get in as quick as you can that kind of thing

Group Experiential Theme: Finding reassurance in the 24-hour labour line		Line number and key quote
		254 - it (calling LL) definitely made a difference in terms of just like listening taking a minute erm rather than kind of going you know where's your pillow? where's this? where's that? is [sisters name] on her way? like sorting out everything else
	Camilla - Being reassured	110 - the team were really really comforting and reassuring erm they put me at ease straight away 545 - it took any anxiety of whether to call or not away if I thought I'm going to call them I just called them I didn't think oh should I? shouldn't I? should I just wait a bit? so yeah it just took any questioning away 226 - even though I'm at home there's still support so it felt like there was sort of a link then between the home space and the hospital that didn't matter that I wasn't there I could still get support from here
	Francesca - Seeking reassurance among the uncertainty	544 - if they'd said you know I think you're in prolonged labour you might have a few more hours yet before you can it might have just calmed me down a bit of what why is this happening? and it actually has a term and this is what is gonna happen and you will get there eventually but your body's just taking a bit longer
	Lucy - Space to be calmly heard and reassured	266 - I think just the way she was really like calm like she wasn't like wasn't panicking or wasn't asking us loads of questions erm like I had a couple of contractions while I was on the phone to them and she just kind of like paused and just let me have the contraction

4.9.9 Step Eight: Looking for patterns across participant groups

Each participant group was analysed separately prior to looking for patterns across the three groups. This decision felt most aligned to the methodology of IPA, due to the importance of homogenous groups and focus on the lived experience of a phenomena. It was my view that the experiences of somebody undergoing labour for themselves, could not be considered collectively with the experiences of somebody supporting another person in labour, as the two are different phenomena. Equally, the experience of a birth partner would likely differ from that of a midwife in a supporting role, due to the differing levels of training and expertise in the area and the emotional distance a midwife has from the situation when compared with the birth partner. That said, as they are experiencing the same episode of care, but from different perspectives, it still felt important to look across the participant groups for congruence and difference in their experience. To do this I used the Group Experiential Theme tables outlined in section 4.9.8 to search for similarities and differences between the findings of each sub-group and synthesise this within the discussion chapter (Chapter 9).

4.9.10 Impact of COVID-19 on data analysis

Part way through the project I was required to analyse a small number of participants as part of the doctoral programme requirement. I chose to undertake and present steps one to seven of the data analysis process for four women participants, to evidence the progress of my study. The four women were recruited prior to the COVID-19 pandemic. While there were no differences in the analysis process for those recruited pre, and during, the pandemic, I did consider how to manage the analysis of the four women I had already formed initial Group Experiential Themes from. I did not re-analyse these participant accounts during the pandemic, as I considered that doing so with the influence of the current pandemic may change my interpretations. Instead, when engaging in step seven onwards I included the Personal Experiential Themes that had previously been formed, and ensured I noted the participants across all three groups that had experienced the 24-hour labour line and been interviewed prior to the global pandemic. This enabled me to draw on areas of congruence and difference in experience within the findings.

4.10 Rigor and assessment of trustworthiness

Rigor relates to:

‘the extent to which a study has been conducted in a thorough, consistent and meticulous way, in accordance with the principles of the particular method and design used’ (Harvey and Land 2017 pg. 378)

Within qualitative research it is maintained that due to the differing philosophy and goals in comparison to quantitative inquiry it is not appropriate to refer to the same terminology and apply the same standards (Polit and Beck 2017) to assess quality by considering validity, reliability and generalisability. Instead, qualitative researchers are concerned with the trustworthiness of the research, as introduced by Lincoln and Guba (1985). There are four areas to consider in relation to trustworthiness: credibility, confirmability, dependability and transferability as defined below:

- Credibility refers to the extent to which the findings are credible and believable
- Dependability refers to the extent to which consistent processes have been applied within the study
- Confirmability refers to the extent to which findings are supported by the data collected from participants
- Transferability refers to the extent to which the findings can be applied to other contexts and populations

Strategies to increase the trustworthiness of the study are presented below.

4.10.1 Prolonged engagement

Prolonged engagement refers to the investment of time in learning about the culture and building trust within the research setting (Lincoln and Guba 1985). This enables the researcher to understand the context in which a phenomenon is observed (Creswell and Creswell 2023) and demonstrate sensitivity to context (Yardley 2000). In turn, this supports detection of any distortions in the data (Lincoln and Guba 1985), enhancing credibility (Creswell and Poth 2018). From the beginning of the project, I spent time at the NHS Trust to learn about the culture and phenomenon of interest. This included observing the set up and implementation of the service, attending training for midwives and observing the service in action. I undertook shifts on the service myself to ensure understanding of the nuances of the day to day running. During the research design phase I spoke with 24-hour labour line midwives, the maternity senior

leadership team, midwifery managers, community midwives, ambulance control managers, call handlers and paramedics. Prior to recruitment I liaised with senior midwifery managers and arranged to meet with postnatal lead midwives on the wards, attending handover to ensure good understanding of the role of the midwife in signposting women and birth partners to the study.

4.10.2 Triangulation

Triangulation, referred to as ‘person triangulation’ (Denzin 1989 cited Polit and Beck 2017) was adopted in this study. This refers to gathering data about the same phenomenon from multiple perspectives (Polit and Beck 2017; Creswell and Creswell 2023), in this case the experiences of women, birth partners and midwives. This form of triangulation was chosen to reflect a comprehensive understanding of the experience of the phenomenon from the perspective of all those experiencing it concurrently. Person triangulation enabled me to consider similarities and differences in the experiences of each participant group, enhancing the credibility of the final themes (Creswell and Poth 2018).

4.10.3 Peer review / peer debriefing

The protocol design was influenced by service users and midwives during regular meetings. As previously explained in section 4.6.4, I also presented the recruitment material, such as participant information sheets and leaflets, to the MNVP and integrated feedback prior to ethical review. The protocol was peer reviewed by an academic prior to being subjected to ethical scrutiny both at the University, NHS REC and the host Trusts to ensure it proposed a high-quality qualitative study. Reflection and questions on the progress of the project, themes and ideas were discussed regularly with the two academic supervisors, both experienced in qualitative inquiry, as a form of peer debriefing to enhance confirmability. Thorough documentation of the research process was undertaken and compiled in the site file and reflective diaries, to enhance the dependability of the research.

4.10.4 Supervisor involvement in data analysis

The data analysis was explored at various points of the analysis process with the primary supervisor. This allowed opportunity for alternative interpretation to be considered and to confirm the accuracy of emerging themes. This process was integral in ensuring a fair reflection of the experiences of participants and included review of the raw data. This gave assurance that

the themes were grounded in the data, despite an interpretative lens, and full independent analysis by a second analyst would yield similar findings.

Further, the Group Experiential Themes and supporting quotes from participants were presented to both supervisors, one of which had a different perspective on the research, in view of not being a health professional themselves, instead approaching the research with a background in psychology. I was challenged to consider how the Group Experiential Themes had been generated from the Personal Experiential Themes and consider my interpretation through a different lens. An example relates to the perception that all patients accessing healthcare want to make choices about their treatment, when in reality sometimes people want a healthcare professional to tell them what the right choice is, when they become overwhelmed or conflicted by the options available. The involvement of the supervisors within the analysis process enhanced the credibility and dependability of the findings.

While member checking is a common tool to further enhance credibility in qualitative research (Creswell and Creswell 2023), it is not recommended within IPA due to the interpretative nature of the methodology and the acceptance that a participant's interpretation of a phenomenon may also change over time (Larkin and Thompson 2012).

4.10.5 Thick description

The research was undertaken in one setting, exploring experiences of one service, as appropriate in IPA research. Rich descriptions of the context, participants and experiences is provided to enable readers to assess the transferability of findings to their context or population (Creswell and Poth 2018). To support the credibility of the themes developed, verbatim quotes from the data is presented within the findings section.

The research methods are outlined in detail and examples of each step of the analysis process is applied to one case for transparency. The decision-making with regards to the methods and analysis process are transparent within this thesis to enhance the dependability of the research.

4.11 Reflexivity

The professional knowledge I have, and the potential impact of this on the interpretation of data, has been considered and appreciated using reflexivity. Reflexivity is the process in which the researcher consciously and critically examines the impact their background, values, understanding and perceptions has on the research process (Carpenter 2010). Gough (2003) referred to reflexivity as acknowledging and understanding the individuality of researchers,

allowing consideration of how this may impact the research (Liamputtong 2013; Creswell and Creswell 2023). In qualitative research the process of reflexivity and the influence of individuality is enriching and can inform, rather than hinder research (Gough 2003). For this reason, a reflective diary, outlining assumptions, thoughts, methodological ideas and questions has been kept throughout the process and formed a reflective account (Gough 2003). An excerpt from this diary, following completion of the first interview, is provided in Appendix BB.

Crucially, as I experienced contact with the 24-hour labour line, labour and birth twice myself during the course of the study, it was imperative I reflected on these experiences. After both births I wrote a reflection on my experience of labour and contact with the 24-hour labour line (Appendix CC). After data analysis was complete, I referred back to these reflections and have commented on similarities between my experiences and those of the participants within the three findings chapters and later in section 10.6.

4.12 Chapter conclusion

This study uses a form of qualitative research, IPA, to explore the experiences of women, birth partners and midwives of using the 24-hour labour line. IPA was selected due to its resonance with my epistemological beliefs and suitability to answer the research questions. Purposive sampling was chosen to ensure appropriate participants were recruited to explore this phenomenon. Data were collected from women, birth partners and midwives via semi-structured interviews. Ethical considerations were explored and presented for scrutiny at UoS and NHS REC for approval. The next three chapters will explore the findings of the research, presenting each sample group in turn.

Chapter 5 Women findings

5.1 Introduction

This chapter outlines the Group Experiential Themes identified from the women participants. First, an outline of the participants, including their demographics is described, before an overview of what has been found is presented. Next, each Group Experiential Theme is described, supported by quotes using the participants' own words. The themes presented focus on addressing the research questions of the study. Further Group Experiential Themes, which were less aligned to the research question, were also developed and may be explored during the post-doctoral period.

5.2 Women participants

Eleven women, six primiparous and five multiparous, were interviewed between six and eleven weeks after birth. Three women were interviewed face-to-face in their own homes, one was interviewed on the telephone as requested by the participant, and seven were interviewed on Microsoft Teams™ using video-calling functions. Four women were recruited before the COVID-19 pandemic, and seven recruited during. One woman, Mabel, opted to be interviewed with her partner Nathan also present and participating in the research at the same time. Eight women were aged between 25-35 years and three were aged over 35 years. All but two women identified as White British, with the other two identifying as Pakistani and White Other. One woman reported that English was a second language. Ten of the women were married, and one was single. All but two women were educated to at least degree level, while the other two women had completed college. Nine women experienced a spontaneous vaginal delivery, one experienced an instrumental delivery and one a caesarean section. Nine women had attended antenatal classes. Seven women accessed care in one Trust, and four from the other.

An overview of each participant is given, as advised by Smith et al (2022), to describe the participants. This information was derived both from the demographic information provided by participants, and extracted from the stories they told about their experience of contacting the 24-hour labour line. Access to this information supported me to maintain the idiographic focus required within IPA, and is presented here to support readers to understand the reason for each participant contacting the service and the outcome of each episode of contact, to provide context to the individual participant experiences within the presentation of the findings. While

information on the parity of each woman is given, there is limited personal information provided to ensure confidentiality is maintained.

5.2.1 Women interviewed prior to COVID-19 pandemic

5.2.1.1 Scarlett

Scarlett contacted the 24-hour labour line while pregnant with her third baby. Scarlett made one telephone call to the 24-hour labour line and was admitted to the local hospital, where her cervix was found to be 6cm dilated.

5.2.1.2 Julia

Julia telephoned the 24-hour labour line when she experienced SROM four weeks before her estimated due date with her first baby. Julia made one telephone call and was admitted to the local hospital. Twenty-five hours after arrival, she birthed her baby.

5.2.1.3 Sara

Sara telephoned the 24-hour labour line twice during labour with her second baby. The first time was when she began experiencing signs of labour – Sara was advised to remain at home. Sara telephoned again the next morning when the pain of contractions increased and was advised to remain at home. Sara remained at home for a short time and then attended hospital, without telephoning again. Her baby was born 30 minutes after arrival at the hospital.

5.2.1.4 Nora

Nora telephoned the 24-hour labour line when she experienced SROM during her first pregnancy. Nora was advised to remain at home and await events, however she telephoned a second time when she became concerned about reduced fetal movements. She was advised to attend the hospital, where she was assessed and returned home. The following day she attended the hospital for augmentation of labour.

5.2.2 Women interviewed during COVID-19 pandemic

5.2.2.1 Francesca

Francesca first telephoned the 24-hour labour line when she thought she had experienced SROM during her second pregnancy. Francesca was advised to remain at home and attend a SROM assessment appointment at the hospital 12 hours later. At this appointment it was

concluded SROM had not occurred and Francesca returned home. Francesca then called the labour line twice more, both times being advised to remain at home. During a final call Francesca reported reduced fetal movement and was advised to attend the hospital. On arrival, Francesca's cervix was found to be 5cm dilated and she birthed her baby three hours later.

5.2.2.2 Lucy

Lucy telephoned the 24-hour labour line two hours after she began experiencing contractions during her first pregnancy. Lucy was given the option to stay at home or to attend the hospital for assessment. Lucy chose to attend the hospital and birthed her baby almost 12 hours later.

5.2.2.3 Dorothy

Dorothy telephoned the 24-hour labour line when she thought she had experienced SROM during her second pregnancy. She was advised to remain at home. Dorothy called again two further times and was advised to stay at home. On the fourth call, she was given an appointment for a SROM assessment appointment at the hospital, where SROM was confirmed and augmentation was booked for the following day. Dorothy returned home and called a final time and attended hospital. On arrival her cervix was 9cm dilated and Dorothy birthed her baby shortly afterwards.

5.2.2.4 Camilla

Camilla made three telephone calls to the 24-hour labour line while experiencing contractions during her first pregnancy. In the first two calls Camilla was advised to stay at home and have a bath. During the final call it was arranged for Camilla to attend the hospital. On arrival Camilla's cervix was assessed to be 6cm dilated and she birthed her baby four hours later.

5.2.2.5 Annabel

Annabel telephoned the 24-hour labour line once during her second labour. Annabel was experiencing contractions and was advised by the labour line to attend the hospital for assessment. On arrival Annabel's cervix was found to be fully dilated.

5.2.2.6 Mabel

During her first labour, Mabel and her partner telephoned the 24-hour labour line three times because Mabel was experiencing contractions. The first two times Mabel was advised to stay at home. During the third call Mabel was given the option and decided to go into the hospital for

assessment. On arrival Mabel's cervix was found to be 8cm dilated and she birthed her baby within three hours.

5.2.2.7 Eliza

Eliza was pregnant with her first baby. Eliza first telephoned the 24-hour labour line when she thought she had experienced SROM. Eliza was advised to remain at home and attend a SROM assessment appointment at the hospital later that day. Eliza's contractions started before the appointment, and she telephoned again to ask for the assessment to be moved forward by a few hours. At this point she attended the hospital for a SROM assessment; her cervix was assessed to be 3cm dilated. Eliza returned home. Approximately eight hours later Eliza telephoned again to ask to go into the hospital. The call went to voicemail, and when the call was returned by the midwife, Eliza was already en route to the hospital, where she stayed until she birthed her baby.

5.3 Overview of Group Experiential Themes

Five Group Experiential Themes were identified among women participants and are presented, with supportive Personal Experiential Themes, in Table 10. Each is then presented, using two or three sub-themes to aid presentation of the findings, and to account for congruence and difference between participants' experiences. Selected verbatim quotes will support each Group Experiential Theme, with further key quotes comprehensively presented in Appendix DD.

Table 10 - Overview of women's findings

		Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
Personal Experiential Themes	Eliza	Managing expectations in the uncertainty of labour	Taking comfort in easy access to reassurance and advice	Balancing risk with comfort during early labour	Respecting professional expertise and guidance	Feeling empowered to take control of the decision
	Lucy	The journey into parenthood that is impossible to prepare for	Space to be calmly heard and reassured	Seeking safety and security		- Being empowered by others to make decisions - Space to be calmly heard
	Julia	Processing the shock of labour	- Reassurance of midwives - Virtual presence of midwives at a point in time	Managing fear and anxiety about safety of fetus	Handing over responsibility to trusted experts	Authentication by midwives
	Nora	Balancing expectations	A sense of reassurance	Prioritising reducing risk	Putting trust in experts	Happily complying with midwives advice
	Camilla	Managing broken expectations among the uncertainty	Finding reassurance in the comfort of the 24-hour labour line	Balancing the comfort of home with the safety of hospital	Putting faith in professionals	Being in control of the decision to attend

		Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
	Mabel	The uncertainty of unmet expectations	Reassurance of 24-hour labour line		Trust in professionals alleviated underlying fear	Seeking to hand over control
	Annabel	The need to know amid the uncertainty	Keep calm and leave as soon as possible		Confidence in self-diagnosis of labour	Appreciating verification of the decision to attend
	Francesca	Seeking reassurance among the uncertainty	Seeking reassurance among the uncertainty	Prioritising safety	Dismissal derailed the experience	Midwives as gatekeepers to control
	Dorothy	Managing the uncertainty of labour		Timing it right in murky waters	- Confidence in self - Being believed	Navigating varied approaches to decision-making
	Scarlett	Navigating chartered waters		Safety first	- Power of trust in mind and body of self and from others - Intuition	Autonomy to be in control
	Sara			Being in a safe place	- Following intuition - Importance of not labouring alone	- Midwife holds the key to admission - Transient control

5.4 “...I didn't really know what to expect” – Navigating uncertain waters during early labour

This theme identified that women, regardless of parity, were uncertain during early labour, which caused them to be anxious. The theme is divided into three sub-themes: uncertainty of labour onset, managing the unique nature of labour and feeling fearful. While this theme does not directly relate to their interactions with the 24-hour labour line, it sets the scene for the next theme in section 5.5.

5.4.1 Subtheme 1 - Uncertainty of labour onset

Participants were uncertain about whether labour had commenced, even when they had experience of previous births to draw on, highlighting the variation in the ways labour onset can occur. While women were aware that labour could start at any time, there was still an element of surprise to this expected event occurring, usually due to the way in which labour commenced. Nora, Lucy and Julia spoke of their disbelief, and that of those around them, that labour had started. They did not know what to expect, as this was a new experience for them, and labour was not commencing in a way they had anticipated or prepared for. This led to Julia mistaking labour commencement in the form of SROM for a leaking bladder:

“I honestly thought I'd wet myself and then erm got up and my water's broke no sign nothing no symptoms well I had sort of Braxton hicks but it turns out that was early labour and I just didn't nobody knew” (Julia 21)

Both Nora and Eliza's expectations about what would happen during labour did not align with their experience. The reading Nora had done and the people they had both spoken to had led to an expectation that they would experience SROM later, rather than before labour commenced. The misalignment between their expectation and experience caused uncertainty. Being the first pregnancy for both, they did not have prior experience to draw on and so based their expectations around the reading they had done and stories they had been told. They said:

“most of the material I'd read talked about um the waters breaking once labours underway rather than you know them breaking you know before labour begins and friends who've had babies um quite a few of them actually had to have their waters broken for them so yeah it was kind of like ‘oh is this is this the right thing?’” (Nora 119)

Camilla and Mabel shared the experience of misalignment, but rather than in relation to SROM, it was concerned with their expectation around what a uterine contraction would feel like. The information they'd been provided suggested contractions would be felt across the abdomen, which they did not experience. Entering labour as a novice with expectations about how a contraction would be experienced, led to Camilla waiting for something that never came. She explained:

"I always thought that erm contractions would be like I'd feel them like all over my whole bump so when they started quite low down I was like "oh this will be I'll wait until they're over the whole bump and then that's the proper contraction" but no so [laughs]" (Camilla 67)

Despite experiencing labour onset with the insight of two previous experiences, the identification of labour onset was no clearer for Scarlett, as she did not realise initially that she was in labour. This did not concern her. Her calm attitude led to her carrying on with her daily business as usual while she awaited events.

"I sort of thought maybe! [exclaims] maybe not! [exclaims] and then we walked back home about 1 dun- it must have been about five thirty and I thought yeah maybe I am [laughs]" (Scarlett 44)

5.4.2 Subtheme 2 - Managing the unique nature of labour

Similarly to the varying ways labour can present itself between women, multiparous women alluded to the uniqueness of their labours by drawing comparison between their experiences. For Dorothy, who was induced with her first pregnancy, the experience of spontaneous labour was new and so she experienced similar uncertainty to primiparous women. For others, labour manifested itself in a different way to previous labours, causing confusion and uncertainty about the stage of labour they were in:

"[speaking of first pregnancy] I ended up staying for couple of days and then getting induced so I never called labour line so I never went into labour so I didn't really know what to expect" (Dorothy 52)

"I was a bit worried in general obviously because I didn't know like how far along in my labour I was and I was in pain and I was worried I'd forgotten things[...]it was really like steady build up erm so cos I didn't have that and I just assumed like I've literally only been in labour for an hour erm and like I said like maybe I'd forgotten everything" (Annabel 90 and 149)

The unique nature of labour was challenging to navigate, particularly for primiparous women, who spoke of being very aware that this was their first experience of labour. Participants differed in the way that they tried to prepare for labour in light of the individuality of the experience. Women tended to either accept it was impossible to prepare or sought to prepare for every eventuality, and even women who felt prepared were still unsure of the right thing to do in the moment. Camilla and Lucy explained:

“where it's different for everybody erm there's only so much preparation that people can put in your head and things they can tell you because otherwise you could look for things that don't happen” (Camilla 80)

“...so I tried to make sure that I read up on like every possibility” (Lucy 166)

5.4.3 Subtheme 3 - Feeling fearful

The uncertainty women experienced in labour left some feeling fearful and uneasy about what was happening to them and what to expect next. Women were waiting for a moment of clarity, though they could not articulate what this looked like, where they hoped the progress of their labour would become obvious. Some participants recalled their partners sharing their own similar uncertainty and fear with them. This feeling is explained by Julia and Dorothy:

“I didn't really know what to expect I was just, we were both, a bit scared I think it was erm yeah we were both quite just unsure of everything, didn't know what to expect” (Julia 106)

“I was like I don't, I don't know if this is the real deal, it doesn't feel like it is but I can't be sure [...] I guess it made me feel a little bit uneasy but I I was fairly sure I wasn't in established labour but I just wasn't really sure what to what I was waiting for if that makes sense” (Dorothy 533 and 537)

5.5 “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line

Most women identified the 24-hour labour line as being important in supporting them to navigate their uncertainty at every stage of the labour process. Eight of the 11 participants had Personal Experiential Themes related to the reassurance provided by the service. Women felt this reassurance at each stage of their interaction with the 24-hour labour line; before they called, during the call and after the call. This is demonstrated in the three subthemes; a 24-hour service adopting an open call policy, the calm in the storm to put you at ease and the comfort of access to a virtual midwife.

5.5.1 Subtheme 1 – A 24-hour service adopting an open call policy

Women generally had good knowledge about the 24-hour labour line and the reasons to make contact, having been briefed by their antenatal community midwives on this. This gave women confidence in making the initial call, as they were reassured they were contacting the right place. Some women inferred that the 24-hour labour line has an open call policy, meaning they were not waiting for a particular criterion to call, but felt able to call when they needed to. This is explained by Camilla:

“it took any anxiety of whether to call or not away, if I thought I’m going to call them I just called them I didn’t think oh should I? shouldn’t I? should I just wait a bit? so yeah it just took any questioning away” (Camilla 545)

Francesca had a slightly different perspective, struggling to identify the right time to call due to the uncertainty felt in identifying labour and a focus on arriving at the birthing environment at the right time. This did not prevent her from calling the 24-hour labour line on four occasions though, suggesting she felt able to access the service. She explained:

“when the midwives tell you, you know and you’ve got labour lines number like yeah well you know when you think you’re in labour give them a ring ok, but what if you don’t know when you’re in labour? or you’re doubting you’re in labour because actually your waters haven’t broken and your contractions aren’t close enough well at what point do you then phone?” (Francesca 484)

For Francesca, the confusion surrounding when to call, even though the guidance was to call whenever you feel you need to, seemed to consume her in early labour as she experienced uncertainty about what the open call policy meant for her.

Participants appreciated the 24-hour availability of the telephone line which provided them valuable direct contact with a midwife, and thus reassurance, when other services were unavailable. The service satisfied what would have otherwise been a gap in their care and removed the need for the women to over-analyse what they needed to do next. Regardless of the time of day, the instruction to call the 24-hour labour line was the clearly promoted action for them to take. This is highlighted by Eliza:

“I think without it I wouldn’t necessarily have known who to turn to because obviously your midwife isn’t necessarily working at the point when you go into labour[...]I wouldn’t necessarily have known what best to do in certain circumstances where as um having that dedicated line for it just makes it really feel like right there’s one point of contact” (Eliza 613)

Accessibility to a midwife discouraged women from seeking advice and reassurance from alternative, less reliable sources, as seen in a quote by Nora:

“so just the fact that rather than having to resort to Google or whatever[...]or even ring 111, you can talk to someone and um and get the kind of the reassurance that it’s it’s all OK and what you should be doing um I found that really really invaluable” (Nora 213)

5.5.2 Subtheme 2 - The calm in the storm to put you at ease

The midwives on the 24-hour labour line encouraged the women to pause and take check, calming them down in the height of their panic. The midwives’ calm approach to the conversation relaxed the women and gave them confidence there was nothing to be concerned about. This is seen by Annabel:

“it (calling LL) definitely made a difference in terms of just like listening taking a minute erm rather than kind of going you know where’s your pillow? where’s this? where’s that? is [name] on her way? like sorting out everything else” (Annabel 254)

The reassurance provided by the midwives was heavily valued by the women. The midwives’ attitude, and lack of urgency to the discussion, grounded the women, encouraging them to live in the moment, rather than think about what was coming further down the line. The calm approach normalised an unfamiliar situation and the process of early labour, enabling them to regroup and focus on the next stages. While the 24-hour labour line midwives did not always have the answers, they were able to provide reassurance that despite whatever was happening, there was nothing to be concerned about. Mabel and Julia said:

“in your mind you’re going, excuse my my language, shit shit shit shit shit shit you know like oh my god oh my god there’s a baby coming, like a duck you know the legs are going underneath and inside you’re going ok you’re already ten hours ahead or a day ahead erm whereas when you ring the labour line and you say ok this is what’s happening I think it was just that [brightly] ok alright well let’s have a you know have you tried this? have you tried that? there was no panic from their side there was none of this oh gosh well you need to get to the hospital then” (Mabel 768)

“...she was very maybe’s and might be’s and just don’t worry so that was good” (Julia 307)

The midwives provided reassurance to women while they were at home, putting their worries at ease and supporting them to feel more informed by explaining some of the symptoms they were experiencing, as seen by Camilla and Mabel:

*“the team were really really comforting and reassuring erm they put me at ease straight away”
(Camilla 110)*

“I said it doesn't feel like contractions it's all in my back and she said oh that's probably because baby's back to back with you um and that's really common I was like oh that's what it is” (Mabel 126)

The 24-hour labour line was the mechanism by which the women could have a plan made regarding the next step. Midwives acknowledged the situation the woman found herself in and gave her confidence that a plan was in place moving forwards. The development of the plan was key for the women in reassuring them, even if it was simply through feeling empowered to remain at home and in their own assessment of the labour. Eliza explains this in relation to having a SROM assessment booked:

“I think once I'd had that initial reassurance and got that initial appointment booked that made me a lot more, a lot more calm cos I felt like I knew what [...] the things to look out for were cos they talk on the line they talk you through what to what to look out for” (Eliza 136)

Francesca was an outlier and had a different experience. For Francesca, reassurance about a prolonged latent phase was absent and this impacted her experience by leading her to be worried about the situation and concerned about the safety of the fetus. Later, when a prolonged latent phase of labour was explained to her at the hospital, she recognised how helpful this information would have been if received from the 24-hour labour line. She said:

“if they'd said you know I think you're in prolonged labour you might have a few more hours yet before you can it might have just calmed me down a bit of what why is this happening? and it actually has a term and this is what is gonna happen and you will get there eventually but your body's just taking a bit longer” (Francesca 544)

5.5.3 Subtheme 3 – The comfort of access to a virtual midwife

Some participants felt the virtual presence of the midwives even once the call had ended, taking comfort in knowing the midwife was there should they need them and that they were welcome to call back at any point. The reassurance provided by the virtual midwife meant the women did not need to go into the hospital for support or advice as it was available to them at home. Until there was something to be gained through in person assessment, such as further analgesia, women generally felt empowered to remain at home. The women described an open call policy to a virtual midwife, reassuring them they were not alone and that they were still cared about, despite being at home. Mabel explained this as:

“they are the midwives at home aren’t they but through the phone[...]that is very clear when you say labour line what’s it for? It’s a ok well it’s your midwives before you go to hospital it’s the people looking after you before you get there so it is it’s an extension of the care that you get at the hospital” (Mabel 911)

For the participants interviewed during the COVID-19 pandemic the extension of the care into the home was regarded as being even more important, due to the restrictions on who they could have physically enter their home to support them. Moreover, as discussed further in section 5.6, some participants were keen to stay at home as long as possible to ensure their birth partner was able to attend the hospital with them. The availability of the telephone support service was therefore integral to their confidence to stay at home, making it particularly valuable during the pandemic. Eliza said:

“I think that’s probably also a thing about the labour line where you can’t just easily you know see people um in person it it’s I think any virtual services like that are really important at the moment like more so than they probably usually would be” (Eliza 303)

Finally, as later also observed in the birth partner findings, women found it comforting knowing that they were on the radar of the hospital. Camilla said:

“it was great to be able to have that central hub and know that they knew they could tell the hospital and that there was sort of then it was kind of on the radar that at some point I might be going in” (Camilla 117)

5.6 “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital

This theme identified two subthemes: the comfort of home and accessing the safety of hospital. Women were generally keen to remain at home during early labour, where they could access their own home comforts and avoid a range of concerns associated with the COVID-19 pandemic. They were also certain they did not want to birth outside of the hospital setting, and so the reassurance provided by the 24-hour labour line midwives only lasted so long, before they wanted the security of being in the hospital setting. Telephone calls with the 24-hour labour line midwives were deemed helpful when balance in these two ideals was achieved, and arrival at the hospital was considered to be timed well. Conversely, late arrival at the birthing environment induced feelings of fear among women. The 24-hour labour line midwife is therefore integral in achieving the right balance between remaining in the comfort of home until the safety and security of hospital is sought.

5.6.1 Subtheme 1 – The comfort of home

Understanding the benefits of remaining at home during the latent phase of labour and wanting to avoid spending longer than necessary in a hospital setting, women tried to balance the comfort of being home with the safety they associated with the hospital. At home they described the convenience of having easy access to food, drink, the bath and other amenities, while also being able to feel more relaxed, which helped them cope in the earlier stages of labour. Women referred to both theirs, and their birth partners, dislike of hospitals in a broader sense, so spending as little time as possible in this environment was favourable. This is explained by Eliza and Camilla:

“I’m not a massive fan of hospitals and so as much as I was I really like I absolutely did not want a home birth but I also didn’t want to find that yeah I was kind of stuck in hospital for hours and hours and hours just going through those early stages of labour I’d much rather be at home where I can or I could get myself some food more easily and like you know being a bit more of a familiar environment” (Eliza 94)

“I wanted to be in my house er and just my own surroundings if I wanted a snack I I could just get a snack you know things like that just just creature comforts I guess um and hospitals generally speaking in most people’s lives are a negative association so it was nice to just even though the the maternity hospital didn’t have that negative association erm my husband really doesn’t like hospitals so it was nice that he then felt more comfortable as well and yeah just made the whole thing a bit easier to cope with” (Camilla 54)

Another factor influencing the decisions made around the timing of presentation at the hospital was the COVID-19 pandemic. All women interviewed after March 2020 spoke of the impact of the pandemic on their experience, which in relation to the 24-hour labour line was threefold. Firstly, despite Government guidance at the time stating that women should have access to a birth partner from the point of admission (NHS 2020) women, such as Eliza, were anxious about the potential of their birth partner not being able to attend the birth at all due to visitor restrictions. Other participants needed to time their admission in a way that facilitated their partner to attend while also complying with isolation requirements, which at the time of interviews involved ten days self-isolation (UK Health and Security Agency 2023). Francesca references this:

“I had to wait until midnight on the [date] because husband had a text er saying he had to isolate for ten days and that ended midnight on the [date] erm so that that was another stress to add er so yeah even though my waters I thought my waters had broken on the Saturday I was like I

cannot I can't go in anyway because I can't take [partner's name] can't come with me"
(Francesca 384)

Secondly, women were acutely aware that if they were not in established labour on arrival at the hospital, their birth partner may not have been able to stay with them. Women had already highlighted the sacrifice they faced in not being able to have additional birth partners, such as their friends or mothers, to support them at home during early labour. While the home environment itself had comforts, it was the presence of the birth partner that was of most importance, and this extended to the hospital setting. This is seen by Lucy, who said:

"I kind of wanted to stay at home as long as I could erm to obviously make sure that [partners name] could come with me" (Lucy 45)

Thirdly, a finding observed only in Camilla's interview, was that during the pandemic the hospital may have been perceived as less safe, due to the likelihood of contracting COVID-19. Camilla noted being concerned about the risk associated with the virus, on top of the risks of labour. Further, the necessity to wear masks and be tested for the virus led to her wanting to stay in the comfort of her home for as long as possible. She said:

"I knew that we would have to wear masks at some stage, have a test at some stage and the comfort of being at home for longer meant that we didn't have to concern ourselves with any of that" (Camilla 416)

5.6.2 Subtheme 2 – Accessing the safety of hospital

While women were keen to remain at home for as long as possible, they were equally clear that birth occurring outside of a hospital setting would not be viewed positively. Telephoning the 24-hour labour line was a means of accessing the safety of the hospital. Participants shared an underlying concern about their fetus and wanted to be in the '*right place*' at the '*right time*' for birth, which was, in all cases, considered to be the hospital. This suggested that women had little confidence in the physiological process of birth, assuming it was associated with risk, though it was unclear where this perception had come from. For women, labour is not an everyday occurrence as it is for midwives, whose training has historically been deep rooted in a trust of physiological birth. This led to women seeking help, despite struggling to articulate why they were concerned or what they were concerned about. This is demonstrated by Julia and Francesca:

"yeah I thought, we kinda thought that we would have to go in to the hospital, er because I just I just thought there was a problem" (Julia 82)

"I wanted to be in hospital so that if anything went wrong I was where it would be okay"
(Francesca 302)

Concern about being in the hospital in good time motivated women to attend earlier than they perhaps needed to. Women were keen to err on the side of caution to seek access to their perceived safe place and avoid birth outside the hospital. Eliza and Dorothy explain:

"I'd rather go in now even if I'm still not you know as far dilated as I might be [laughs] but just be in the security of knowing that I was in the hospital" (Eliza 524)

"I didn't want to go in too early but I obviously wanted to make sure that I made it rather than giving birth at home or in the car" (Dorothy 505)

Women considered the hospital environment as a place in which safety could be achieved through access to both health professionals and equipment, should an emergency occur or an intervention be required. As their pain increased at home, so did their anxiety and fear, which arrival at the hospital diminished through the reassurance of a face-to-face assessment. This is seen by Lucy:

"I was more calm once I got to hospital cos I knew there was obviously the intervention there if I needed it[...]obviously they're professionals aren't they they know exactly what they're doing they do it every day" (Lucy 276)

For Sara this strategy did not work. Sara's arrival at the hospital just thirty minutes before the birth of her baby led her to become very scared of delivering outside of the hospital, which was considered the safest place to be and a place in which her pain could be relieved. This aspect of her experience consumed her, as she was taken over by fear:

"it was I would say it was very in the nick of time I was scared that I was gonna deliver in the car that was really the only thing I was thinking" (Sara 220)

Meanwhile, Scarlett had been diagnosed with Group B Streptococcus and was keen to receive intravenous antibiotics in labour, leading her to want to arrive at the hospital with time for these to be administered. The risk of Group B Streptococcus was an important factor, and one that she had shared with midwives during the antenatal period to ensure a clear plan was in place. Despite this, Scarlett felt the midwives on the 24-hour labour line did not mirror this concern, suggesting the experience of women is dependent upon which midwife they liaise with. Scarlett summarised this:

“I think some midwives are very concerned about strep b and others aren’t so concerned about the strep b and where I very very very very tiny risk I’d rather have those antibiotics” (Scarlett 128)

Conversely, for primiparous women seeking support from the 24-hour labour line gave them, and their birth partners, a sense of relief that the risks they faced would be addressed and they would be looked after. They experienced a sense of handing over responsibility to midwives to ensure a positive ending to their pregnancy. Julia explained:

“it [the 24-hour labour line] did really help it really helped cos I think then it confirmed it for him that I wasn’t in any sort of danger cos you know you always think awful things” (Julia 284)

Finally, both Sara and Nora had concerns about the drive they would need to undertake to attend hospital and the risks of experiencing a road traffic accident.

“[laughs] being heavily pregnant in the middle of the night and the road from here to [place name] is um its very windy and it is basically wooded on both sides and so there’s deer and what not kicking about” (Nora 162)

This concern was for both themselves, others and the fetus. For Nora the midwives on the 24-hour labour line shared this concern and suggested that it may not be safe to drive herself to the hospital, prompting her to telephone her doula. For Sara, this fear came from the necessity for her husband to drive quickly, due to the imminent arrival of her baby, making the delayed invite to the hospital by the 24-hour labour line midwives escalate from concern about herself and the fetus to concern about her wider family and other road users. This was distressing for Sara, as she tried to focus on coping in established labour, while being so fearful. Sara explained:

“my husband was trying to drive the car very quickly but erm it because I was it could be dangerous to anyone who is in a driving seat because the person can have an accident or something” (Sara 310)

5.7 “...for them it is very bread and butter, isn't it?” - The significance of trust in self and others

Trust was a multidimensional theme, referring to their trust in the midwife, in themselves and their bodies, and the trust the midwife places in them. These form the three subthemes of this section. Trust was related to the intuition of women to attend the unit; when the woman’s trust in herself and her body overpowered the advice provided by the midwife, or negated the need for agreement from them that they should attend. There was a stark difference between the

experience of primiparous and multiparous women, with primiparous women putting more trust in the midwife, while multiparous women sought for the midwife to trust in them.

5.7.1 Subtheme 1- Women's trust in midwives

For Nora, Julia, Sara, Camilla, Mabel and Eliza their default position was to trust in the midwife on the 24-hour labour line, as they are experienced experts, who know better than themselves what action is necessary. Primiparous women particularly trusted the midwife explicitly, arguably due to the uncertainty they had around labour due to their inexperience, making the issue of control and trust particularly important to them.

Women were aware that midwives had prior exposure to the experience of labour, meaning they were well placed to detect any deviation from the norm, being accustomed to the process of labour. This put them in an ideal position to assess the safety of the woman and her fetus, by judging the normality of the presentation before them. Eliza and Mabel say:

"...the fact that you know they've seen so many people that um they're probably a lot better judge as much as I can tell them what my symptoms are they're a lot better judge then of whether that's kind of in that category of being like relatively normal and in keeping with what they've seen" (Eliza 178)

"...also what's new and exciting or scary or unknown for us you know [frantically] should it be like this? should be like that? for them it is very bread and butter isn't it?" (Mabel 804)

For others, the trust was a result of the expertise and professional registration of the midwife. Both Nora and Julia's immediate instinct was to telephone the 24-hour labour line after SROM occurred to seek help, hand over responsibility and follow the advice given. They valued the idea that the midwife would not be providing care to women in early labour if they did not have the correct skills to do so. As a professional herself, Nora valued the professional training midwives would have undertaken and their experience, influencing the level of trust she had in the midwife. She said:

"it was my first thought to talk to someone who was a professional [laughs] rather than anybody else" (Nora 225)

Similarly, the way the midwives communicated demonstrated their professional expertise and knowledge and this enhanced trust. Consequently, Julia did not feel the need to question the advice provided but instead accepted the reassurance given by the midwife as she entered a new, unknown experience. Julia stated:

“...then I felt right ok well this lady she’s obviously an expert she obviously knows what’s or she has a rough idea of what is going on we are going to go with what she said you just trusted her, trusted what she was saying, so that was, that made me feel a lot better you know” (Julia 340)

This view was reiterated by Camilla, who highlighted the extent of her trust by making reference to handing them the responsibility of facilitating the delivery of her most precious thing – her unborn child. The trust in the midwife was therefore unquestionable for Camilla, despite her doubting how they could make a full assessment of labour progress using telephone assessment. Camilla spoke of the magnitude of the trust:

“I mean it was it was my plan to let them deliver the baby so [laughs] but you know I was I was happy that I trusted them” (Camilla 386)

Mabel further supports the extent of the trust by explaining that all the fear, that consumed her during pregnancy due to the heartache of previous miscarriages, was resolved when labour commenced. She completely trusted the midwives from this point to take care of both her and the baby to achieve a safe outcome:

“...those thoughts were gone it was a case of she's gonna get here one way or another these amazing ladies and midwives cos I know you’ve got male midwives too but erm you know these amazing midwives they're gonna they're gonna look after us” (Mabel 990)

Meanwhile, although Sara had a poor experience, arriving soon before the birth after being advised to remain at home, she remained positive that midwives should be professionals in which women can put their trust. There was a sense of longing for this experience, to enable women to hand over responsibility and control to the midwife. She said:

“you need someone who in which you can put your trust in and er[...]by talking will help you out and where you are at the moment and[...]where to go from that stage onwards” (Sara 284)

5.7.2 Subtheme 2 - Midwives trust in women

Multiparous women, Scarlett, Sara and Francesca perceived a lack of trust from midwives in their judgement of labour progress, despite experiencing labour with the benefit of previous experience. While midwives did not specifically tell women during the phone call that they did not trust their assessment of labour progress, women interpreted their communication in this way. Scarlett spoke explicitly about the lack of trust midwives have in women generally, and for her this was more important than the friendliness of the midwife on the surface, stating:

“...it’s friendly but not [exhales] there’s that [exhales] it’s hard to explain that feeling of you’re not believed” (Scarlett 69)

Francesca felt similarly that her previous experience of labour was not acknowledged, and that what she was reporting was being considered only superficially:

“I don’t think they’d really taken me seriously on the phone when I said they’re really strong they’re lasting at least a minute and they are really really strong” (Francesca 350)

It was strongly felt by women that midwives should trust in them, take their word and undertake an assessment before dismissing that they may be in established labour, perhaps as a means of showing respect for the process their body is undergoing and their prior experience. Labour was considered by women to be an unknown phenomenon that differed between women and that midwives should appreciate this individuality. This seemed to women as the obvious way to manage labour assessments, over and above assuming the midwife must know best, as the woman is the one experiencing the labour. This is demonstrated in the quote:

“...you never know when labours gonna happen or when the baby is going to be born or how fast it goes or how fast it doesn’t go but that’s why I think it’s a bit weird why the woman isn’t believed first and then its changed later once she is examined” (Scarlett 301)

Sara also felt that women should be invited earlier, assuming all women will transition to the second stage of labour and therefore midwives should trust in women’s bodies and the physiology of labour and assess them sooner. For Sara, this would have prevented the distress caused by arriving at the hospital, which she considered the safest place to have her baby, just thirty minutes before the birth. She states:

“...at the end of the day everyone will go into second stage of labour so they should call the mothers earlier than at the stage that I was” (Sara 301)

Scarlett and Dorothy suggested this feeling of not being trusted was not confined to the 24-hour labour line midwives, but extended to the midwives undertaking assessment within the hospital. The lack of trust the midwives had in her own confident diagnosis of labour was confirmed to Scarlett when it transpired, after her cervix was assessed to be 6cm dilated, that the midwives had placed a bet on her progress. She described:

“...my husband said to me afterwards ‘you lost the bet then!’ cos you could see on their faces that ‘ah she’s not in labour’ when you walk in and they said ‘ah yeah we lost the bet’ ‘what bet – so there was a bet on!’ [laughs]” (Scarlett 93)

While Scarlett laughed about this during the interview, there was an underlying tone that the behaviour observed of midwives was unacceptable, and a sense of pride in having proved them wrong, with her own diagnosis confirmed to be correct. This was similar to Dorothy whose clear history of SROM was trusted by the midwives on the 24-hour labour line but later questioned by staff at the hospital due to a lack of evidence on a sanitary pad. It was later confirmed via ultrasound that SROM had occurred. Having midwives not believe them made women question their own assessment of the situation, damaging their confidence and impacting their birth experience. This is demonstrated in the quote by Dorothy:

“I was fairly sure that that was my waters had gone erm but yea, I was just sort of being told from the examination side of things there's no evidence that your waters have gone and it almost sounded like they didn't believe me” (Dorothy 585)

“...anyway obviously having the scan proved that I wasn't going bananas” (Dorothy 608)

5.7.3 Subtheme 3 - Trusting in themselves

Finally, women spoke of the trust they had in themselves and their intuition. While primiparous women spoke to this, the strongest sense of this was among multiparous women, who had the benefit of the experience of a previous labour to draw upon. Regardless of the trust they had in the midwife, and the trust the midwife had in them, they would have made the decision to attend the hospital regardless, following their maternal instinct. Despite the focus placed on trusting an expert with professional qualifications, in the end this was not as powerful in determining their behaviour as following their gut. Scarlett and Julia recall:

“...I was going in whatever they said [laughs]” (Scarlett 164)

“...I mean, we were, regardless we were gonna go straight up to [hospital name]” (Julia 111)

Women seemed to have a sense of knowing when it was time to go in, despite the uncertainty that grappled them in early labour. Although being concerned about arriving at the right time earlier in the labour process, women seemed to reach a point of clarity where presentation at the hospital became the only option for them. Multiparous women Dorothy and Annabel explain this feeling:

“I was confident that the first couple of times that I'd called that I shouldn't have been going in and that it was too early erm by the time I'd called the last time I knew I definitely did need to be going” (Dorothy 500)

“...like I talked about being worried that I had forgotten but at the same time like I knew it was a big deal and I knew it had gotten to the point where it was painful enough for me to think no I

can't like I don't think my body can cope with this like long term without actually being looked out or checked or whatever" (Annabel 191)

This feeling of knowing led to Sara and Francesca presenting at the hospital regardless of the opinion of the 24-hour labour line midwife, as discussed in the next theme. For other women, in following their intuition they made the decision themselves to attend, but wanted to be courteous by informing the 24-hour labour line midwife that they were going to the hospital. Eliza said:

"...I sort of thought in my head like well it would be it's nice to let them know if we can but fundamentally if we needed to go we needed to go" (Eliza 546)

Sara, on the other hand, initially trusted the midwife over her own instincts and followed the recommendation to remain at home. It was only once she began to feel scared about how quickly labour was advancing that she followed her instinct to regain control and seek admission to reduce anxiety. It was at this point that Sara became defiant, deciding not to contact the 24-hour labour line again, but instead present directly at the hospital.

"...and then I just thought that no, I should go now, so I didn't call the labour line again and I just went to the hospital" (Sara 92)

5.8 "...it's your labour" - Being empowered to take control (with hints of occasional autocracy)

This theme centres around the extent of control women felt in relation to the management of their labour, particularly related to making the decision to stay at home or attend the birthing environment for a face-to-face assessment. Women also sought varying levels of involvement in the decision making process, and the degree of autonomy they desired in relation to their care sometimes differed for the same woman across different telephone calls, depending on their level of uncertainty regarding the progress of their labour.

Analysis identified three levels of control related to the final decisions made during the telephone calls; with some women being empowered by the midwife to take control of the decision, other women seeking to hand over the decision to the midwife, and a small number of women having their control removed and the decision made for them. Within this, women evidenced different types of decision-making approaches from the midwife. Most frequently, shared decision-making was described, however in a smaller number of cases the women

either followed the recommendation of the midwife, or experienced a paternalistic approach, with the decision made by the midwife.

For those experiencing shared decision-making, women were provided with information regarding the options available to them, including the risks and benefits of each decision, before their personal preferences were explored, and a final decision was made. While women described the decision as being theirs to make, their description of the conversation suggested principles of shared decision-making. These women sought autonomy over the decisions related to their care, and the shared decision-making model facilitated this autonomy.

For women that had their decision verified by the midwife, they sought reassurance from the midwife that they had identified the right time to present at the hospital, and felt confident having received this confirmation ahead of admission. For other women, a paternalistic approach to decision-making was sought, whereby women wanted to be instructed by the midwife what to do next and adopt less autonomy over that decision themselves. Some women recalled the midwife striving for shared decision-making, which became frustrating when they wanted to hand control of the decision to the midwife.

During a few phone calls with multiparous women, the decision was made solely by the midwife – on three occasions for the woman to remain at home, and on one occasion for the woman to attend for face-to-face assessment. In these cases, the women felt their autonomy had been removed, and they experienced an initial loss of control, before identifying ways to reclaim their autonomy and control over their care.

While related to decision-making, this theme is structured in sub-themes focused on control. This captures the various levels of autonomy women wanted over the decision to either remain at home or attend for a face-to-face assessment. To capture the different levels of control over decisions, the three subthemes are: being empowered to take control, seeking to hand over control and a sense of paternalism.

While most women's experience aligned neatly to one of these subthemes, Francesca and Dorothy, who called the 24-hour labour line on multiple occasions during early labour, experienced different approaches depending on the midwife they spoke to and therefore feature in multiple subthemes. Further, two multiparous women, Scarlett and Annabel, contacted the 24-hour labour line during a previous labour, and spoke of their experiences during these interactions and the impact this had on their perception of the service prior to calling during their more recent birth. For this reason, they also feature across multiple sub-themes.

5.8.1 Subtheme 1 - Being empowered to take control

Participants mostly had positive experiences in relation to accessing a face-to-face assessment at the hospital. The women, particularly those interviewed during the pandemic, were provided with individualised care and described strong examples of shared decision-making. Women were encouraged to tell their story, before being given information by the midwife, usually followed by the presentation of the option to either stay at home or attend for assessment. After, the midwife encouraged the woman to make a final decision, depending on their preference.

“...they listened to what I had to say on the phone and then kind of gave me the option” (Lucy 134)

“so she was almost kind of leaving the ball in my court I suppose” (Dorothy 491)

In these calls, the midwife sought to establish what the woman wanted, rather than needed, to do. Participants described being advised that they could remain at home, but if they would prefer to have an assessment, or explore further pain relief options, this was an option available to them. This accommodation empowered women to remain at home longer while providing a safety net in which they could change their mind at any point and this decision would be respected. Francesca said:

“I was just about coping now that it was daytime erm with the breathing and with people being here to try and take my mind off of it erm but it was nice to know there was the option if I wanted to go in and get some form of painkiller I could” (Francesca 203)

The decision regarding whether to attend for an assessment was very much perceived as the midwife putting the ball in the woman's court, enabling a sense of control over their care. This was particularly important, in view of the lack of control over labour that was generally felt by women. Eliza explained that she was given the option to bring an assessment forward by a few hours, or attend for SROM assessment at the original booking time:

“...equally if I'd had the choice and I'd gone for the later one at least would have felt like it would have been my decision rather than feeling kind of forced into a set of circumstances that I potentially didn't have as much control over” (Eliza 491)

The midwives' skill in listening to the women was seen as a key feature in making them feel heard. Midwives were interested in how the women were feeling, how they were coping with the

pain of labour and what their preferences were, rather than focusing solely on the threshold of contraction frequency and length, which women had often not met. Eliza said:

“...they were very much listening to how I was feeling and not just kind of the facts of the facts of it” (Eliza 447)

Some participants had an idea before the call regarding their preferred outcome of the call. These women had signals that suggested to them that they required face-to-face assessment, for example SROM or regular contractions. Speaking with the 24-hour labour line midwife and having their initial decision verified reassured them and gave them confidence they were doing the right thing in attending the hospital. Annabel said:

“we were all kind of in agreement that that sounded like the right like next step erm and obviously it's nice to have the reassurance that you know you think if you're ready to call I called thinking I was ready erm so then it's obviously nice having that confirmed that they think you're ready and therefore you can go in and kind of get it started but at hospital” (Annabel 84)

When women initially chose to remain at home, they felt confident to contact the 24-hour labour line again when their decision had changed. At this point the women were not seeking permission to enter, but courteously informing the labour line of their decision, highlighting the extent to which women felt able to take control over their labour.

“...by about three I was like no you know what? let's let's call them back let's let's tell them I think we're gonna go in” (Camilla 28)

The extent to which women felt empowered to take control of the decision was highlighted through their confidence in challenging the midwife, or ignoring their advice, if it had not aligned with their own wishes. This was not necessary, as their decision was respected by the midwives. These women had a great sense of autonomy over their labour, feeling fully in control of the timing of admission. They said:

“it wouldn't have mattered I think what they if they'd said to me oh you could wait a bit longer I I wouldn't have so [laughs]” (Eliza 529)

“like I say it doesn't really matter with me because I'll do what I chose to anyway” (Scarlett 296)

5.8.2 Subtheme 2 – Seeking to hand over control

Three of the women, Mabel, Nora and Julia, needed more than verification of their own decision, instead seeking to hand over control of the decision to a professional. For Nora, this linked to

the theme of trust, and the importance of a health professional with more expertise than herself making decisions about her care. In this instance, the midwife on the 24-hour labour line seemed to observe that Nora was seeking instruction, rather than shared decision-making, and therefore presented the information in a way that enabled Nora to decide whether or not to consent to the recommendation to initially remain at home, and during the second call, to attend the hospital.

“I wasn’t looking to make a joint decision I was looking for an expert to you know tell me” (Nora 198)

Conversely, Mabel became frustrated when the midwife was unwilling to make the decision for her, consistently using the phrase *“it’s your labour”* to encourage Mabel and her partner to take control of their care and come to a shared decision using the options, risks and benefits presented by the midwife to inform this decision. While a seemingly good intention, this was not what Mabel sought as she tried to alleviate her anxiety about presenting at the hospital too early by seeking professional guidance and delegating the decision to the midwife. While Mabel felt reassured by the 24-hour labour line and appreciated the service, speaking of it positively, it appeared their need with regards to decision-making was not met, with Nathan eventually making the decision to attend. Mabel said:

“[laughs] I think I probably needed somebody to say ok it’s time to come in now [laughs][...]whereas they were they were reluctant to do that” (Mabel 515)

In addition to these three experiences, Dorothy expressed the desire to be told what to do by the midwife, due to being uncertain. Dorothy experienced several approaches to decision making, ranging from being advised to remain at home, being encouraged to participate in shared decision-making, and eventually having the decision to attend verified by the midwife. Dorothy found being given clear measurements to wait for a certain contraction frequency helpful in managing labour at home, and inferred that this direct instruction was preferable over being encouraged to participate in the decision-making process. When the midwife attempted to facilitate shared decision-making, Dorothy wanted to defer autonomy and be told what to do, which the midwife detected and responded to. This case demonstrates that women may seek different approaches to decision-making at different points within their labour, and the shared decision-making model provides opportunity for these varying degrees of autonomy to be addressed.

“I kind of just wanted someone to tell me what to do at that point I think” (Dorothy 531)

5.8.3 Subtheme 3 – A sense of autocracy

While most participants experienced control over the timing of admission to hospital, two multiparous participants felt that on some calls they were prevented from attending hospital at the time that felt right for them. For these participants there was no discussion at all about the decision, but rather an instruction from the midwife to remain at home. The women reported not being presented with the option to choose admission to have an assessment of progress or to receive reassurance or analgesia, even with the caveat that they would likely be sent back home. The perception was that the midwife was in charge, held control of the decision and that their only option was to do as they had been advised.

“they said it’ll be some time at the moment so you have to wait” (Sara 65)

*“she just said no you’re gonna have to wait erm cos they’re not close enough together you wouldn’t you wouldn’t get seen they’re not close enough together there’s no point you going in”
(Francesca 88)*

This approach to the call had a lasting effect on women, with Francesca noting that one interaction ruined the entire experience of contacting the 24-hour labour line four times, and discouraged her from contacting the service again. Moreover, while Scarlett was admitted during her first call to the 24-hour labour line during labour in this pregnancy, her previous experience of encountering the service and being prevented from attending the hospital influenced her perception of the midwives as gatekeepers. Annabel, though describing shared decision-making during this labour, also referenced similar concerns from a previous pregnancy:

“I think the first time around we maybe didn’t we’d not not have a positive experience but I think we were put off by our first call to labour line so obviously I think that possibly was in the back of our heads the second time round” (Annabel 305)

These interactions with the midwife removed the women’s sense of control over their care, and to regain control women adopted a number of strategies. Sara did not telephone the 24-hour labour line again, instead presenting at the hospital to take control of her labour. Despite recalling two phone calls that evidenced shared decision-making, Francesca appeared to manipulate the midwife to gain admission, by reporting reduced fetal movements. This suggests she was unsure which approach from the midwives she would encounter next and so strategised to ensure control over the situation in the final phone call. They said:

“...cos I thought they they they going to say again [laughs] that there’s still time and that’s why I just went there” (Sara 99)

“I ended up at the hospital because I phoned again and said that I didn't feel him kicking as much cos I just I I wanted to be seen” (Francesca 20)

The benefits of individualised care and shared decision-making were acknowledged by women that did not receive this in every call themselves. Sara noted that her experience may have been different had her preference been valued by the midwife and she been asked whether she wanted to attend the hospital, providing the opportunity to take control over her care.

Meanwhile, Francesca, who was encouraged to make a shared decision with midwives she spoke to later in her labour, recalled taking comfort in being given the option and would have valued knowing this sooner.

“I think it [being asked by midwife if she wanted to go in] it might have changed because I wanted I might have gone to the hospital if they asked me” (Sara 376)

5.9 Conclusion

This chapter presents five Group Experiential Themes generated from interviews with woman participants. The research questions were concerned with how women experience the 24-hour labour line and how decisions are made about whether to remain at home or attend the hospital for face-to-face assessment. These findings highlight that, regardless of pregnancy parity, women were uncertain about labour onset and the progress of labour at home but that the presence of the 24-hour labour line provided reassurance during this time. Women took comfort in the virtual support of a midwife at home during early labour, which was especially important due to restrictions to social support they could access during the COVID-19 pandemic. The service supported women to balance the comfort of home with the safety of hospital, with them recognising the benefits of remaining at home until they felt the need to feel the security of being in what they perceived to be the safe environment of the hospital. In most cases, the midwife on the 24-hour labour line empowered women to take control of the decision regarding when to attend, though this control was not always wanted by the women, who instead sought to hand control back to a professional. A smaller number of women felt they did not have control over the decision to attend for face-to-face assessment and used different strategies to take back control from the 24-hour labour line midwife. Finally, women spoke of the importance of trust between them and the midwife, and the trust they had in themselves as being significant to their early labour experience. Next, the experiences of birth partners will be outlined.

Chapter 6 Birth partner findings

6.1 Introduction

Within this chapter the Group Experiential Themes identified from the analysis of birth partner interviews are outlined. To begin, the demographics of the participants are presented, followed by a description of their calls to the 24-hour labour line. A summary of the findings is then provided, before each Group Experiential Theme is described, supported by the participants own words. Four key Group Experiential Themes are included in this thesis, with further Group Experiential Themes which were less aligned to the research questions disregarded at this time.

6.2 Birth partner participants

Four birth partners, for three of which it had been their first time supporting a woman in labour, were interviewed between 6-10 weeks after birth. Two were interviewed in person, prior to the onset of the COVID-19 pandemic, and two were interviewed on Microsoft Teams™ using video-calling functions during the COVID-19 pandemic. As explained in section 5.2, Nathan was interviewed together with his partner Mabel. All participating birth partners were in a relationship with the mother of their child and had been educated to at least degree level. Three birth partners were aged between 30-35 with the other being aged between 36-45. All birth partners identified as White British, and English was their first language. All their partners experienced a normal vaginal birth, except one whose partner delivered via instrumental delivery. All birth partners had attended a form of antenatal class.

6.2.1 Anthony

Anthony was interviewed prior to the COVID-19 pandemic, following the birth of his first baby. Anthony telephoned the 24-hour labour line in the middle of the night when his partner thought that she had experienced SROM. Anthony was advised that they should remain at home and attend an appointment at the hospital that afternoon. Anthony telephoned again as his partner was experiencing contractions and was advised to remain at home. At lunchtime Anthony telephoned a third and final time to inform the 24-hour labour line that they would like to go in for assessment.

6.2.2 Bernard

Bernard was interviewed prior to the COVID-19 pandemic, following the birth of his second child. Bernard telephoned the 24-hour labour line when his partner was experiencing three contractions in ten minutes. Bernard was advised that they should aim to stay at home for a further two hours. Bernard called again from the car just over two hours later to inform the 24-hour labour line that they were en route to the hospital as his partner had experienced a small amount of vaginal blood loss.

6.2.3 Charlie

Charlie was interviewed during the COVID-19 pandemic, following the birth of his first child. Charlie telephoned the 24-hour labour line on two occasions. The first time he called because his partner was experiencing contractions but was concerned that the fetal movements were reduced. This call was not answered, and Charlie left a voicemail before his call was returned by the 24-hour labour line midwife. Charlie attended the hospital with his partner for assessment and they returned home. Charlie called a second time when the contractions had increased in frequency and attended hospital thereafter.

6.2.4 Nathan

Nathan was interviewed during the COVID-19 pandemic, following the birth of his first child. Nathan and his partner telephoned the labour line three times because his partner was experiencing contractions. The first two times they decided to stay at home. During the third call they decided to go to the hospital for assessment.

6.3 Overview of Group Experiential Themes

Four Group Experiential Themes were identified among birth partner participants and are presented, with supportive Personal Experiential Themes, in Table 11. Theme two is further divided into three subthemes. Selected verbatim quotes will support each Group Experiential Theme, with further key quotes comprehensively presented in Appendix EE.

Table 11 - Overview of birth partner findings

		Group Experiential Theme 1: “...we will listen to what we’re told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	Group Experiential Theme 2: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	Group Experiential Theme 3: “...it was more like a telling” – Tension and togetherness in early labour	Group Experiential Theme 4: “...it’s in everybody’s best interest to stay at home for as long as possible” – Timing the admission right by relying on signs of labour
Personal Experiential Themes	Anthony	Following professional advice above the wants of the partner in labour	The reassurance of virtual support at home in labour	Negotiating with partner	Aiming to arrive at the “right” time
	Bernard	- Delegating to trusted professionals and following their advice - Seeking the security of professionals in the face of anxiety	- Taking comfort in the availability of the labour line - Taking comfort in being on the radar	Trusting partners lead to address concerns through face-to-face assessment	- Monitoring contractions to reach the criteria to call - Staying in the comfort of home to achieve birthing goals
	Charlie	Being led by the professional	- Instilling calm reassurance - Easy access to an efficient system		Focussing on frequency and duration of contractions
	Nathan	Unwanted control	Virtual support and reassurance	- Negotiating with partner - Advocating for Mabel	Aiming to meet non-existing criteria

6.4 “...we will listen to what we’re told to do...and obey instructions”

– Seeking and trusting the professional recommendations of the midwife

This theme centres around the birth partners’ need to be provided with clear instructions during early labour by the 24-hour labour line midwife. The birth partners appreciated and trusted the advice of the midwives due to their previous experience of caring for women in labour and professional expertise, and were happy to follow it, even if it did not align with the wishes of their partner. When birth partners were not given clear instruction by the midwife, they felt confused and frustrated.

Three out of four of the birth partner participants wanted to be told by the 24-hour labour line midwife what to do. There was a sense that this is what the telephone support line was there for – to advise on the best time to transition to the hospital setting. None of the participants recalled questioning the advice provided by the 24-hour labour line, and were compliant in following the recommendations given, as though this was the obvious thing to do. This suggests that the birth partners trusted the advice of the midwives completely. Bernard and Charlie said:

“...it was sort of erm well its over to the labour line now so kind of tell us what to do as such, we’ll follow you know, you tell us what to do and we’ll do it essentially er I think that’s certainly how I felt from my perspective” (Bernard 158)

“...we were quite happy to kind of follow their advice” (Charlie 65)

For Bernard, there was no need to question the advice provided by the midwife, as it was in line with what he had expected them to say, based on the preparation he had done for labour. He was confident that, while he did not hold medical training, he would have been able to detect any unusual advice, which would have triggered him seeking a second opinion. This was not the case, as he described:

“...there was nothing that they told me that surprised me erm it all seemed to be relatively logical” (Bernard 216)

The participants were comforted by the idea that they were handing decisions about the labour over to somebody with more experience and expertise in early labour than themselves or their partner. They valued the professional registration, and accompanying education, of the midwives of the 24-hour labour line and consequently trusted the advice they were given. One of

the participants made reference to being prepared to “obey” the instructions of the midwife in view of their familiarity with early labour. Bernard and Nathan said:

“...but also perhaps comforted that people are aware, people that are much more er savvy and much more educated on such things are aware of such, so we’re sort of now giving ourselves over to the advice of others as such” (Bernard 324)

“...it felt like you were talking to a medical professional that had probably at one point in time been on the labour ward and they’ve done this with people you know it was just that they were on shift on the phone that night but they knew what they were talking about they’d been there done it before” (Nathan 823)

While Bernard felt well prepared for supporting his partner in early labour, he recognised that the lived experience of labour was different to the idea of early labour. So, while confident in his ability to support his partner, and in the criteria required to indicate established labour, he was still happy to draw on the expertise of the midwives and follow their advice.

“...it doesn’t really matter how many books you read or dvd’s you watch or whatever, it is[...]still quite an unknown entity as such erm so fairly fairly happy to be sort of delegating beyond that to the labour line” (Bernard 184)

While Charlie, Anthony and Bernard were all given clear instructions from the midwife about what to do next, Nathan had a different experience. He sought professional expertise and became frustrated when the midwife was reluctant to share their view on the best action to take. This was presumably due to the philosophy that families should be in control of decisions about their care, but with little recognition that sometimes people are seeking a professional to take control of the decision in view of their comparative expertise. Nathan felt lost and did not know the right thing to do, so was seeking further direction from the midwife. He said:

“I think the frustrating term for us that was a bit like it’s it’s your pregnancy you know it’s up to you to decide which again I wholeheartedly understand but I think as sort of first time parents we were a little bit like but we need someone to make a decision and tell us that this might not be well this might be the time this might not be the time” (Nathan 324)

The participants recalled little discussion with the 24-hour labour line midwives about the decision that was made – the process was structured as being asked questions, then being told what to do, and then doing it. The midwife did not offer the opportunity for further discussion and the participants did not show any interest in exploring other options further, seemingly taking the advice at face-value and implementing it. They said:

“...they kind of like just took the details and then kind of like gave me instructions on what to do next” (Anthony 202)

“...they weren’t waiting for an acknowledgement on that, the instructions were given, I’d understood, that was probably the end of it” (Bernard 286)

“...she said I think it would be wise that you go and have your assessment done at this point and we were on the same page with that so it was kind of a mutual decision I suppose but I think midwife led no less” (Charlie 130)

While the midwife recommended to either stay at home or attend hospital, the participants also spoke of the involvement of their partner in this process. While none of the participants referred to the woman being involved in the telephone call itself, they did describe their subsequent reaction to the recommendation given. The participants had different experiences in this area. For Anthony, calling the 24-hour labour line and taking the midwives’ advice on appropriate next actions resolved tension between him and his partner, expanded on in section 6.6. Anthony wanted to remain at home for longer, while his partner, who was in labour, felt it was the right time to attend the hospital. Anthony led the telephone call, and the midwife sided with him, advising that the couple remain at home a little longer. Anthony said:

“...she kind of like almost made the decision for us cos I was [partners name] was very much like ‘we need to go in’ and I was very much like ‘well I don’t think like we should necessarily go in straight away’ so it kind of made the decision for us really” (Anthony 382)

For Nathan, neither his partner nor the midwife wanted to take control of the decision whether to remain at home or attend for face-to-face assessment. Nathan’s partner, Mabel, was fearful of making the wrong decision and so removed herself from being involved in the decision-making process. This led to Nathan being forced to make the decision when neither the midwife nor his partner would. He said:

“I think had I have not said I really think you need to go in now I I wouldn’t say it was one hundred percent my decision but I think you know probably sort of seventy thirty that I was at that point going oh I’m I’m I’m gonna take you into the hospital you know” (Nathan 538)

Comparatively, Bernard described both him and his partner being satisfied with the recommendation of the 24-hour labour line midwife to remain at home.

“I would say decision wise we made that, we took that decision together that er erm that they said wait for two hours so we’ll do our best to wait for two hours” (Bernard 272)

While three of the four birth partners were initially advised to remain at home, when the birth partners called again later, usually triggered by their partner wanting to go in, the midwife verified that this was an appropriate next step.

“...she’d tried to to kind of relieve the pain but it was becoming more of a pressing matter and they were happy that that was that was good signs to go in” (Charlie 124)

6.5 “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line

All participants spoke of the reassurance the 24-hour labour line provided, be it through easy access to a healthcare professional, reassurance that no clinical risk had been identified, or the receipt of calm advice and support. The three subthemes are: clear instruction to call, being on the radar and calm, clear advice.

6.5.1 Subtheme 1 - Clear instruction to call

Similarly to the women participants, at labour onset birth partners were clear that they should call the 24-hour labour line, due to the preparation they’d been given by the midwife during the antenatal period. This clear instruction reduced anxiety about what to do next when their partners exhibited signs of labour, as they were aware there would be a health professional available to help and give advice on the appropriate action to take. None of the participants expressed any concern about making the decision to call, suggesting they felt fully able to call the 24-hour labour line whenever they deemed it necessary. They said:

“it was very clear for us that that we should be using that er that was er recommended numerous times by midwives er etc etc during any every visit that that was sort of the number once you started thinking things were going to happen calmly call the number” (Bernard 41)

Participants were provided with the time they needed, with calls being answered promptly and no sense of there being a rush during the conversation. This easy access to the midwife was both surprising and reassuring. Nathan said:

“you never felt like they had to get to another call and also we never we never really had to wait on the line for more than a minute[...]they just picked up they just answered” (Nathan 1069)

The midwives were clear that the birth partners could call again at any point if they had any concerns or questions. This gave the birth partners confidence in seeking further contact if the

clinical presentation changed, or they, or their partner, felt it was the right time to transition to hospital.

“...you know always saying like well if anything does change or if you’ve got any more concerns ring us back there wasn’t any ‘right we’ve told you to do that don’t call us back for another hour’ or anything like that it was very much like ‘you know if anything changes if it gets worse or anything like that then give us a call’” (Anthony 642)

The participants were grateful for the presence of the service, appreciating the availability and access to the midwife and the comfort and clarity it offered. Bernard recognised the 24-hour labour line as a luxury to have. He said:

“...it struck me that it is something that didn’t have to be there, if we weren’t organised as such as a an entity as the NHS is as a sort of an organism as such erm it doesn’t have to be there, they could say when you get to this stage go on to the website, or whatever, but the fact that that was there I thought was quite, you know, I took comfort from that” (Bernard 535)

6.5.2 Subtheme 2 - Being on the radar

The 24-hour labour line provided reassurance and company during the early stages of labour. The virtual presence of a midwife, to provide support and advice on the journey preceding admission to hospital, was particularly valued. The idea that there was somebody with them, even if not physically present, provided reassurance that they were on the radar of a health professional and had a “support team” in the background. This virtual presence gave a sense of togetherness, with Nathan and Anthony saying:

“‘we are with you’ as as much as you can be at the other end of the phone but it was kind of like yeah it was it felt like a little support team in the background” (Nathan 786)

“it gave us a bit more confidence I guess that you know they knew our situation and were kind of like giving us advice on what to do next so we kind of like knew that we weren’t alone I guess” (Anthony 648)

For Bernard and Anthony, there was comfort in being on the radar of the hospital, while continuing to spend time at home during labour. Making the telephone to the 24-hour labour line was a milestone within their labour journey, which provided reassurance that they were recorded as being on their way to admission. The participants were under the impression that the 24-hour labour line would inform the birthing environment, on their behalf, that they would be attending for the birth in the not-too-distant future. Bernard said:

“I felt confident that we sort of ticked that off the box we’d informed the labour line so kind of as far as we were concerned um the hospital and the appropriate authorities were aware that you know we’d reached that stage and perhaps er you know fairly short period of time we’d be coming in to the hospital so in a way I was sort of er sort of erm erm satisfied that that was done”
(Bernard 320)

Completion of this milestone freed up mental capacity for Anthony to focus on supporting his partner while at home. He said:

“I think once I’d spoken to them and kind of like I knew that we were booked in to come in then it was really just like back to checking like [partners name] is alright and seeing how she was feeling” (Anthony 229)

6.5.3 Subtheme 3 - Calm, clear advice

The calm nature of the midwives on the 24-hour labour line instilled a sense of calm within the participants, and this was furthered by the advice being in line with what they had learned about labour. Charlie said:

“on both the first and second occasion of phoning the labour line the the lady we spoke to was very calm and collected and gave us complete reassurance that everything was kind of ticketyboo” (Charlie 37)

“...you kind of get hinted at beforehand by you know midwives and the NCT people saying you know this happens this happens this happens and when that kind of co aligns with the labour line and everything they were saying doing you’re like oh ok this is working out well because we are following their little plan of action that everyone said we would and their marrying up with exactly what we think should be happening to that that there’s a reassurance in that” (Nathan 794)

The participants valued the clear advice about what to do next, making it easy for them to follow the recommendations of the midwives. Anthony said:

“very calm kind of like very clear on what she wanted us to do as well so you know there was no ambiguity about what does she mean by that type thing um so no I thought they were very clear and concise” (Anthony 640)

All the participants spoke of the nervous anticipation experienced in labour, which speaking with the 24-hour labour line relieved. Discussions with the midwife provided reassurance that the labour was progressing as expected and that there was no cause for concern. This alleviated

anxiety around the labour and helped give confidence to the birth partners in continuing to support their partners at home during early labour.

“...it was always the excitement and the fear that something's kind of happening and might go wrong so speaking to them because they were so so relaxed and calm about everything it kind of made you feel that bit more secure” (Charlie 73)

“...first of all they were really calming which I thought was cos you can quite easily get wrapped up in it all can't you? you know you're having a baby it's exciting it's a bit scary so they kind of quite helpful in taking the pressure out I think a little bit” (Nathan 301)

For Nathan specifically, the midwife provided external validation that the things he was doing for his partner were the right things to do in the circumstances, assuring him he was doing all he could for her. He said:

“...to get that little bit of reassurance from them sort of saying you you as a you as a partner are doing the right things[...]it was nice to have the reassurance for me to say actually you as a birthing partner are doing the right things by Mabel if that makes sense like you are supporting her the best way that they know how kind of thing” (Nathan 744)

6.6 “...it was more like a telling” – Tension and togetherness in early labour

This theme relates to the tension or togetherness of birth partners and women at home during early labour, and the role of the 24-hour labour line midwife in this.

The period of early labour at home was hindered by tensions and supported by togetherness with their partners, with participants experiencing either one, or both, of these feelings. Both Nathan and Anthony spoke of tension between them and their partner during early labour, with Nathan wanting to present at the hospital sooner than his partner, and Anthony wanting his partner to stay at home for longer than she felt able to.

Nathan faced tension with his partner with regards to when to call the 24-hour labour line, oscillating between wanting to support his partner's choice, while also being concerned that they should seek medical advice.

“[laughs] we spent most of the evening not arguing is too strong a word but discussing heavily like when I was gonna be allowed to phone them and when I wasn't allowed to phone them” (Nathan 101)

The discussion between them turned into a negotiation, with them eventually both compromising to agree together a timeline to call. He said:

“we’d sort of discussed between the two of us so we phoned at midnight and then it was we’re gonna phone again I wanted to phone again at half twelve you wanted to phone again at half one we settled on one o’clock” (Nathan 543)

Nathan was required to balance his own anxiety about getting to hospital, where he would feel more secure, with his want to respect his partners wishes for early labour. Nathan was determined not to ignore his partner’s requests, to maintain trust and her autonomy over her own body. He said:

“yeah more more my decision but definitely not solely if you’d said to me I’m not going to hospital I I wouldn’t have done anything other than” (Nathan 547)

Anthony was able to use the 24-hour labour line to gather support for his decision to stay at home for longer than his partner wanted to, using their recommendation to help negotiate with his partner. Consequently, he found the labour line helpful in supporting his agenda to stay at home for longer, with greater trust and value placed on the advice of the midwife than the needs of his partner. He said:

“I said look if their telling us like not to come in then we probably stay at home for a little bit longer so the labour line were really helpful” (Anthony 156)

This decision only lasted so long, when the balance tipped and his partner insisted that it was time to go into hospital. At this point, his partner was uninterested in his view of the right time to attend and had made the decision that that was what would be happening. He said:

“yeah it was more like a telling [laughs]” (Anthony 583)

“...in one of the courses we’d done they said something about I think it was three contractions within 10 minutes or something like that so we said OK when I was looking at the times I was like well actually it pretty much is that now and [partners name] by this time was pretty like ‘yeah no we’re going in we’re going in whatever’” (Anthony 174)

On the contrary, Bernard had a different experience, approaching the labour as one with his partner, which he described as being reflective of all aspects of their life. Bernard trusted his partner completely, and her behaviour influenced his, such as when she noticed vaginal bleeding:

“...perhaps when we discovered the bleeding maybe became a bit more concerned certainly [partners name] was and then I was more concerned cos she was concerned” (Bernard 148)

While Bernard was happy to follow the advice of the labour line, this was only the case when his partner was also comfortable with the instructions given. He was entirely led by his partner's view on whether to remain at home. While she was happy staying at home, he was content with that decision, but once she made the decision to go in, he followed her lead in arranging this with the labour line on her behalf. He said:

“...her position was ‘I think its time to go in’ and as far as I was concerned ok, if she’s decided that, we’ve been here now over two hours erm if she’s obviously concerned it’s time to go in, I’m now concerned that it’s probably time to go in” (Bernard 355)

Being in tune with his partner meant he was able to know when things had changed for her, and she had become concerned. She did not need to tell him this verbally, instead he was able to detect more subtle changes in her behaviour.

“...probably in her um voice, her responses probably she was a little bit more er panicked is not the right word but probably closer to that in terms of anxiety that I could sort of tell in her voice” (Bernard 353)

6.7 “...it’s in everybody’s best interest to stay at home for as long as possible” – Timing the admission right by relying on signs of labour

This theme refers to the birth partners understanding of early labour and their role in monitoring contractions to support them in arriving at the hospital at the right time. Unlike the women, some birth partners felt the need to prove that a certain contraction frequency had been met in order to gain admission to hospital.

Participants were aware of the advantages of remaining at home during early labour to facilitate a quicker and less painful labour, with reduced likelihood of intervention. Consequently, they had planned with their partners to stay there as long as possible:

“...as I say we were happy, I keep using the word happy, erm we were er quite willing to stick it out at home as long as necessary erm in order to facilitate erm an easy and smooth and straightforward birth as possible” (Bernard 217)

It was clear that it was to the benefit of both them, and their partner, to remain at home, with nothing to be gained in presenting at the hospital earlier than necessary. Birth partners were concerned that being admitted, assessed and asked to return home could have a negative impact on the labour journey. They were concerned a self-misdiagnosis of established labour could impact the confidence of their partner as they tried to cope with the pain of contractions. They said:

“I think we’re thinking like if you get sent home it’s almost like well what do we do now then? cos it feels like its imminent but you know you’re back to almost square one again” (Anthony 312)

“...I guess you’re probably that is probably quite a blow to the self-esteem and everything else that you know I’ve been weathering this for hours and it’s been hideously painful” (Bernard 438)

The focus therefore became on achieving admission to the hospital at the “right” time, as this was considered the safest place for birth to occur. Identifying the appropriate time to attend was, however, challenging.

“...so it was kind of like a really fine line between like we wanna get there but then we wanna get there when the baby is ready as well” (Anthony 328)

For Bernard, it was clear that timing admission right was beneficial to not only him and his partner, but the hospital too:

*“...we were aware that the earlier you go in that you are tying up resources you are getting in people’s way[...]it’s best in everybody’s best interest to stay at home for as long as possible”
(Bernard 414)*

To help them time the admission right, three of the four participants referred to the frequency of contractions forming the criteria to call or attend the birth environment. This criteria had been learned before the labour, through attendance at antenatal education classes, their own research or discussion with their antenatal midwife. All of the participants assumed the role of timing the contractions to help assess the frequency. Charlie said:

“...after a good few hours we were timing the contractions and as we getting towards the the kind of the length and frequency we were advised to be calling the labour line” (Charlie 21)

For Nathan, evidencing that his partner had met this criteria became all consuming. At home he and his partner had been monitoring the frequency of the contractions using an App. Despite the approach of the labour line midwife suggesting to the couple that they were fully in control of the decision to stay at home, or to attend the hospital, Nathan still felt pressure to prove that the

criteria had been met. Although the midwife enquired about the frequency and length of the contractions, Nathan placed more focus on this than the midwife. It may be that subconsciously it was his partner, Mabel, who was concerned about arriving at the hospital at the right time, that he needed to prove this to. He said:

“I’m like but you need to keep telling me when the contractions are coming cos we need we need to be able to tell them because that’s the deciding factor” (Nathan 571)

6.8 Conclusion

This chapter presented four themes constructed from interviews with birth partner participants. These findings reveal that birth partners sought professional expertise and guidance from the midwives working within the service and felt reassured and confident as a result of their interactions. All the participants in this study wanted to be advised by the midwife on the 24-hour labour line of the appropriate next action – handing control of the decision to them. Birth partners were appraised of the benefits of remaining at home during the latent phase of labour and were aware of the signs of established labour. Consequently, they assumed the role of monitoring these signs while at home in the earlier stages of labour and relayed this information to the 24-hour labour line midwife. An unexpected finding was that some fathers experienced tension with their partner while at home during labour, usually associated with one of them wanting to present at the hospital earlier than the other. The midwives on the 24-hour labour line sometimes became involved in resolving this tension. The same, and other fathers also experienced a sense of togetherness; where they supported the choices of their partner above all else. Next, the experiences of midwives will be outlined.

Chapter 7 Midwife findings

7.1 Introduction

This chapter outlines the Group Experiential Themes generated from analysis of the interviews with midwife participants. Five midwives, all with more than ten years clinical experience and English as a first language, were interviewed. Three midwives were from one NHS Trust, and two from the other. One midwife was interviewed face-to-face and the other four were interviewed using video-calling functions on Microsoft Teams™. As explained in chapter four, section number 4.8.2, a description of each midwife is not provided, to maintain anonymity. The midwives were allocated the pseudonyms: Monica, Naomi, Penelope, Michaela and Stephanie. All but one midwife participants were recruited during the COVID-19 pandemic, except Monica, who was recruited before. A summary of the findings are provided before considering each Group Experiential Theme in turn, supported by participant quotes.

7.2 Overview of Group Experiential Themes

Five Group Experiential Themes were identified among midwife participants and are presented, with supportive Personal Experiential Themes, in Table 12. Each is then presented, using sub-themes to aid presentation of the findings, and to account for congruence and difference between participants experiences. Selected verbatim quotes will support each theme, with further key quotes comprehensively presented in Appendix FF.

Table 12 - Overview of midwife findings

		Group Experiential Theme 1 - “...the end decision is always theirs” – Doing right by women	Group Experiential Theme 2 - “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses	Group Experiential Theme 3 - “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	Group Experiential Theme 4 - “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	Group Experiential Theme 5 - “...all round everybody gains from it” - A symbiotic relationship with the ambulance service
Personal Experiential Themes	Michaela	- Supporting women’s choice through prioritising psychological wellbeing - Advocating for women free of the influence of external pressures	Utilising visual tools to support assessment	Questioning professional recommendations	- Unseen value of labour line - Managing divert	Mutual benefits of collaboration
	Penelope	Promoting women’s choice following professional recommendation	Confidence in and restriction of midwifery using listening	- Managing the tension of removing control - Advocating for women	- The challenges of working across multiple Trusts - Managing the disappointment of diversion	The benefits of collaborative working to the care of families and professional development
	Stephanie	Empowering women to have the final say, free from external factors	The strengths and restrictions of midwifery practice using only the ears	Unprofessional attitudes of hospital-based staff	- A lack of appreciation for a complex role - Bearing the brunt of broken expectations - Emotional burnout	Working collaboratively
	Naomi	Advocating women’s choice	The constraints and signals of telephone assessments	Coping with criticism from colleagues	The weight of responsibility	

		Group Experiential Theme 1 - “...the end decision is always theirs” – Doing right by women	Group Experiential Theme 2 - “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses	Group Experiential Theme 3 - “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	Group Experiential Theme 4 - “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	Group Experiential Theme 5 - “...all round everybody gains from it” - A symbiotic relationship with the ambulance service
	Monica	• Shared decision-making • Advocating for women by taking control • Prioritising psychological wellbeing	• The art of midwifery through the ears	• Advocating for women by taking control	• Managing the challenges of labour-line	• Collaborating with the ambulance service for the good of all

7.3 “...the end decision is always theirs” – Doing right by women

This theme centres around the decision-making processes undertaken by the 24-hour labour line midwives and is divided into four subthemes: empowering women to decide, being reluctant gatekeepers, prioritising psychological wellbeing and having true autonomy. Ultimately this theme captures how important it was to the midwife participants that women were supported to make decisions about their care based on their emotional, as well as physical wellbeing. Midwives were confident in their ability to do what was right by women, free of the influence of organisational demands.

7.3.1 Subtheme 1 - Empowering women to decide

All the participants were clear that they always give women the final choice regarding whether to attend the hospital for an assessment. The only exception to this philosophy was if there was a clinical risk factor identified that would warrant face-to-face assessment, in which case they would advise the woman to present at the hospital. It appeared well embedded in the culture of the 24-hour labour line for women to be given the choice, with Naomi confidently suggesting all her colleagues offered the same.

While the midwives wanted the woman to make the choice regarding whether to remain at home, they were not deterred from supporting women to understand their options, nor giving a recommendation either way. When it was the midwife's professional opinion that the woman could remain at home, the woman's choice was achieved by explicitly asking them whether they agreed with the recommendation, or if they would prefer to go in. This offered the woman the opportunity to take control of the decision with all the information necessary.

Consequently, the midwives were still aware of their role in the decision-making – it was not simply a case of asking the woman what she wanted to do, but involved them providing some professional guidance and education to enable the decision. This was a strategy all the midwives reported adopting to promote the woman's choice in their care and evidence informed decision-making.

“...its a joint thing it's not just me saying you can't come in or you should go in it's more of a case of actually this is what I think what do you think? how do you feel? do you have more reserves? what what do you want to do? I always say what you want to do and I always write at the bottom

of the SBAR plan happy to do this happy to do this and I always give them a choice” (Stephanie 436)

“...all women have the option we will always say to them this is what I suggest is that okay with you? or are you thinking you would like to go in? so the option is always there for them that the end decision is always theirs” (Michaela 87)

The framing of this question was acknowledged by Monica as being an important aspect, ensuring it is presented in a way that promotes the woman having the final say. This acknowledges that women may perceive that the midwife is in control of the decision and that their preference is of lesser importance. The way the question is framed was thought to make a difference as to whether it was a futile question, with the decision already made, or one being asked with genuine concern for the honest answer provided by the woman, which would be acted upon accordingly. Monica explains:

“...when I am talking to people after explaining the process and why we need those 3 things to be working in the best way they can be erm making the suggestion and then saying ‘how do you feel about that?’ quite often you get the impression that its that authoritative thing they don't feel they can go against it so it's trying to put things in such a way that you're giving them permission to say no if they want to” (Monica 316)

7.3.2 Subtheme 2 - Being reluctant gatekeepers

Participants were adamantly clear that they did not view their role as being a gatekeeper to the hospital. Participants felt strongly about this, describing themselves as advisors, or support, rather than as making decisions for the family which either facilitated admission or denied entry. They said:

“we are not gatekeepers [laughs] we are advisors [laughs]” (Monica 482)

“...we're not the gatekeepers so it's more of a support role really support for both the women and their partners and the staff in the hospitals really” (Naomi 199)

Penelope and Naomi however acknowledged that 24-hour labour line midwives could certainly be perceived by women, their families, and staff at the hospital as gatekeepers. There was a sense that the mechanism by which women gain admission to hospital made them gatekeepers, though this could be overridden by families presenting at the hospital regardless

of the recommendation given. Essentially, there was an understanding that they are viewed as gatekeepers but this was not an identity they adopted themselves. Being a gatekeeper had a negative connotation associated with a reputation of keeping women at home against their wishes, while the midwives' reality was that their role as a gatekeeper was grounded in doing what was right for each individual woman.

"...you know they don't need a passcode to get in we can say I don't think it's the right time are you happy with that? Yes – they can still go in if they want turn up unannounced" (Monica 480)

"so what I definitely don't see us as is I think some people think of us as the gatekeepers as in some staff in the hospitals maybe think we should be keeping people out who are still in the latent phase and maybe ladies and their partners at home are thinking we're stopping them from going into hospital" (Naomi 113)

While the midwives recognised that the women could present at the hospital without agreement from the 24-hour labour line midwife, there was no recognition expressed that some women would not have the confidence to do this.

To counteract the reputation of being gatekeepers it was seen as a valued part of the midwives' role on the 24-hour labour line to promote the hospital as having an open-door policy – i.e that women would not be prevented from entering this environment at any point that they felt it best for them. There was a sense that women did not need permission to enter, but that because this is how maternity services have historically been organised, that it must be advertised that if requested, permission would always be granted.

"...at the end I will say so I'm happy maybe for you to continue at home at the moment if you're happy with that however we will never stop you going into hospital if that's what you would like to do so at the end of the day you've given them advice to help them continue to cope at home at the moment if that's what they'd like to do but I would never want the responsibility of having upset someone or ruined their birth experience because it appears that we are the gatekeepers and not letting them in" (Naomi 117)

"...we now say that pretty much every time so they don't feel like we're gatekeeping because you know how we tone what we say to them can affect their mind set so much that it affects their labour" (Monica 84)

7.3.3 Subtheme 3 - Prioritising psychological wellbeing

While there was some weight applied to the contraction frequency, length and strength the women were experiencing, the midwives acknowledged that ultimately it was the woman's ability to cope, that would influence whether a face-to-face assessment was provided.

The midwives appeared to be exceptionally compassionate towards the women and keen to prioritise their psychological wellbeing alongside assessing the physical progress of labour. As such, there appeared no criteria to be met to pass the threshold for admission. Michaela said:

"...if we can get them to those magic numbers then fantastic but if they need to go in because they're not coping they need a face to face" (Michaela 70)

Aiming to achieve the "magic" three strong contractions in ten minutes which last for sixty seconds was considered to be a very basic way of assessing the progress of labour to establish the next steps. Instead, the midwives viewed the assessment as a puzzle, in which they need to find all the correct pieces to come to a well-informed shared decision with the woman. While contraction frequency, length and strength formed part of this jigsaw, there were many other pieces to consider such as: the amount of sleep had, the ability to eat and drink, whether spontaneous rupture of membranes had occurred, the location of the pain, the support available, what analgesia had been taken, positions that had been utilised and distraction techniques adopted.

"...it's like a massive puzzle for me massive massive puzzle erm to for the decision-making process and stuff with obviously the joint collaboration of them their involvement as well what they think how they feel they can handle it" (Stephanie 446)

Their acknowledgement that there was something the hospital could provide women, that they could not, was an interesting observation and is highlighted by the terminology chosen by Michaela that some women need a "human element" to help them continue confidently on the journey of labour. There was a sense that for some women, there was little point in trying to reassure them on the telephone, as it would not work, and they needed a face-to-face assessment. There was little explanation as to what a face-to-face assessment could offer over and above that offered on the labour line, other than that some women prefer to be in hospital, as identified 5.6.2 , and some felt the need to physically see a health professional to be reassured. Penelope and Monica explain:

“...we all know that the home environment is better for them psychologically and the food is nicer it's more comfortable all of those things but actually some women that's just they just want to be in hospital” (Penelope 487)

“...if they're not coping and they're not in the right place and they just need to see somebody who they know is the professional for that event in their life to say 'it's ok you're doing fine'” (Monica 68)

The midwives saw the benefit for women in having a face-to-face assessment when they were struggling to cope psychologically, recognising the value in women receiving some tender-loving-care from health professionals to provide reassurance. Michaela said:

“...she just needs a bit of tlc a bit of hand holding and explaining that everything is ok face to face and that's why she's coming in [laughs]” (Michaela 58)

7.3.4 Subtheme 4 - Having true autonomy

Importantly, midwives were assured that the decisions they made on the 24-hour labour line were in no way influenced by their wider understanding of the level of activity within the service or the reaction their decisions may receive from staff working on the hospital sites. The separation of the service from the birthing environment empowered midwives to make decisions without pressure from other staff, competing responsibilities or a lack of physical space. The midwives evidenced a woman-centred approach, delivering the art of midwifery by being “with woman”, meaning they were able to prioritise a woman’s need for a face-to-face assessment, while also distancing themselves from the organisational pressures within the service as being their concern. Stephanie and Michaela state:

“personally if a woman needs to go into hospital she needs to go in it doesn't matter whether the hospital is full diverted whatever or they haven't got any staff that isn't that isn't the woman's issue and that isn't ours” (Stephanie 474)

“...if they need to go in because they're not coping they need a face to face or for whatever other reason then they need to go in, it's as simple as that” (Michaela 71)

7.4 “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses

This theme refers to the assessment undertaken by the 24-hour labour line midwife, including facilitators and restrictions to their practice. There are three subthemes: an improvement to previous practice, heightened hearing – to hear what is not said and utilising visual aids. The midwives described the 24-hour labour line arrangement as being more conducive to properly assessing women during early labour than that they had experienced in the hospital setting. The quiet environment and the time available to focus on what was being said, and not said, enabled the midwives to arrange pieces of a puzzle to form an overall picture of what is happening at home. Visual aids to support the formation of this jigsaw were valued by the midwives.

7.4.1 Subtheme 1 – An improvement to previous practice

The midwives were clear that the benefit of the 24-hour labour line was that they had space and time to listen intently to women in labour. This differed from their previous experience in clinical practice, where the early labour triage and support they were attempting to provide was regularly interrupted and distractions were rife. In the past midwives had been redirected by hospital managers away from their responsibility to provide telephone support to women in early labour, to respond to high acuity or poor staffing within the hospital. Participants recalled that their experience of telephone triage in this setting was time-limited and, if it were to happen at all, the assessment was very task orientated to quickly identify a decision regarding whether to attend for an assessment, enabling the midwives to quickly return to their other responsibilities. The midwives recalled that the support offered to women previously was minimal and the lack of time to undertake an assessment led to women simply being invited in, which was contrary to the advice to encourage women to remain at home for as long as possible. Naomi said:

“...we never spent the time talking to people like we do now literally people would ring I don’t even remember now actually properly assessing them they rang in we’d just say yeah come in”

(Naomi 291)

In comparison to the 24-hour labour line, where they had a dedicated and protected space to perform this task, the telephone support role was not separated from the routine and everyday activity of the ward. Participants valued the situation of the 24-hour labour line away from the

hospital due to the removal of distractions and ability to solely concentrate on the job at hand. Penelope said:

“...with this I think it's consistent you know we're we're out of the hospital which makes a big difference erm we've got brilliant communication lines into the hospital but it means that we can focus erm and it's kind of a different role it's a different hat erm and I think that's really important because we're kind of focused on our triage skills really” (Penelope 107)

While having the luxury of time to talk with women and their birth partners was identified as a clear advantage of the 24-hour labour line, it was also the quiet space within the control centre environment that supported the midwives to fully focus on the conversation. This also differed from their previous experiences, where they contended with intrusions to their ability to listen that were beyond their control. Monica said:

“it's not just about the time constraints it's about everything that is going on around you you know if you stood with your eyes closed on the phone on labour ward people would think you're a bit nutty [laughs] but otherwise you know you've got people running round you've got noises beeps and all sorts going on and you can't shut it down you're tuned in to all of it you know you can be chatting to someone on the phone you can hear a bradycardia in the room next to you [laughs]” (Monica 347)

Despite being confident in their listening skills, the participants recognised that their assessment was bound to be limited by the absence of touch. Both Stephanie and Penelope explained that face-to-face assessment enabled better understanding of the clinical picture by being able to offer abdominal palpation, presumably to assess contraction frequency, length and strength, and vaginal examination, presumably to assess cervical dilatation. They said:

“...on the ward you've got the vaginal examination you can feel the palpation and things like that so erm you can palpate sorry the contraction” (Stephanie 268)

“...I mean obviously nothing beats face to face” (Penelope 604)

7.4.2 Subtheme 2 - Heightened hearing - to hear what is not said

Unsurprisingly all the participants spoke of the importance of their listening skills to the role of being a 24-hour labour line midwife. As midwives conducting their midwifery assessments using predominately only their hearing, they reported heightened listening because of the removal of the option to rely on their other senses to form a judgement. Focusing on their

listening enabled them to remove other distractions from the workspace and attend fully to what is being heard on the telephone line. They said:

“I have found that my listening has heightened[...]the only thing I can liken it to is if you were deaf or blind and your other senses heightened to compensate because you’re so focused on what’s going in here [points at ears] and there’s nothing else” (Monica 138)

“...I’ve tuned in over the years and I’ve learned to block out everything else” (Michaela 302)

As much as the participants described the importance of taking time to listen to what the women had to say, they were equally interested in what was not being said and the sounds coming from the environment the woman was in. Often, this was considered more useful to the clinical assessment than the spoken conversation between them and the woman in helping them gauge the situation and state the woman was in. Stephanie said:

“...listening to them get helps me to get to know them listening to them what’s happening in the background what they’re saying what they’re not saying whether they are confident whether they are expressive I definitely can get a grasp of them roughly I think” (Stephanie 319)

“...I think you can tell a lot from a conversation you can tell a lot you can tell a lot you can hear pain you know you can you can you can hear fear you know you can you can listen to crying you know there’s lots of things there’s lots of erm what do I mean not but not body language because I can’t see them but you can pick up on the cues can’t you from women” (Penelope 579)

The midwives were able to draw on the tone of the woman’s voice, the noises made in response to a contraction and additional cues such as laughter or exasperation to form their assessment. While not able to utilise the senses of touch, sight or smell, the midwives used the intricacies of what they could hear to form a picture of what was going on at home. Monica and Naomi explained:

“I mean its not just about questions and answers its about hearing what’s not said and that again comes from nearly [x] years of doing my midwifery through my ears [laughs][...]it’s the tone it’s the breathing pattern it’s the way things are the senses are constructed its all the little bits around the words themselves” (Monica 338)

“...you also um get an idea of how the contractions are as to whether they can actually hold the conversation with you or not so even just doing that helps you” (Naomi 244)

Within 7.3.3 the midwives refer to the jigsaw of assessment, with each part of the assessment providing another piece to the puzzle to eventually provide a full picture from which to make a judgement. On the labour line, the additional senses that would be employed in practice were not available and as such they were filling in the gaps with plausible pieces constructed from what they could hear. To do this, they would utilise their experience from clinical practice to assemble the picture of what was going on at home and this even supported them in detecting other aspects for consideration, such as safeguarding issues. For Monica, it helped to visualise being with the woman at her home to support the formation of these pieces:

“...it’s almost because I guess I’ve been in that situation where in a labour room with a woman I can visualise what’s going on in that lounge at home and I I put myself there so then when I speak to her on the phone again I talk to her as if I’m sat on the sofa with you” (Monica 147)

Another strategy the midwives used to help complete their puzzle was their intuition – the feelings that they had about the woman’s progress which they were unable to explain through tangible means. The participants had difficulty articulating this aspect, presumably because it was not grounded in any evidence presented by the women or literature. Naomi and Penelope said:

“...sometimes you can just [pause] feel it” (Naomi 332)

“...you can just tell” (Penelope 570)

Despite this, it was clear that while it was not relied on solely, it did form part of the assessment in the absence of other means. Stephanie explains:

“...it can be tricky but then you just use all of your other senses and your gut intuition and your experiences from before and just go with it” (Stephanie 193)

The continuity offered by the rostering of long shifts for midwives on the labour line provided opportunities to detect the more subtle signs of labour progression over time. This was indicated by a range of means, including changes to their tone of voice, their increasing inability to talk through contractions, changes in their breathing regulation or who makes the telephone call to the midwife. They said:

“sometimes you’ll have the lady will ring twice and then the third time the partner rings because the lady can’t speak anymore which is also quite a good sign” (Naomi 603)

“...you know they perhaps they can just about talk through a contraction and then on the next phone they say ‘oh I’m sorry can you wait a minute I’m about to have another one’ er and the next time it’s the partner [laughs]” (Monica 27)

Reflexivity

In Appendix BB, when reflecting on my own experience of labour, for the second time, I state:

‘I also noticed that I had begun making a classic “moo” sound, which confirmed to me that I wouldn’t be making a mistake in calling’

I had recognised in myself the progress of labour by the sounds I was making, which is a similar observation to the midwives description of assessment here. This is an example of hearing what is not said.

Finally, the midwives used the background sounds of the environment, the spoken words, their intuition and the tone of the caller to assess more than the progress of labour. Two participants recalled stories of telephone conversations which alerted them to safeguarding concerns about families.

7.4.3 Subtheme 3 - Utilising visual aids

To resolve some of the challenges associated with undertaking telephone assessment the participants explained that the 24-hour labour line had implemented an email service called “Show the Midwife”. When there was ambiguity about what the woman was experiencing at home and which could signal either cause for concern, or a normal physiological sign of labour, the email service enabled women to send a photograph for the midwife to consider as part of the assessment. An example of this included women that describe vaginal blood loss, which after review of a photograph of the loss on a sanitary pad, is often diagnosed as a blood stained operculum – a cervical mucus plug that passes from the cervical canal, into and out of the vagina, and which is not a risk factor for labour, like a fresh, red vaginal blood loss would be. This tool was considered of good value to the participants in supporting their clinical assessment, reducing unnecessary referrals into the hospital for a face-to-face assessment.

“...it's really helpful for all those 'I'm bleeding' that's a show that's completely normal and that's fine and they tell you it's loads and they send you a picture of a pantyliner with a five piece smudge on it so that's been very helpful” (Michaela 417)

Coupled with their triage and other assessment factors the midwives can gain a better picture of the situation at home. Stephanie explains that this supported her in filling the gaps of the jigsaw:

“...that is quite good so it gives you a bit more like more puz more pieces for the jigsaw to put together” (Stephanie 186)

To further develop this idea Penelope explained that the 24-hour labour line was considering implementing video-calling, enabling the blindfold to be removed and the midwives to be able to see what was happening in the home environment, something deemed particularly important in certain clinical situations.

“...we're also looking into erm some erm phone technology where we can actually kind of video link with them[...]I think that would be quite useful in some situations erm not all situations but I think erm like a baby being born or some bleeding would be really useful to actually visualise what you're seeing and I think that would be really useful for women so I think that we can get better at that” (Penelope 597)

7.5 “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues

This theme presents the midwives experience of liaising with staff in the birthing environments and is presented in three subthemes: managing relationships with hospital staff, empathy for hospital staff and advocating for women. While the midwives understood the demands faced by midwives working in the birthing environments, they were clear that their role was to advocate for women and ensure their needs were met. Sometimes this led to a hostile response from their clinical counterparts and questioning of their professional judgement. Despite this, the midwives felt able to make detailed plans with women and expected these to be followed by staff at the hospital, suggesting a sense of control over the clinical environment.

7.5.1 Subtheme 1 - Managing relationships with hospital staff

Alongside managing relationships with the families, the midwives also liaised with midwifery colleagues in the hospital to refer women in for face-to-face assessment. The reception they received from these colleagues was variable. Participants reported that the staff at the hospital often questioned their professional judgement, rather than understanding the assessment and resulting plan that had been formed on the 24-hour labour line. A particularly contentious issue was face-to-face assessment for women who had not yet met the “threshold”, in terms of contraction frequency and length, for established labour, but required further psychological support. The midwives had accepted that recommending a face-to-face assessment for women with no evidence of established labour would not be a popular decision among their colleagues in the birthing environment, as explained by Monica:

“...you’re sending someone who is not in labour into the hospital and you know that is not going to go down very well [laughs]” (Monica 379)

For Naomi, while her professional judgement was generally accepted by colleagues at the hospital, she spoke frequently of a generation of midwives with less empathy for women in this circumstance, where the value of a face-to-face assessment for psychological support was not recognised:

“...I would say that you know generally they know that what we’ve done and gone through the processes and er will know that we’ve done whatever we need to to get to this this stage I think it’s just the odd ones that are a bit old school and a bit like well she’s not in labour yet what’s she doing in here and you’re like well she’s not coping she’s distressed at home” (Naomi 391)

Stephanie also experienced frustration at the idea that women either present at the “right” or “wrong” time, based on the progress of labour as measured by cervical dilatation on arrival at the birthing environment. The view of some colleagues at the hospital differed to the ethos of the 24-hour labour line, which strived for individualised care in which women could be seen face-to-face if they wanted to be. This misalignment in priorities had led to colleagues at the hospital seeking to prove that the 24-hour labour line midwife was wrong, and telling them so. Stephanie explained:

“...you know sometimes you get people questioning your your judgement your clinical judgement or basically insinuating that you’re stupid erm and ringing you back to tell you that

actually by the way you're wrong [laughs] erm which I think is really quite rude but anyway"
(Stephanie 537)

Further, several midwives recalled instances where their clinical decision-making in relation to antenatal concerns, such as reduced fetal movements, was questioned by colleagues. While at the time of data collection, antenatal calls were not routinely diverted to the 24-hour labour line, due to the system of a phone menu some calls erroneously ended up being passed to the 24-hour labour line midwives. This usually resulted in the woman being recommended a review at the hospital, with the midwives being challenged by their colleagues upon making the referral. Michaela and Penelope spoke of their frustration about this often resulting in the women being triaged for a second time, in order for control of the decision to be handed back to those at the hospital site.

"...we will say we've got a lady to come in and they'll question actually whether they need to be seen and I think some professional courtesy would be nice in those situations when we've made that decision" (Michaela 31)

"...we phone them in and they they almost want to re triage them because they feel that we maybe not we wouldn't have done it to their standard so[...]sometimes that's quite difficult"
(Penelope 806)

Regardless of by who, when their clinical decisions were questioned the midwives felt a lack of respect for the skills and experience they have, despite them holding the same qualifications as the midwives working in the hospital.

"...I think sometimes it it does get forgotten that actually we're all qualified to the same level and so actually a little little bit of respect for each other goes a long way and I think they're so tired they're so worn out they're so pressured that that goes by the wayside a lot lately"
(Michaela 45)

This led to the 24-hour labour line midwives feeling the need to defend their decisions and the assessment they have undertaken when doubted by staff in the birthing environment. This is suggestive of a lack of trust between professionals.

"...the midwife in charge was [sternly] very assertive why on earth are you sending this lady in? she's only contracting every five minutes what kind of assessment tool are you using out there?[...]I said but she was upset at the end of the call I cannot leave someone at home crying

like that and she was like criticising our assessment tools what on earth do you think you're doing etc etc and anyway the lady went in I spoke to this midwife an hour later and that lady was an anterior lip when she arrived" (Naomi 322)

"I just feel disappointed because you don't wanna be questioned clinically if there's been no adverse outcome erm and you want the support and you want the understanding" (Stephanie 560)

In view of the midwives taking telephone calls from women booked to birth their baby at several NHS Trusts, often they had not met the midwives in person that they spoke with when referring women into the hospital. Stephanie felt that she was less likely to receive rudeness from the midwives she had worked with in a clinical capacity, suggesting that being "not just a faceless person" prevented negative attitudes. This may be because hospital colleagues could visualise the person on the other end of the line and had professional respect for them. Other midwives valued the anonymity associated with speaking with midwives they didn't know, with Naomi explaining that judgement from them about her abilities did not affect her in the same way as negativity from those she had worked with clinically. She said:

"I don't know who they are[...I] don't take it personally I find I'll just say exactly what I think cos I think I don't know if they judge me they don't know who I am [laughs] I don't know why, I think [repeated words] you're sort of more confident because you don't have any worries about who you're speaking to (Naomi 546)

7.5.2 Subtheme 2 - Empathy for hospital staff

Despite the negativity they received from some colleagues, the 24-hour labour line midwives were empathetic of the challenges the hospital midwives faced in managing acuity in the unit with constraints on staffing numbers. They showed insight that capacity, such as a physical bedspace to undertake an assessment of the woman, may not be available, or that there may not be a midwife to commence the assessment. While this did not influence the outcome of the telephone call with the woman, it meant the 24-hour labour line midwife was often caught in the uncomfortable position of doing the right thing for the woman while simultaneously making the environment more challenging for their colleagues at the hospital.

"...that's quite tricky sometimes because especially at the moment with acuity you know midwives in the units only want women coming in in full blown labour [laughs] they haven't

really got the resources or the bedspace sometimes to support them in the early stages of labour like back in the old days” (Penelope 490)

The midwives understanding of this context, and the burnout of midwives working at the hospital, supported them in excusing some of the unprofessional or unpleasant behaviour they experienced by their colleagues as described in section 7.5.1. They said:

“...it just depends so sometimes there's conflict sometimes there's aggression sometimes there's anger sometimes there's just everyone like exhaustion sometimes there's burnout sometimes you are literally just the you just get the flack because it feels as though you are that person sometimes” (Stephanie 523)

“...I think they're so tired they're so worn out they're so pressured that that [respect] goes by the wayside a lot lately” (Michaela 46)

Their own experience of working in the unit and needing to manage resources made Michaela and Penelope particularly empathetic to the demands placed on the service, proposing that this could reduce the tolerance of hospital midwives in accepting women for psychological support while they are evidently still in the latent phase of labour. This shared understanding led to them acknowledging that it was a challenging climate to be advocating for women to be admitted in early labour, but that ultimately their role was to support the women and facilitate their choice. Michaela explains that without the 24-hour labour line service women would not be given the same options:

“...I know having worked in that position coordinating labour wards that when it's tight there you can easily be biased in what you're saying to patients and partners by what else is going on... whereas I know for a fact of if that conversation was being had direct that that patient wouldn't get the time for her to be listened to and may even be put off coming in when she really needs to come in just because she's not meeting the magic three in ten when she actually needs to be in there for some psychological support” (Michaela 18)

7.5.3 Subtheme 3 - Advocating for women

Despite the challenges in managing the complex relationship with the birthing environment the midwives positioned themselves as being advocates for women. Their own confidence in their decision-making and responsibility to support women regardless of staffing or patient acuity within maternity services was strongly evident as they were determined to support women's

choices. This was particularly pertinent when their clinical presentation did not indicate established labour but they required a face-to-face assessment. The advocacy role included co-ordinating the woman's admission to the birthing environment while also formulating provisional plans for them on arrival. Their drive to advocate for women fostered a sense of control over the hospital environment, despite their geographical distance from it. This is highlighted by Penelope and Michaela, who describe the lack of control the birthing environment have over accepting the referral from the 24-hour labour line:

"I think I've got quite broad shoulders I know what they're thinking erm it is what it is my job is to do that I'm the advocate for the woman I've triaged her I've risk assessed her that in my opinion or in the woman's choice she wants to come in so they have to see her [laughs] that's it that's their job you know it's our job isn't it?" (Penelope 500)

"I'm quite assertive in my midwifery nature [laughs] and erm I think people know that[...]if I said I want someone to come in then they're coming in it's not up for discussion" (Michaela 28)

Monica makes reference to the "game" played with the birthing environment to facilitate the woman's choice. Monica suggested that the 24-hour labour line midwife advocating for the women, rather than the women needing to advocate for themselves directly with the hospital, amplifies the voice of the woman and makes her more likely to achieve admission to the hospital at her chosen time. She says:

"well I guess [pause] mmmm it's us standing up for the women no matter what and perhaps they have more of a voice now" (Monica 393)

The extent to which the 24-hour labour line midwives appear to have control over the birthing environment is emphasised by Monica's confidence in her ability to make a collaborative plan with the woman before admission regarding the care to be delivered at the hospital. Later she would ensure these plans were followed by midwives at the birthing environment. Monica says:

"...you know those that have been in twice already and gone home say 'but I don't want to go in again to be told I am going home' I say 'don't worry I will tell them this is the plan we are going to do this' and that's what happens and erm you know if they end up going home again I want to know who they spoke to when they went in [laughs] and I will follow it up! [laughs] so yeah I guess we're representing them [laughs]" (Monica 402)

For the more confident members of the 24-hour labour line team, such as Monica, Michaela and Penelope, the role of advocate was easier to undertake than for others. Experienced and stoical midwives held a clear stance that they are not seeking permission from the hospital staff for the assessment to take place, but instead instructing them that it is. Holding the boundary was viewed as important by Michaela, who was willing to escalate if met with resistance.

Michaela said:

“...I will stand up for them and you know it's not a request I'm telling them she's coming erm because that's my own assessment of that woman that she needs to be seen[...]so for me it's not a problem and I will go higher if I need to and I have done erm but I know for some of my colleagues they do find those conversations quite difficult” (Michaela 33)

Reflexivity

When considering my previous practice, I would always strive to ensure the woman made the final decision about their care. That said, I also had experience of feeling concerned about referring women in for face-to-face assessment in the absence of signs of established labour, due to feeling guilty for clinical colleagues and worrying about their reactions.

When women were unsure what decision to make, I cannot be sure that I have never encouraged them to remain at home as a result of these concerns. I would not have made an unsafe decision and would always have advocated for a woman's choice had she been clear she needed an assessment, but if I considered it suitable for the woman to remain at home, my practice may have been influenced by these concerns. On reflection, I do not think I was as confident in my interactions with my clinical colleagues than the midwives participating in this study.

Box 3 - Reflection on practice

7.6 “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives

The participants described that there appeared to be a false impression of scope of the 24-hour labour line midwife role among their colleagues based within the birthing environment, who did

not seem to appreciate the complexity of the role, the challenges that they faced or the responsibility they held. The subthemes were: understanding the scope of the role, being the bearer of bad news, caring for women from multiple NHS Trusts, the weight of responsibility and offering solutions to dissolve misconceptions.

The naivety of other staff surrounding the work conducted on the 24-line labour line appeared to frustrate midwives, who had a broader perspective on their role outside of supporting women in early labour. This role included supporting members of the maternity senior leadership teams to divert women to other hospitals when activity at one site necessitates, and support the ambulance service in responding to maternal or neonatal emergencies occurring in the community. It also included the stressful scenarios of managing obstetric emergencies and unplanned homebirths which required them to support the woman and family, while simultaneously co-ordinating a response from the ambulance service and community midwifery teams.

7.6.1 Subtheme 1 - Understanding the scope of the role

There was a consensus among midwives that the work undertaken on the 24-hour labour line is misunderstood and unnoticed by colleagues based at the hospital. The midwives were aware that there was a perception that working on the 24-hour was an easy, simple role which removed experienced clinicians from the hospital while contributing very little to the overall workload of the service. They said:

*“I think that sometimes like my colleagues think oh yeah you're just having a jolly there”
(Stephanie 40)*

“I'm still sure that people think we're just sat out there with the desk reading “Take a Break” feet on the desk and answering you know an old style phone maybe once every half hour and saying yeah take some paracetamol and have a bath and that's all we do” (Michaela 370)

The midwives suggested that the hospital midwives expected the 24-hour labour line midwives to hold the same perspective in return. They assumed the midwives in the hospital considered that they had no understanding of the demands faced by midwives working in a busy clinical environment and were well protected from these stresses by working on the 24-hour labour line role.

“I know certainly in the early days they felt we were just firing women into the hospitals left right and centre [laughs] and that we had no understanding as to what was happening in the unit at the time it was busy we were fine sat out there on our tods just sending people in” (Monica 368)

A lack of understanding and thus appreciation for the role they were undertaking led to a perception that 24-hour labour line midwives would be best placed using their expertise supporting the workload within the hospital setting.

*“we’ve got experienced midwives there we could do with them on the floor so I think it’s that kind of mentality really that needs to change or the culture or the understanding of it all”
(Penelope 282)*

While the participants recognised the challenges their colleagues working in the birthing environment faced, there was not the same empathy for the struggles encountered by the 24-hour labour line midwives in return. The participants suggested their colleagues were naïve to the idea that although they did not face the same challenges, they still had difficulties to contend with. This is reflected by Stephanie:

“...some of the staff are like oh you’re having it easy we’re struggling actually they don’t realise that sometimes where we’ve got different struggles” (Stephanie 80)

7.6.2 Subtheme 2 - Being the bearer of bad news

The 24-hour labour line midwives are the face of the service to the public, and with that comes being the bearer of bad news when women’s birth choices are impacted by staffing pressures and acuity within the service that may impact on safety. The extent of this impact varied from there being no birthing pool available, no provision to facilitate homebirth or full diversion to another hospital. The COVID-19 pandemic was considered by midwives to have impacted the service provision options available to women, and it is noteworthy that Monica, who was the only participant interviewed before the pandemic, did not refer to a role in bearing bad news to women. As the midwives communicating with families before admission, their role included explaining the diversion was in place and supporting the families to make decisions about what to do next. Despite the midwives’ compassion and empathy for the women in this situation and their apologetic approach to the conversation, unsurprisingly this frequently led to dissatisfied responses from families, which they were left to manage. While some participants reported some families understanding the rationale of the decision to divert being built on a foundation

of maintaining safety, some responded angrily to the upset caused. Participants cited experiencing rudeness, swearing and even threats during their time working on the service. They said:

“...that [diversion] has a massive impact on people's birth choices people get really angry with you we are definitely definitely notice that people have become more abusive and rude on the labour line because we're telling them bad news” (Stephanie 44)

“...I had a woman the other day that just put the phone down on me erm an and it and I can understand why she was so upset” (Penelope 227)

Penelope appeared to distance herself from the decision to divert, by apologising on behalf of the service, rather than approaching it from the view that she personally was apologising. This deflection of responsibility extended to encouraging the families to complain about the service offered as a means to diffuse the situation in the moment.

The midwives perceived that their colleagues in the hospitals did not appreciate their role in managing these difficult and emotionally charged situations, the extent to which it impacted women's birth choices or the amount of time it took to deal with diversion. Michaela said:

“...when there's a divert on I think people forget that we're then having to have that difficult conversation with them[...]and those conversations are hard and I think people forget that we're the ones stuck having to do that” (Michaela 332)

Michaela refers to being “*stuck having to do that*”, which highlights the removal of choice in the matter for the 24-hour labour line midwives. For them, there is no way to escalate to a senior member of staff to engage in difficult conversations; they have no option but to be the bearer of bad news. This differs to the model they may be used to in face-to-face clinical practice, where they could invite the support of a senior ward manager or midwife in charge to attend these discussions.

The participants were also acutely aware that the timing of the information to women and their families was far from ideal, meaning they had to adapt to a new idea of what their birth would look like and readjust their expectations at a time when they are already feeling vulnerable and experiencing pain.

“...the knock on effect has had a massive impact on women because their expectations or their birth plans have kind of gone out of the window erm and of course they've got to adapt to that and it's not a great time to adapt to that when you're you know anticipating a home birth and then you phone the labour line and we say I'm so so sorry we we're gonna have to ask you to come in and of course that's hard for the midwives on the labour line because it's giving news like that it's a really wrong time” (Penelope 221)

The consequences of undertaking this role appeared to impact Stephanie, who described experiencing rudeness and abuse from families the most. This led to Stephanie becoming increasingly frustrated with the narrative that women have such a degree of choice over their labour, particularly during the COVID-19 pandemic. For Stephanie, the mismanagement of women's expectations affected the environment she was faced with in the workplace. This was exacerbated by the promotion of women having choice when the service could not facilitate this choice. She said:

“...I feel like why are their expectations so that they feel like they can have exactly what they want when we can't guarantee it and I always think that we should say actually this is what we want to do we want to facilitate everything that you want however this current climate half the staff are shielding depressed anxious pregnant that is having a dramatic effect on the amount of people that are there so on the shop floor there aren't that many people so that is going to effect birth choices but we're carrying on acting as though we can do everything and then when women don't get their options and they get angry we're the ones that get the brunt of that” (Stephanie 50)

Michaela and Penelope explained the strategies they adopt when communicating the information about a diversion to women. Safety was the focus, as this underpinned the decision made by the senior leadership to divert in the first place, so it was deemed important for women and their birth partners to understand the rationale in the context of the greater good for themselves and other families. Michaela furthered this by trying to frame the diversion in a way that encouraged families to choose safety over their first choice, ideal scenario.

“...I said all I can do is apologise you know it's all about safety and at the currently it's not safe for us to send midwives to your house and you know it's heart-breaking but it's about safety” (Penelope 228)

“...you have to keep it positive so[...]if you said to them I’m really sorry but actually [place name] is having all their ladies seen over in [place name] at the moment because there just isn’t room available for you on the [place name] site whereas there’s a room and a midwife ready to look after you in [place name] so that would be a much safer place for you to be in you would get that care that you deserve (Michaela 352)

Michaela used another technique, which gave families the perception of choice when their first choice had been removed as an option. This meant handing the decision about where they would be diverted to the family, enabling them to take control of the plan moving forward.

“...I sold it the other day by saying[...]I’m afraid you are going to have to go into one of the main units because we don’t have home birth midwives to send out to you what’s your preference [one hospital site] or [other hospital site] so I worded it in a way that they had to give me an answer as to which unit rather than I’m not going [laughs][...]and then I said think of it this way what would you like on baby’s birth certificate? [laughs]” (Michaela 360)

7.6.3 Subtheme 3 - Caring for women from multiple NHS Trusts

At the time of the interviews, there were three NHS Trusts using the 24-hour labour line to provide advice in early labour to approximately 15,000 women per year (NHS Digital 2022). The role of supporting women in labour across three NHS Trusts also presented complexities, as organisations had different pathways of care for clinical scenarios such as spontaneous rupture of membranes. While at the time of the interviews, a team member had been allocated to review the governance of the service, with an aim to make the policies, procedures and guidelines more cohesive, for many years the midwives had been challenged by working with different processes for different Trusts. The nuances in the care they provided did not appear well comprehended by their clinical counterparts at the Trusts. Michaela said:

“...people have got no idea about the differences and the things that we deal with the fact that we’re having to direct through different Trusts and different pathways and the emergencies on top of that” (Michaela 372)

Participants described being on high alert to the different management of cases between Trusts, which enabled them to become more skilled in tailoring advice to both the individual woman and the Trust from which she was accessing care. These differences were not substantial and required close attention to ensure the right woman received the right advice.

“...some of the guidelines and things are very slightly different so just having to bear that in mind when you get one lady from one area another lady from another area same story but you treat them differently” (Monica 307)

The differences in processes became more complicated during the COVID-19 pandemic, when the three Trusts also had different rules regarding the attendance of birth partners, giving another variation for the midwives to manage. Penelope said:

“...everyone was sort of finding their way in the dark and that was tricky at first because one hospital might allow this and the other might not allow that and that's not helpful for people” (Penelope 200)

While the participants were generally skilled in managing the different guidelines of each Trust, Penelope explained that sometimes she encountered resistance from organisations to adhere to their own guidelines. The example provided was that one of the Trusts advised that women with spontaneous rupture of membranes attend for assessment, but that when the 24-hour labour line midwife tried to liaise these calls in, they were advised to delay the woman presenting due to the pressure on the service. This put the midwives in a vulnerable situation, as demonstrated by the awkward and nervous laugh from Penelope, as she knew her practice could be called into disrepute in the circumstance of a poor outcome:

“...I know it's only a guideline but that's what we do we follow guidelines so that could be tricky [laughs]” (Penelope 310)

Other than managing different Trust guidelines, the midwives did not recall the same challenges associated with caring for women from multiple Trusts. Stephanie and Penelope both provided examples of how serving women across a large geographical area could present complications for them. For Stephanie this included becoming embroiled in an argument between organisations over which hospital a woman in labour should attend, due to her living on the geographical boundary of two NHS Trusts. Stephanie, who was trying to arrange care for a woman she had assessed to be progressing in established labour, struggled to get either hospital to agree to admit the woman.

“...it was this problem between [Trust name] and [Trust name] it's something that was beyond my control” (Stephanie 119)

While Stephanie recognised that the issue was between the two organisations, it became her issue as she was the one liaising between them and with the family. The stressful nature of this call is demonstrated through Stephanie referring to “frantically” making calls and the exasperation in her voice.

For Penelope, the lack of commitment to the service from one of those involved was disappointing and led to challenges with staffing and managing the service. It was felt that better quality care could be provided to women if this organisation had better “buy in” to the service.

“...it’s our problem but it’s not really because actually we’re working for our own Trusts you know we shouldn’t have to take on their jobs as well” (Penelope 363)

7.6.4 Subtheme 4 – The weight of responsibility and abuse

The 24-hour labour line midwives dealt with a variety of calls that induced a feeling of stress, such as “born before arrival” (BBA) – when a baby was born unexpectedly at home, or during the journey to hospital, and obstetric emergencies. Midwives were heavily impacted by any adverse outcomes they experienced while working on the 24-hour labour line, even if these were not attributed to a decision they had made. Despite their physical distance from what was happening in these scenarios, they appeared as affected by the outcomes as if they had been present with the family in person. If the outcome was negative and they had been part of the chain of care, their mental wellbeing was affected, regardless of any subsequent investigation concluding that they had delivered appropriate care. One participant reflected concern that the telephone calls being recorded meant any mistakes were exposed for all to see, and while the recordings had only protected her to date, she was acutely aware that her practice was being captured for future review. Incidents in practice led midwives to question themselves and these situations stayed with them, as they attempted to process what had happened. Naomi said:

“...still I’d say I think about that case and several times every week and I didn’t actually do anything that wasn’t right but because of what was said about you whatever it just stays with you forever” (Naomi 736)

There was no detachment from professional responsibility while working on the telephone service. Instead, instances such as these highlighted to the midwives the weight of

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responsibility on their shoulders, as they tried to provide a telephone support service alongside dealing with emergency situations. Penelope and Naomi say:

“...it's quite stressful and it you know it just reminds you of the responsibility you have”

(Penelope 744)

“...even though you know there's nothing else that you can do other than what you've done it's still stressful you still feel kind of responsible even though you're doing the best you can”

(Naomi 710)

Both during and after BBA's the midwives were consumed by the potential adverse outcomes that could occur, even once the baby had been born.

“...it's only when you sort of have a moment to reflect isn't it that you kind of think about all of the what ifs erm as we do as midwives but you know we're always thinking about the next manoeuvre aren't we the next problem the next” (Penelope 752)

Naomi neatly captures this by highlighting the contrast between the reaction of those in the ambulance control centre against her fear of what awaits her next. She said:

“...even when the baby is born obviously they all think it's exciting but I'm still thinking I've got a placenta to come yet or bleeding” (Naomi 694)

When midwives were involved in cases that resulted in poor outcomes the trauma felt by them was significant. One participant referred to caring for a family where the outcome was “catastrophic”, highlighting the extent of the effect it had on them. In these scenarios the participants felt restricted by being unable to see what was happening in the home environment, inferring a loss of control. They said:

“...you know that's hard because if I had been able to see what he was doing I could have said to him no just put her in an ambulance and take her right now but he was like oh the baby is coming” (Stephanie 168)

Surprisingly, midwives also spoke of the abuse they received from families. This included anger, displayed through shouting at the midwives, and rudeness. While the midwives were unable to detach from the families they were caring for while communicating only by telephone, some members of the public seemed more able to be abusive to a faceless person, with Stephanie

describing herself as a “*nobody*” to them. Stephanie was particularly impacted by receiving abuse and felt as a healthcare professional there was no recourse to this behaviour.

“I just think there's this under there's this agreement that because you're a midwife and a health professional on the front line that you are just going to lap it up” (Stephanie 92)

7.6.5 Subtheme 5 – Offering solutions to dissolve misconceptions

In recognising the limitations of their colleagues understanding of the role undertaken on the 24-hour labour line, the midwives provided suggestions to address this gap in knowledge. It was felt that further education of clinical staff either through study days or by observing their daily work would better their understanding and appreciation of the contribution that is made from the service. This suggests that the staff in the birth environments could not know the realities of the 24-hour labour line activity as they have not been to see it in action – an empathetic view for their naivety.

“I think more people should perhaps come and have a moment there just to get some insight into what we actually” (Penelope 770)

“...I would love to get in on study days and actually do a session and teach people what we do but there's just no space on study days to do it so I think for that reason unless you've worked on labour line you've got no clue” (Michaela 374)

It could be considered that the lack of space offered on study days to showcase the 24-hour labour line further highlights the lack of respect and value of the labour line within the organisations to the participants.

7.7 “...all round everybody gains from it” - A symbiotic relationship with the ambulance service

This theme presents the mutual benefits midwives recalled from working with the ambulance service. It is formed of two subthemes: adopting a new cross-disciplinary role within the emergency services and a sense of belonging in a wider team. The additional responsibilities afforded to midwives, such as being able to request or stand down an ambulance and support paramedics, supported them to feel a sense of satisfaction in their work. Midwives appreciated

the shared learning and support of the ambulance service, which left them with a sense of belonging in the organisation.

7.7.1 Subtheme 1 – Adopting a new cross-disciplinary role within the emergency services

At times, it is necessary, after undertaking a risk assessment, for the 24-hour labour line midwives to require support from the ambulance service. Examples of this described by participants include: unplanned homebirths, antepartum haemorrhage and obstetric emergencies such as cord prolapse, breech birth or postpartum haemorrhage. The midwives spoke of the ease in which they could make this request through the ambulance control system by simply inputting a postcode and clicking one button. Participants explained this process as a very trivial, everyday occurrence, referring to being able to action this “*whenever*” they wish, by “*just*” a click of a button. This infers that the 24-hour labour line midwives are well integrated into the culture of the ambulance service, with the decision to dispatch an ambulance having become an insignificant action for them. They say:

“...we have got the screen in front of us already and open all we all we need is a post code all that's all we need and we can just erm send erm a time critical level one ambulance erm and that's just done” (Penelope 760)

The midwives were trusted by the ambulance service to have this privilege, recognising their professional expertise and clinical judgement. Usually, the response would be a time critical ambulance, with a target to arrive at scene within eight minutes of the request. The midwives were confident in the system and the commitment of the ambulance service to ensure a resource was dispatched to the job as soon as possible. Equally, they were aware of the strain on the ambulance service and were less confident in the speed in which the resource would arrive. They said:

“...we can get I think it's an eight or an eighteen minute response they're normally pretty quick if we if it's a time critical and the team are really really good they're really responsive” (Stephanie 654)

“...they will absolutely send a resource so I'm always reassured that they will do their utmost to get there” (Penelope 763)

The participants recalled the usefulness of using the same computer system as the ambulance dispatch team, enabling them to see when a resource had been attached to the job and follow it while it travelled en route to the woman's house. This supported the midwives in giving the family updates, reassuring them that paramedics would arrive and the progress of their journey to them. Additionally, the midwives found it useful being able to communicate with the crew while they were en route to promote a smooth and expedited response on arrival of the paramedic team. Michaela said:

"... 'I can see your ambulance coming you know it is coming a bit of distance but it is on lights and sirens so it won't take too long' or 'they're just coming down onto your estate now they're just coming around the corner you should hear them any minute' you know we can track them right to the door" (Michaela 435)

Midwives also had the ability to stand down an ambulance, essentially cancelling the paramedic team that had been dispatched to the job. Crews were routinely dispatched to maternity cases due to the triage by the ambulance service being very structured and not undertaken by trained professionals, but rather call handlers with no clinical background. Call handlers are constrained to pre-determined questions which the caller must answer to progress with the assessment. Within this system pregnant women are considered high priority and this, coupled with the default of the system to err on the side of caution, frequently results in the dispatch of a time critical ambulance. Participants explained that the assessment undertaken by them is more nuanced and viewed through the lens of professional knowledge, extensive training and experience. Consequently, the midwives felt confident in standing down an ambulance where their clinical judgement deemed it not required and when it is safe and appropriate for the woman to make their own way to the hospital if a face-to-face assessment is required. They said:

"... we will take over those calls and we triage in a non- saying non-structured sounds bad in an individualised way erm get a bit more history which they don't do" (Monica 502)

This role was deemed by the midwives as being helpful to the ambulance service, enabling them to direct resource to those most in need. The significance of this was not lost on the midwives, with them being acutely aware that the response of the ambulance service could be the difference between life and death for those experiencing emergencies such as a cardiac arrest. Their contribution to protecting the ambulance service, which is under pressure with

limited resource, and to helping others was viewed by the midwives as their opportunity to make a difference to those outside the maternity system.

“it could be that they don’t need to go to A&E yes they need to see a midwife and we can make that happen but without lights and sirens so we can save the ambulance service some money and save somebody else’s life by letting that crew go off to a cardiac arrest” (Monica 504)

Another way the midwives assist the ambulance service in helping the public is to provide support and advice to paramedic crews attending at the scene. This was captured by Penelope, who refers to the 24-hour labour line as a “*hotline*” to the midwives, enabling crews to call for clarification, advice or reassurance regarding the plans they had made. This was a protective factor to ensure nothing had been missed outside of their scope of practice, supporting paramedics existing knowledge and previous experience, while securing efficiencies in the service in having an expert to call upon. She said:

“obviously the paramedics you know have a huge you know huge education but obviously maternity’s probably a smaller part of it so it’s us it’s kind of like filling in the gaps just adding a bit more to their jigsaw [laughs] erm so it’s just just a general support for them really whether they use us or not but we’re there for them to use as as they see fit and if we can help we will” (Penelope 74)

For Michaela, undertaking this role supported her in feeling valued, perhaps compensating the lack of appreciation felt by midwives based at the hospital:

“I know that the paramedics like having us there as a resource to go to they’ll quite often call in if it’s a job that we’ve missed cos we were busy and they’ll say oh I’m with so and so and she’s this that and the other we were going to do this do you think that’s ok? so it’s quite nice to be a bit of a backup for them” (Michaela 280)

Midwives identified the positive impact this role has on staff and women alike, describing the benefits of better communication channels between paramedic and midwifery services; resulting in detailed handovers, recommendations of treatment to commence en route to hospital, such as cannulation and the administration of fluids, and women being transferred to the most appropriate location on arrival at the hospital. There was a sense among the midwives that women were able to gain from greater collaborative working between the ambulance service and maternity service, explained neatly by Monica:

“...I just think all round everybody gains from it the women get better care because its more specialised the crews are advised better so they can do a bit more for the women” (Monica 535)

7.7.2 Subtheme 2 - A sense of belonging in a wider team

Participants spoke of being fully integrated into the team within the ambulance control room. Rather than being midwives sat within the vicinity of others, they felt a sense of belonging in the team, which was signalled through several means. Firstly, the ambulance service valued their contribution, by regularly asking them for help – something Naomi cited as occurring during every shift – and respecting their professional expertise. Secondly, the midwives had the full support of the departments within the ambulance NHS Trust, meaning they could access support with aspects of their work involving information technology and audit, without having to rely on their own Trust. Finally, employees within the ambulance control centre made efforts to ensure the midwives felt welcome in the environment, including them in correspondence and treating them in the same way as those employed by the ambulance Trust. Collectively these signals led to Michaela referring to them as *“one big happy family”* – a blissful relationship which juxtaposed with the relationship they’d recalled with their midwifery colleagues in the birthing environment. They said:

“they've been really supportive [Ambulance Trust] have really welcomed the midwives in the room and I feel that we are quite a valued member actually and we're we're treated really really well erm you know [name] who's the lead erm of [Ambulance Trust] has always really encouraged us and always involved us with the bigger [Ambulance Trust] you know we're not just the midwives sitting over there[...]you know we we very much feel part of the team”
(Penelope 48)

“...we're one big happy family we're seen as part of the team they will come to us to ask us for help in the same way that you know we will naturally assist them if we see any maternity jobs coming up” (Michaela 186)

For Michaela, there was the sense of a dual role, with equal importance, in supporting women at home in labour and the ambulance service. Rather than simply being a midwife situated in the ambulance control room, Michaela felt fully integrated into the ambulance service NHS Trust and a valued member of the team in supporting the public. Consequently, although employed to work for maternity services in a different NHS Trust, Michaela had a dual identity and together these two roles form part of her overall identity, she jokes:

“...I do kind of see myself as 50/50 so I’m there helping emergency services but I’m also doing my bit for the Trust as well so I don’t really see it as an assistance thing for me personally I am I always joke that if you cut me in half I’m partially green [laughs]” (Michaela 283)

Michaela was confident in undertaking work for the ambulance service and found it easy to oscillate between the two roles, referring to the “*hat*” that she wears depending on the nature of the call she is dealing with.

Working with the ambulance Trust has expanded the knowledge of the midwives in understanding the role of paramedics, and vice versa. This has led to added benefits that had not formed part of the initial justification to base the 24-hour labour line midwife within the ambulance control room. Penelope said:

“...the people on the roads call us if they need advice erm and that’s really been useful for both it’s given us some understanding of what they have to deal with and their fears and anxieties and it’s helped us well it’s helped them and our relationships[...]so I think it’s just useful for everyone cos we’re just kind of sharing knowledge between department’s that we might not never have known” (Penelope 55)

The sharing of expertise extended to wider than that of the emergency services. Within the ambulance control room, the midwives worked alongside other midwives, social workers, mental health practitioners and a range of professionals supporting the NHS 111 service. The range of health care professionals they worked with provided the midwives with the opportunity to undertake their own professional development, through learning more about different systems of healthcare and different diagnosis for a range of clinical presentations, demonstrating both interprofessional working and learning.

“...I think that’s really important the sort of single point access is great for labour line but it’s actually single point access for every clinician in the room to liaise with each other and you know draw on each other’s experience as well” (Penelope 39)

“...you get to listen to other specialties and so you get to learn things as well” (Michaela 292)

For Penelope and Stephanie hearing from other professionals about the service they worked in broadened their horizons in relation to the work undertaken with the NHS. For Penelope, this led to a sense of pride in the NHS, as the work taking place to improve the services offered to the public was apparent to her:

“...it almost makes you feel much more proud of NHS because actually we're really trying to do joined up thinking we're all trying to work a bit more cohesively together” (Penelope 36)

Meanwhile, for Stephanie it confirmed that, regardless of which NHS Trust you were employed by, they were all facing similar issues.

“...I think we're all in the same boat like we've all like everybody's knackered everybody's burnt out everybody is struggling and stressed etc so it it feels like it's not a you haven't got issues exclusive to just [Trust name] it's actually this is [Trust name] this is [Trust name] this is the whole of [county] that is experiencing all of these issues” (Stephanie 615)

Specifically, the participants appreciated the opportunity the labour line offered to build networks with midwives from other Trusts and felt they could learn from the midwives they sat alongside – an example being that Naomi began advising women to position themselves in all fours in the bath after listening to another midwife suggest this to women.

“...it's nice to work with different midwives outside of the hospital environment from different Trusts and get to bond with different midwives to broaden your midwifery colleague network” (Stephanie 684)

They also valued the support given when they experienced poor outcomes and the celebrations provided when they managed a challenging situation well.

“...I got a round of applause” (Penelope 739)

7.8 Conclusion

In summary, this chapter presents five themes generated from interviews with midwife participants. The research questions aimed to explore the experiences of midwives working on the 24-hour labour line and the extent to which they felt able to make decisions regarding the delivery of care based on the woman's needs. Midwives in this study sought to provide information to women about early labour based on the assessment they completed, before asking the woman to make the final decision regarding whether to attend for face-to-face assessment. The midwives aimed to prioritise women's psychological wellbeing by undertaking a holistic assessment and offering genuine choice, recognising that home is not the best place for all women during early labour. Midwives were aware that they are perceived as gatekeepers but rejected the idea that their role was to keep families at home against their will. Midwives in this study described being able to make decisions free of the influence of organisational

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demands, though this does lead to tension with their clinical colleagues, with them reporting a lack of mutual respect. A further source of frustration was found to be a lack of understanding of the scope of the role of a 24-hour labour line midwife. Midwives were found to be confident in their ability to undertake their midwifery practice using only their ears and had identified innovative ways to overcome barriers associated with this. Finally, the midwives had a sense of belonging as part of a new team, working with the ambulance service, which provided opportunity to broaden their professional horizons and make a valuable contribution to assisting the public. In the chapter that follows, the final data analysis step which identifies final themes across the three participant groups will be outlined.

Chapter 8 Forming final themes across participant groups

8.1 Introduction

This chapter will outline step eight of the data analysis process used to identify the final themes across the three participants groups. As described in chapters 5-7, each participant group was analysed separately, prior to the final process of data analysis which searched for patterns in findings across the three groups. Each participant group had recalled their experience of the same phenomenon – the 24-hour labour line – but from different perspectives. It was important as a final step in the data analysis process to look across the participant groups for areas of congruence and difference in their experience, allowing the findings to be drawn together to present a comprehensive interpretation of the service and offer possible explanations of the findings identified. The final themes developed from this step encompass the perspectives of all participants, to acknowledge overlap, connection and difference in the findings. This step provided a way to manage the findings of the three groups in a meaningful way in preparation for the discussion. This chapter will expand on the description provided in the methodology section (chapter 4) of this data analysis step and present the final themes to be discussed in relation to the wider literature within chapter 9.

8.2 The purpose of the process

As is usual with multi-perspective IPA studies, the analysis began with each group (outlined in findings chapters 5 to 7), with each providing a one-dimensional perspective of the phenomena, before moving outwards to consider the relationships between the groups (Larkin et al 2019). The findings chapters had answered the research questions related to each participant group and provided insight into the lived experience of the 24-hour labour line from the three different perspectives in isolation of each other. The final step in the analysis process was to identify patterns, connections and differences across the experiences of the three groups, in order for them to inform each other.

It was recognised that while there may be areas of similarity in the experience of the phenomena of the 24-hour labour line, the context in which each participant group was

experiencing the phenomena was different. As previously explained in section 4.9.9 the experiences of somebody undergoing labour themselves, and accessing the 24-hour labour line, could not be considered collectively with the experiences of somebody supporting another person in labour. Equally, the experience of both women and birth partners differs from that of a midwife in a supporting role, who is employed to undertake a job, has the benefit of training and prior experience to draw upon, and has some emotional distance from the experience of being in labour or supporting a loved one in labour.

Consequently, it was accepted that the approach during the final stage of data analysis needed to be comparative across the groups, as there may be some conflict, as well as shared experience, between the three different perspectives (Larkin et al 2019). In keeping with the IPA process, and to maintain the idiographic perspectives of the three participant groups, the aim was not to identify overarching themes that could be applied to all three groups, but rather consider relational aspects that interplay across the existing themes. This enabled synthesis of the existing findings from within each sample group to consider areas of congruence and difference in experience, as well as recognise experiences that were identified in isolation for a participant group.

Each participant group provided a lens through which to examine the 24-hour labour line, in order to understand the broader meaning of the service and the dynamics between the three groups (Larkin et al 2019). Each perspective helped to provide further context to and inform the findings from within the other groups, and consider how the themes could be drawn together to make sense of the relationships, interactions and experiences at play. This offered opportunity for evaluation of the service (Larkin et al 2019), to provide an overall picture of the phenomena from the three perspectives. This overall picture will inform the discussion and conclusion of the research and enable service providers to consider the benefits, disadvantages and potential of the 24-hour labour line informed by the three groups.

There is no standard method of analysis at this stage of multi-perspective IPA studies, with researchers synthesising findings in different ways depending on the number and nature of perspectives in each study (Larkin et al 2019; Smith et al 2022). In view of this study exploring the experiences of three sub-groups of one service, the decision was made to form final themes that draw together the findings across the three groups. These themes were a way to manage the findings from across the three groups, and would then be used to inform the structure of the discussion to capture key knowledge contributions from the research.

8.3 Searching for themes across participant groups

To identify themes across the three participant groups the Group Experiential Themes for each group were utilised across three steps.

8.3.1 Step one – reviewing Group Experiential Themes for obvious areas of similarity to identify initial patterns

While the tables with the Personal Experiential Themes that led to each Group Experiential Theme were helpful, the amount of information was initially overwhelming, so to begin the focus was on the titles of the Group Experiential Themes. Highlighters were used to categorise the Group Experiential Theme titles into broader patterns. Working with these titles enabled very noticeable areas of similarity across the existing themes to be identified. The pattern of reassurance and trust were clear within the Group Experiential Themes for both women and birth partners, and the pattern of decision-making was clear within women, birth partners and midwives. Table 13 demonstrates the initial identification of key patterns.

Table 13 - Initial patterns across Group Experiential Themes

Woman Group Experiential Themes	Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
Birth Partner Group Experiential Themes	Group Experiential Theme 1: “...we will listen to what we're told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	Group Experiential Theme 3: “...it was more like a telling” – Tension and togetherness in early labour	Group Experiential Theme 4: “...it's in everybody's best interest to stay at home for as long as possible” – Timing the admission right by relying on signs of labour	Group Experiential Theme 2: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	
Midwife Group Experiential Themes	Group Experiential Theme 1 - “...the end decision is always theirs” – Doing right by women	Group Experiential Theme 2 - “...it's all the little bits around the words themselves” – Undertaking assessment with the absence of senses	Group Experiential Theme 3 - “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	Group Experiential Theme 4 - “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	Group Experiential Theme 5 - “...all round everybody gains from it” - A symbiotic relationship with the ambulance service

Through this initial analysis it became clear that the midwives were the outlier across the three groups, with less obvious patterns observed between the midwives and women/birth partners. On reflection, it was thought this could be explained by the difference in the phenomena. For women, labour is a physiological and psychological process for them to journey to the birth of their infant, while for birth partners, supporting their partner in labour is a significant, life changing event (Johansson et al 2015). In comparison, for midwives, the experience of the 24-hour labour line, and supporting women during labour, was part of their everyday lived

experience. Being a 24-hour labour line midwife was their job, and so their experience would encompass things that could not be related to by women and birth partners. I was led to consider aspects from the findings that explored what it was to be a 24-hour labour line midwife, including the remit of the role and what the rewards and challenges were.

This resulted in a temporary focus on the midwives, and how the aspects of their role could be grouped to explain their experience as employees on a specific service, within a particular working environment. The Group Experiential Themes were therefore reviewed again through a different lens, so aspects of the midwives' experience - that could not be informed by the findings of the women, or birth partners - were not lost in the discussion and the overall considerations of findings. Table 14 shows the identification of these Group Experiential Themes highlighted in orange.

Table 14 - Inclusion of midwife specific initial patterns

Woman Group Experiential Themes	Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour	Group Experiential Theme 2 – “they put me at ease straight away” - Finding reassurance in the 24-hour labour line	Group Experiential Theme 3 – “the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others	Group Experiential Theme 5 - “it's your labour” - Being empowered to take control (with hints of occasional autocracy)
Birth Partner Group Experiential Themes	Group Experiential Theme 1: “...we will listen to what we're told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	Group Experiential Theme 3: “...it was more like a telling” – Tension and togetherness in early labour	Group Experiential Theme 4: “...it's in everybody's best interest to stay at home for as long as possible” – Timing the admission right by relying on signs of labour	Group Experiential Theme 2: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	
Midwife Group Experiential Themes	Group Experiential Theme 1 - “...the end decision is always theirs” – Doing right by women	Group Experiential Theme 2 - “...it's all the little bits around the words themselves” – Undertaking assessment with the absence of senses	Group Experiential Theme 3 - “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	Group Experiential Theme 4 - “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	Group Experiential Theme 5 - “...all round everybody gains from it” - A symbiotic relationship with the ambulance service

This first step led to the initial development of four themes – with focus on reassurance, trust, decision-making and being a 24-hour labour line midwife, as identified in table 15.

Table 15 - Initial patterns across groups

	Women	Birth Partners	Midwives
Reassurance	Finding reassurance in the 24-hour labour line	Finding reassurance in the 24-hour labour line	
Trust	The significance of trust in self and others	Seeking and trusting the professional recommendations of the midwife	
Decision-making	Being empowered to take control (with hints of occasional autocracy)	Seeking and trusting the professional recommendations of the midwife	Doing right by women Advocating for women amid resistance from colleagues
Being a 24-hour labour line midwife			Undertaking assessment with the absence of senses A symbiotic relationship with the ambulance service Advocating for women amid resistance from colleagues A lack of appreciation for the multiple challenges faced by midwives

8.3.2 Step two – Reviewing Group Experiential Themes with focus on sub-themes and underpinning Personal Experiential Themes, to create clusters

Step one had provided the opportunity to identify similar patterns across the three groups, but did not offer the opportunity to search for connections between the Group Experiential Themes that could be used to help explain each other.

The next step therefore involved reviewing the subthemes of the Group Experiential Themes as presented in chapters 5 to 7. Alongside this, to keep the idiographic focus, tables 10, 11 and 12, which can be located in section 5.3, 6.3 and 7.2, were utilised during this step. These tables offered the benefit of having the supporting Personal Experiential Themes included below each

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Group Experiential Theme, and enabled the similarities and differences between individual experiences to be reviewed, to ensure these were not lost in this phase of the analysis process.

The same approach as in step one was adopted, with a highlighter used to identify areas where there was connection between the different Group Experiential Themes and subthemes. This enabled more subtle relationships between the participant groups to be identified, enabling the final clustering of Group Experiential Themes and subthemes. Table 16 shows how the Group Experiential Themes were clustered to form the final themes.

Table 16 - Clustering of Group Experiential Themes using sub-themes

Woman Group Experiential Themes	Group Experiential Theme 1 – “I didn't really know what to expect” – Navigating uncertain waters during early labour - Uncertainty of labour onset - Managing the unique nature of labour - Feeling fearful	Group Experiential Theme 2 – “they put me at ease straight away” - Finding reassurance in the 24-hour labour line - A 24-hour service adopting an open door policy - The calm in the storm to put you at ease - The comfort of access to a virtual midwife	Group Experiential Theme 3 – “the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital - The comfort of home - Accessing the safety of hospital	Group Experiential Theme 4 – “for them it is very bread and butter isn't it?” - The significance of trust in self and others - Women's trust in midwives - Midwives trust in women - Trusting in themselves	Group Experiential Theme 5 – “it's your labour” - Being empowered to take control (with hints of occasional autocracy) - Being empowered to take control - Seeking to hand over control - A sense of autocracy
Birth Partner Group Experiential Themes	Group Experiential Theme 1: “...we will listen to what we're told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	Group Experiential Theme 3: “...it was more like a telling” – Tension and togetherness in early labour	Group Experiential Theme 4: “...it's in everybody's best interest to stay at home for as long as possible” – Timing the admission right by relying on signs of labour	Group Experiential Theme 2: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line - Clear instruction to call - Being on the radar - Calm clear advice	
Midwife Group Experiential Themes	Group Experiential Theme 1 - “...the end decision is always theirs” – Doing right by women - Empowering women to decide - Being reluctant gatekeepers - Prioritising psychological wellbeing - Having true autonomy	Group Experiential Theme 2 - “...it's all the little bits around the words themselves” – Undertaking assessment with the absence of senses - An improvement to previous practice - Heightened hearing – to hear what is not said - Utilising visual aids	Group Experiential Theme 3 - “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues - Managing relationships with hospital staff - Empathy for hospital staff - Advocating for women	Group Experiential Theme 4 - “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives - Understanding the scope of the role - Being the bearer of bad news - Caring for women from multiple NHS Trusts - The weight of responsibility and abuse - Offering solutions to dissolve misconceptions	Group Experiential Theme 5 - “...all round everybody gains from it” - A symbiotic relationship with the ambulance service - Adopting a new cross-disciplinary role within emergency services - A sense of belonging in a wider team

8.3.3 Step three – forming clusters into final themes

Searching for relationships across and clustering the Group Experiential Themes enabled five final themes to be drawn. The themes were then named to capture the overall interpretation of the connections identified, as outlined next.

Firstly, on reviewing the Personal Experiential Themes associated with each Group Experiential Theme, the pattern “Being a 24-hour labour line midwife” was divided into two themes. The first was associated with being a 24-hour labour line midwife, conducting their work in the setting of the ambulance control centre and the expansion of their work through being based in this environment. The second was associated with their interactions with colleagues based in the hospital setting, including the challenges of these interactions. This formed the two themes: “Understanding and explaining tension” and “Being a 24-hour labour line midwife”.

Secondly, the clustering of themes identified a relationship between uncertainty, reassurance and finding balance between the comfort of home and safety of hospital. Reassurance was identified in step one as a clear theme across the women and birth partners groups, but considering this in the context of the other themes offered further explanation. While five Group Experiential Themes formed this theme, there was connection between them that, when considered collectively, gave further insight into the overall experience of women and birth partners. The clustering suggested that women are uncertain during early labour, but through contact with the 24-hour labour line they can gain reassurance, which enables them, and their birth partners, to time their arrival at the hospital in a way that balances the benefits and comforts of being at home, with the perceived safety of birthing in the hospital. This overall theme, which was named “Feeling reassured by midwives, amid the uncertainty, to find balance in early labour”, therefore draws different themes together, to offer more nuanced understanding of the experience of the 24-hour labour line as a whole, which can then be considered in relation to the wider literature.

Thirdly, the decision-making pattern identified in step one was considered in further depth. The Group Experiential Themes spoke to the way that the majority of women experienced, and midwives aimed to achieve, shared decision-making. This led to the idea that the 24-hour labour line provides opportunity for shared decision-making – however this was not always the lived experience of women. For this reason, the theme was named “The 24-hour labour line as a facilitator to shared decision-making in early labour”. This title captures an indication that the

service offers the environment for shared decision-making to be achieved, without claiming that within this study it was always found to be.

Finally, the initial pattern of trust was revisited. Through more closely examining the patterns across the Group Experiential Themes, using the underpinning Personal Experiential Themes, trust was identified as a facilitator to reassurance and shared decision-making during early labour. Through reviewing the Personal Experiential Themes it became clear that those participants that trusted the 24-hour labour line midwife were the same participants that felt reassured following their telephone call, and recalled the experience of shared decision-making. Trust was therefore identified as being important to the achievement of both reassurance in early labour and engagement in shared decision-making. Consequently, the theme was titled “Trust as a facilitator for reassurance and shared decision-making in early labour”.

8.4 Final themes

The final themes identified are presented in table 17 with the Group Experiential Themes that underpin them. Each theme is then surmised, to demonstrate the contribution made from the findings of each participant group. This provides context to the overall findings, prior to further exploration in the context of wider literature in the next chapter.

Table 17 - Themes across Group Experiential Themes

		Feeling reassured by midwives amid the uncertainty, to find balance in early labour	The 24-hour labour line as a facilitator to shared decision-making in early labour	Understanding and explaining tension	Trust as a facilitator for reassurance and shared decision-making in early labour	Being a 24-hour labour line midwife
Group Experiential Themes	Women	Navigating uncertain waters during early labour Finding reassurance in the 24-hour labour line Balancing the comfort of home with the safety of hospital	Being empowered to take control (with hints of occasional autocracy)		The significance of trust in self and others	
	Birth partners	Finding reassurance in the 24-hour labour line Timing the admission right by relying on signs of labour	Seeking and trusting the professional recommendations of the midwife		Seeking and trusting the professional recommendations of the midwife Tension and togetherness in early labour	
	Midwives		Doing right by women Advocating for women amid resistance from colleagues	Advocating for women amid resistance from colleagues A lack of appreciation for the multiple challenges faced by midwives		Undertaking assessment with the absence of senses A symbiotic relationship with the ambulance service

8.4.1 Feeling reassured by midwives amid the uncertainty, to find balance in early labour

This study found that, for both women and birth partners, the 24-hour labour line was a source of reassurance among a period of uncertainty, as they tried to balance the benefits and comfort of being at home, with their perception of the safety of the hospital.

Women participants identified being uncertain during early labour, finding it difficult to recognise labour onset and manage the unique ways in which labour presents. Uncertainty was exacerbated by their expectations of labour onset not being aligned with their experience. This uncertainty led to fear, which was reportedly shared by their birth partners.

The 24-hour labour line was the mechanism for women and birth partners to seek reassurance from a healthcare professional during this period of uncertainty. The 24-hour availability of the service, the open door policy and the calm approach of the midwives all contributed to a sense of reassurance. The 24-hour labour line service was identified as an extension to the care they would receive in a hospital, and provided reassurance that they were both on the radar of healthcare professionals, and had a support team available to them remotely. This reassurance empowered women to stay in the comfort of their home, which both them and their birth partners were aware was beneficial for the progress of labour. Remaining at home was particularly important in the context of the COVID-19 pandemic, to facilitate the attendance of their birth partner, who was identified as being crucial to a positive experience of labour. The 24-hour labour line was the mechanism of balancing the right time to transition to the hospital setting.

8.4.2 The 24-hour labour line as a facilitator to shared decision-making in early labour

The results of this study found that most women felt fully involved in the decision to attend for face-to-face assessment. Many women experienced shared decision-making, with midwives completing an assessment, outlining the options, the risks and benefits of each, and then exploring the woman's preferences. This enabled women to have control over the next steps in their labour journey. Some women preferred to defer the decision to the midwife due to their professional expertise in labour and birth, and seek a paternalistic approach, a view that was echoed by birth partner participants.

The midwives in this study aimed to engage in shared decision-making, whereby options were discussed with women and their preferences explored before the woman made the final decision regarding whether to remain at home or attend for face-to-face assessment. Midwives were mindful of the psychological impact of early labour, as well as the physiological symptoms women would experience, and sought to prioritise both during their discussions with women. Despite this, midwives were aware that they may be perceived as gatekeepers by women and birth partners, as well as by their colleagues at the hospital. Instead, midwives positioned themselves as advocates for women, suggesting that they had adopted the position of negotiator between the hospital and the woman's wishes. The situation of the service at a geographical distance from the hospital enabled midwives to make shared decisions with women without the influence of the demands of the hospital, and the time afforded to midwives for discussions with women facilitated an environment for shared decision-making to occur.

While shared decision-making was not experienced during every call by every woman, broadly speaking the setting of the 24-hour labour line away from the hospital was found to offer an environment that facilitates shared decision-making in early labour. There are indications from women and midwives in this study that shared decision-making was more usual practice and for this reason, the 24-hour labour line is identified as a facilitator to shared decision-making.

8.4.3 Understanding and explaining tension

This study identifies tension between 24-hour labour line midwives and their colleagues working on the hospital sites, and offers explanation for this tension from the 24-hour labour line midwives perspective.

The 24-hour labour line midwives felt that the midwives working at the hospital were not privy to the challenges faced by them and did not appreciate the complexity of their role. Although the midwives on the 24-hour labour line were empathetic to the challenges endured by midwives at the hospital, such as a depleted and burnt out workforce, they were not afforded the same empathy in return due to the lack of insight their colleagues had into their role. While the 24-hour labour line midwives were able to draw on their own experience of working in the hospital in order to empathise, they recognised that midwives in the hospital were unable to do the same, and so they did not have a full understanding of the workload associated with the role, which could have resulted in mutual empathy. Instead, the perception of the 24-hour labour line midwives was that little value was attributed to their role by the hospital midwives, with them considered better placed at the hospital to support the workload in that environment. The

midwife participants explained that their hospital colleagues do not see the work undertaken that protects the clinical environment from additional strain, for example managing divert, dealing with obstetric emergencies in the community and supporting the ambulance service to get women to the right place at the right time.

A lack of understanding of their role became particularly contentious when 24-hour labour line midwives referred women into the hospital for face-to-face assessment in the absence of signs of established labour. These instances furthered the tension due to the negative feedback endured by the 24-hour labour line midwives from their colleagues at the hospital. A common result of this tension was the questioning of the 24-hour labour line midwives' professional judgement, and demonstration of a lack of respect for their own professional expertise, leaving the midwives feeling the need to defend their decisions and negotiate on behalf of the woman.

The midwives spoke of the importance of doing the right thing by the women, and advocating for their needs, regardless of the pressure this would put upon the clinical setting. They believed their position advocated for women and their choices, by giving them more control over the timing of their admission. The midwives recognised that the control they held over admission to the hospital, despite their physical distance from it, diminished the control felt by their clinical colleagues. While this met the needs of women, it simultaneously increased tension between the two sites.

8.4.4 Trust as a facilitator for reassurance and shared decision-making in early labour

This study found that primiparous women and birth partners recalled high levels of trust in the professional expertise of the 24-hour labour line midwife. The midwives were considered to have the necessary training, knowledge, skill and experience to keep women and their fetus safe. Trust in the midwife was reaffirmed during their telephone conversations, where women and birth partners perceived midwives provided the relevant advice and options to women and birth partners to promote safety.

Women and birth partners that trusted the midwife also recalled high levels of reassurance before, during and after telephone interactions with 24-hour labour line midwives. While not all birth partners recalled the experience of shared decision-making, with them generally seeking and following the advice and instruction of the midwife, the trust they had in the midwife meant they felt confident in the decisions made by midwives, even when they did not align with the wishes of the woman. For women participants, those that trusted the midwife, and felt

reassured by them, also spoke of strong involvement in the decision-making process. This suggests that trust can be a facilitator to both reassurance and shared decision-making during early labour.

For some multiparous women, there was scepticism regarding the midwives' trust in them, and their previous experience guided some of their decisions as a result of their perception of trust. This led to them relying on their intuition to guide the timing of their admission to hospital. This highlights the importance of trust in both directions – from woman to midwife, and midwife to woman – for shared decision-making to be achieved.

8.4.5 Being a 24-hour labour line midwife

This study has captured, from the perspective of midwives themselves, what it means to be a 24-hour labour line midwife. Midwives spoke of this in two ways; supporting women and birth partners during early labour, and working collaboratively with emergency and out of hours services within the ambulance control centre.

The midwives spoke to a number of roles that they have assumed while working on the service, some of which are directly related to the care provided to families in early labour. These included negotiator, advocate, expert, supporter, bearer of bad news, advisor and educator, and others that relate to their new identity within the ambulance control centre, including co-ordinator of care, ambulance worker, pathway planner and risk assessor. In undertaking these two roles, the midwives spanned the boundaries of several care pathways, by contributing to maternity service provision and emergency service provision.

While contributing to maternity service provision the environment of the ambulance control centre provided optimal conditions for midwives to focus fully on their interactions with women and families, free from the distractions they had experienced when undertaking the same role in a clinical setting. In order to deliver in this role, being a 24-hour labour line midwife required precision in listening skills to form multiple pieces of a puzzle into an overall picture. A quiet and focused environment facilitated this, enabling midwives to feel confident in the thorough and considered assessment of women.

Contributing to emergency service provision provided the opportunity for the midwives to make a greater difference by not only providing what they deemed high quality early labour care, but also by supporting the health and wellbeing of the general public through collaboration with the ambulance and NHS 111 services. Adopting a new identity in the ambulance control centre,

midwives felt valued in the contribution they made and a sense of belonging, which led to professional satisfaction from working in this environment.

8.5 Conclusion

In summary, this chapter presents the data analysis process that synthesised the findings across the three participant groups, into five final themes. These themes draw on the Group Experiential Themes from within and across participant groups, to explain the relationships between them and draw ideas together to provide an overview of phenomena. The analysis process that led to these themes was outlined, including the three analysis steps undertaken, and examples provided, before the final themes were presented. In the chapter that follows, these themes will be situated in the context of wider literature for the findings of the research to be considered in further depth.

Chapter 9 Discussion

9.1 Introduction

This penultimate chapter considers the findings of the research in the context of wider literature, including that presented in Chapter 3, and proposes explanations for what has been observed. While the discussion focuses on answering the research questions presented in section 3.9, the experiences of women, birth partners and midwives are not considered separately, but instead by the themes identified in the previous chapter. The themes encompass the perspectives of the three subgroups to acknowledge overlap in the findings, consider the themes from multiple perspectives and provide explanation to the experiences found.

9.2 Feeling reassured by midwives amid the uncertainty, to find balance in early labour

This study found that women faced uncertainty during the early stages of labour due to difficulty recognising, sometimes unexpected, labour onset and unmet expectations of the latent phase of labour. The theme of uncertainty is congruent with previous research (Beebe and Humphreys 2006; Cheyne et al 2007; Carlsson et al 2009; Nolan and Smith 2010; Eri et al 2015; Borrelli et al 2018; Myhre et al 2021) and this study therefore adds to the existing evidence base that women feel uncertain during early labour due to the varying ways labour presents.

It would seem logical that maternal education around what to expect in early labour would reduce uncertainty. In the time it has taken to complete this project numerous web-based educational interventions have been designed and implemented with aim to improve the experience of women in early labour. These interventions have generally utilised advancing technology to create and evaluate web-based education resources or Apps using the ELEQ (Edwards et al 2023; Myhre et al 2023). Despite the hypothesis that women with access to the intervention would have a more positive experience than those without, neither Edwards et al (2023) or Myhre et al's (2023) studies identified a significant difference between the two groups, with the exception that women in the Myhre et al (2023) intervention group felt significantly more relaxed while in early labour.

One could consider that the ELEQ does not directly measure levels of uncertainty and therefore is not best placed in determining the impact of educational interventions in reducing uncertainty and the experience of unmet expectations for women during labour. That said, all but two women in this study had attended antenatal education classes and yet still experienced uncertainty. It can therefore be theorised that it is impossible to fully prepare for early labour, regardless of how much antenatal education or educational interventions are engaged with. Women have previously identified that labour is an '*unknown territory*' due to its unique nature (Borrelli et al 2018 pp. 44) and so it may be, as suggested by participants in this study, that women cannot fully prepare for something that is a unique experience each time it happens, even for the same woman. This study explored an additional layer to this unique experience by examining the experiences of women during an unprecedented global pandemic, which was found to further uncertainty around the timing of attendance to hospital.

Antenatal education remains valuable to women for a variety of other reasons, such as having their fears allayed, being informed for labour and forming friendships with new parents (Berlin et al 2016; Spiby et al 2022) but does not appear to alleviate uncertainty in early labour. Efforts, therefore, may be best placed in providing reassurance for women during the process, rather than focussing efforts on the education that occurs beforehand. Of interest is that in both Edwards et al (2023) and Myhre et al's (2023) studies, women in the intervention group scored lower on measures relating to the perceptions of midwifery care. This measure examines the experiences of women when making telephone contact with a midwife in early labour, inferring that, despite the use of a web-based intervention, the expectations and needs of women were not met through access to professionals. In comparison, the results of this study indicate that both women and birth partners feel reassured by the 24-hour labour line and appreciated the midwifery care available to them through this service. The sense of reassurance provided was widespread, with participants finding reassurance in the service before they called, during the call and after the call had ended.

Women and birth partners had clear instructions from their community midwives during the antenatal period to call the 24-hour labour line if they experienced any signs of labour onset or were concerned. The broad criteria for which they could call provided reassurance and removed uncertainty about when to call. Instead they had easy access to the support and advice of a professional midwife and felt able to call without hesitation. In previous studies women recalled being provided with more rigid criteria to call, such as to wait until contractions were established at a certain frequency (Eri et al 2010) and consequently did not feel

comfortable calling the hospital in early labour (Allen et al 2020). Both the name of the 24-hour labour line service, which encapsulates the round-the-clock availability of the service, and the antenatal information provided by community midwives, likely helped women and birth partners perceive the service as being easily accessible. It is therefore important that women continue to be prepared in the antenatal period and that such services are advertised as being available 24-hours a day. The more recent change in the name of the service to the “Maternity Triage Line” may not advertise the round-the-clock nature of the service in the same way. When offering a dedicated telephone support line for labour, maternity service providers should consider the way the service is marketed to emphasise the open-call policy that women and birth partners found comforting in this study.

The presence of the dedicated telephone line resulted in women being less likely to access advice and information from elsewhere due to the comfort provided by the option to access a midwife. The ease of accessing readily available and unlimited information from digital sources on the internet has been identified by women as a convenient way to access information during pregnancy (Lupton 2016), though this information can cause women to be concerned (Bjelke et al 2016). While it has been identified that the majority of women use the internet to access information during pregnancy (Bjelke et al 2016), often due to limited opportunity to ask health care professionals questions (Lagan et al 2010), they value expert advice provided by clinicians more highly (Lupton 2016). This is likely due to the higher levels of trust they have in information from professionals, such as midwives, when compared to digital sources (Vogels-Broeke et al 2022). Women in this study furthered the idea that professional reassurance, from somebody with expertise in early labour, was particularly appreciated by women (Nolan and Smith 2010). Women have previously identified a desire for easier access to the advice and support of healthcare professionals outside of routine appointments (Lupton 2016). The valued reassurance and access to expert opinion during early labour identified by women and birth partners in this study further supports the case for this, over and above focus on technological interventions, and provides an example of how to structure a service of this kind within maternity services. Further, consideration of this finding in relation to the wider literature suggests women will find the expansion of the service to triage all calls from 20 weeks’ gestation equally as reassuring.

During the telephone call, women and birth partners found the calmness of the midwife reassuring and were comforted by their lack of panic and concern about the situation. The midwives normalised early labour, and feelings of reassurance in turn led to women feeling

more confident to remain at home. Reassurance in early labour has previously been found to support women to remain at, or return, home (Cheyne et al 2007; Carlsson et al 2012; Weavers and Nash 2012) and the importance of normalising early labour for women is apparent (Carlsson et al 2012; Eri et al 2015). However, much research exploring experiences in early labour has found that although women sought reassurance from the midwife, it was not provided (Cheyne et al 2007; Barnett et al 2008; Nolan and Smith 2010; Eri et al 2015). This highlights the importance of a dedicated telephone line which prioritises psychological wellbeing, reassurance and support but may also support women to remain at home for longer, meeting the needs of women while simultaneously reducing intervention.

Importantly, this study has found that families interpret the service as an extension of the care they would receive at hospital, which has not been observed previously. The availability of the service was particularly reassuring due to the context at the time, with most data collected during a global pandemic, when there were restrictions in place to wider social interactions. Being at home in early labour has previously been described as being in the “*twilight zone*”, with women feeling left alone and unsupported by health professionals (Larkin et al 2012). The women and birth partners in this study experienced the opposite, describing a sense of a support team offered by the midwife, despite their physical distance. This leads to consideration regarding what it means for a midwife to be “available” during labour, and how this changes as labour progresses. The availability of a midwife to women during labour has been cited as an important aspect in feeling reassured during established labour, with women wanting midwives to be readily available, rather than needing to manage other competing responsibilities (Borrelli et al 2016). It was not clear from participants in this study whether they considered the midwife to be free of other responsibilities, but they certainly felt the midwife had adequate availability to support their emotional needs. The emotional, as well as physical, availability of a midwife has also been identified as being sought by women during labour (Vedeler et al 2021). The dedicated nature of the service allowed the midwives space and time to provide this virtual support.

The appreciation for a virtual support service is contrary to previous studies exploring women’s experiences of virtual appointments during the COVID-19 pandemic. While focussed on care across the antenatal and postnatal setting, studies conclude that women considered these appointments to be of less value and to provide less reassurance than a face-to-face schedule (Silverio et al 2021), leaving them with unmet needs (Sanders and Blaylock 2021). Specifically, women were concerned that risks would not be detected in using this form of assessment

(Karavadra et al 2020; Silverio et al 2021; Stacey et al 2021; Flaherty et al 2022). The impersonal nature of telephone consultations was also cited, with communication between them and the health care professional feeling compromised through the lack of in-person contact (Karavadra et al 2020; Stacey et al 2021).

It is difficult to explain the different finding within this study, but it might be related to the provision of telephone support during early labour not being a new phenomenon. Prior to the pandemic, little to no antenatal care was provided to women virtually, so the concept of antenatal assessments taking place virtually likely has lower acceptability than telephone support in early labour. Alternatively, it could be associated with the availability of the 24-hour labour line service, with women and birth partners feeling reassured by their option to call again at any time, or that the service facilitates access to the hospital, which was considered the safest place for the birth of their baby. The results of this study show that women tried to balance the need to arrive in this safe place at the right time against remaining in the comfort of their own home for as long as possible. The 24-hour labour line was identified as the mechanism to enable the correct timing to be established.

COVID-19 was identified as a factor that encouraged women to remain at home during the earlier stage of labour to facilitate their birth partner attending with them and to reduce the risk of contracting the virus. These results are in line with those of previous studies which explored women's experiences of maternity service restrictions during the COVID-19 pandemic, also identifying that women were concerned about restrictions to birth partners attending with them before labour was established (Karavadra et al 2020; Irvine et al 2024). Similarly to the finding of this study, a consequence of this concern was that women wanted to remain at home for as long as possible to reduce the likelihood of being separated from their partner. Indeed, in some instances this concern influenced their decision about place of birth, leading women to opt for a home birth, instead of attending a hospital (Irvine et al 2024), explaining an increased demand for home birth between 2020-21 (Brigante et al 2022). Government guidance at the time stated that women should have access to a birth partner from the point of admission (NHS 2020), a recommendation mirrored internationally by the World Health Organisation (2020), due to the associated reduction of intervention when women are supported by a birth partner (Bohren et al 2017). Despite this guidance women in this study appeared uncertain whether their partner would be able to attend with them until they were in established labour, a finding congruent with Aydin et al (2022). Indeed, literature confirms that this was the lived experience of some women during the pandemic, who were forced to experience labour alone until labour had been

diagnosed as established (Flaherty et al 2022; McLeish et al 2022). These circumstances are reported by women to be particularly distressing and anxiety inducing (Sanders and Blaylock 2021), leading to feelings of loneliness and isolation during the latent phase of labour (Panda et al 2021; Flaherty et al 2022).

These results appear to suggest that although women associate the hospital with safety and the home with comfort, a key aspect of labour is the support from their loved ones (Irvine et al 2024). Women appeared more inclined to remain at home if they also had the comfort associated with the presence of their birth partner. This is unsurprising in view of the importance of birth partners to a positive birth experience, which has long been acknowledged (Lavender et al 1999; Bruggemann et al 2007; Bohren et al 2019), though not in the early labour literature.

This study, coupled with the supporting evidence exploring women's experiences of labour during the COVID-19 pandemic, highlights the important role of the birth partner during early labour. The importance of this role has not been readily acknowledged in previous early labour literature; on the contrary some literature instead indicates the pressure women can feel from birth partners during this phase (Eri et al 2015). The difference identified in this study could be explained by the notion that the things that are most important to people are taken for granted, until there is risk that they could be taken away, and control over this decision is removed. It has become routine practice in Western countries for fathers to attend with and support women during labour and birth (Kothari et al 2022), therefore the idea that this option would be removed was not identified as a concern for women previously. The context of the pandemic shifted the focus of women onto the importance of the presence of their birth partner, which this study shows led them to reassess their options to ensure continued togetherness as transition to the birth environment occurred.

The paucity of literature exploring the role of birth partners during early labour, and exploration of their experience, suggests widespread ignorance of their importance to women. Indeed, fathers themselves minimise their importance during this period of time (Roberts and Spiby 2020). In this study, fathers identified the helpfulness of clear instructions from the midwife to support them in supporting their partner, which contrasts with previously reported feelings of being of little use during early labour (Roberts and Spiby 2020). It is recommended that birth partners' experiences and supportive mechanisms are explored and evaluated further to help provide the tools and confidence required for undertaking their role in early labour.

Overall this study can conclude that dedicated telephone support lines for labour can support women and birth partners in navigating uncertainty, and provide reassurance in early labour. While safety was a key motivator for women during this phase, this needed to be balanced with ensuring the continued presence of their birth partner.

9.3 The 24-hour labour line as a facilitator to shared decision-making in early labour

The results of this study show that most women felt fully involved in the decision to attend for face-to-face assessment, with the midwives handing them control of the final decision. This finding is contrary to previous qualitative studies which suggested that midwives are gatekeepers to the hospital and that mothers must negotiate their credibility during telephone interactions with midwives (Eri et al 2010) to gain permission to attend (Allen et al 2020). In these studies, the women were either passive in the decision, suggesting a paternalistic approach to decision-making, or were given information to encourage them to agree to the midwife's recommended decision, described by Charles et al (1997) as a less extreme model of a paternalistic approach. In contrast to earlier research, which identified that focus was placed on evidencing that the threshold for contraction frequency had been met (Eri et al 2010; Spiby et al 2014), most women in this study experienced a more holistic consideration of their labour by the midwife, including assessment of their pain, ability to cope and personal preferences surrounding admission. There was attention paid to the value of shared decision-making, which had been observed as absent within previous early labour literature (Shallow et al 2018).

Reassuringly, this study observes the same finding in the midwife participants, who sought to give control of the final decision regarding whether to attend for face-to-face assessment to the woman, after providing further information about their options of care based on their telephone assessment. Midwives remained mindful of the frequency of contractions that may be indicative of labour having established, however this was not the most crucial aspect in deciding whether face-to-face assessment should take place and the decision was not cited as theirs to take. This finding differs from those of Eri et al (2011) where midwives made it a feature of their telephone interactions to encourage women to remain at home and warned them of the potential that they may need to return home if they were not found to be in established labour on admission. The midwives in Eri et al (2011) did report that they gave women the choice regarding whether to attend, though they wanted them to agree with their decision. This raises

questions about how the choice was presented to women by midwives in Eri et al (2011), compared to in this study.

There are several possible explanations for the finding of shared decision-making in this study. Firstly, it may be reflective of the initial aim and ethos of the 24-hour labour line, to ensure families are involved in decision-making in early labour through offering informed choice (Mackenzie 2014). Collectively, the results from both women and midwife sub-groups support that the preliminary ethos of the 24-hour labour line has been adopted by midwives working in the service.

Secondly, the clinical landscape has changed since previous publications exploring the experiences of telephone interaction between women and midwives in early labour. This change is an outcome of a series of damning reports relating to maternity services between 2015-2022 (Kirkup 2015 and 2022; The Independent Maternity Review 2022), with more independent investigations expected to conclude in 2025 (NHS England 2023). At the time of Eri et al (2011) and Spiby et al's (2014) studies, before the publication of Kirkup (2015), focus remained strongly geared to "normalising" birth and reducing intervention rates. More recently, there has been campaign to focus on women's psychological wellbeing, personalised care and safety, over and above rates of intervention, which may explain the midwives relaxed approach to early admission in the latent phase of labour in this study. Consequently, these findings may observe a shift in culture, whereby there is less focus on reducing intervention rates associated with early labour, and more focus on maintaining safety and enhancing the experiences of women. This idea is supported by the data for this study being collected over an extended period of time. Two of the participants that felt the midwife held control of the decision were interviewed earlier in the research process. These two interviews followed very shortly after the publication of the Kirkup report (2015), meaning there was limited time for a cultural change. This may explain the difference in experience for these two participants, when compared to women interviewed later in the data collection period.

The placing of the 24-hour labour line midwife at the ambulance control centre, away from additional caring responsibilities, afforded the midwives the time to promote shared decision-making. A lack of time has previously been identified as a constraint in facilitating shared decision-making among healthcare professionals (Elwyn et al 2012; Kloester et al 2022), however midwives in this study valued the time they had to speak to women. This was possible due to the midwives' situation away from the hospital setting where they could focus solely on their telephone interactions with women, which in turn supported them in facilitating an

assessment that involved more than the spoken word. The dedicated nature of the telephone support service being a facilitator for shared decision-making is a new finding not previously observed in the early labour literature. This is presumably due to the absence of previous research exploring this phenomenon.

Since the publication of *Changing Childbirth* (Department of Health 1993) the importance of women's choice and control over their maternity care has been at the forefront of policy and frameworks (Department of Health 2004; Department of Health 2007; National Maternity Review 2016). Feelings of control during labour lead to multiple benefits including positive childbirth experiences, increased satisfaction and enhanced emotional wellbeing (Meyer 2013). Having choice over care through shared decision-making is intrinsically linked to the feeling of control one has (Snowden et al 2011), in turn increasing the likelihood of a positive experience. There is good evidence in maternity care that when women are provided with adequate information they are supported to make an informed choice (Crepinsek et al 2023) and in turn feel in control, leading to positive experiences of the childbirth continuum (Cook and Loomis 2012; Meyer 2013). Previous research has indicated that women consider it important to lead decisions about their labour care (Vedam et al 2019) and that in most examples of women feeling in control they also recalled being actively involved in decisions about their labour (Meyer 2013).

It therefore seems logical that in midwifery practice, where focus is on 'woman-centred care' (Crepinsek et al 2023), that shared decision-making would be a default position over a paternalistic approach to decision-making. Comparatively, birth partners in this study preferred a paternalistic approach, seeking for the 24-hour labour line midwife to tell them what to do next. This differs to previous qualitative literature exploring women's experiences of early labour suggesting that fathers can be particularly influential with regards to the timing of admission (Cheyne et al 2007; Barnett et al 2008; Eri et al 2010). The midwives on the 24-hour labour line appeared to value the role of birth partners more than had been cited in previous studies. In Roberts and Spiby's (2020) study the experience of fathers was that their role in the telephone call was simply to pass the phone to the woman, but this was not the experience of the birth partners within this study, who were encouraged to engage in decision-making processes, sometimes at the exclusion of the woman herself. This difference may be explained by the selection of participants, in that birth partners that were asked to hand over the call to the woman were less inclined to participate in the study.

The concept of shared decision-making is one that is promoted as needing to become the norm across all healthcare settings, as outlined by the Department of Health (2012) “No decision about me, without me” publication and the NHS Long Term Plan (2019). From a nursing and midwifery perspective, the importance of shared decision-making is alluded to in the NMC code of conduct, which requires registrants to “*encourage and empower people to share in decisions about their treatment and care*”. Midwives too have been found to value and see themselves as integral to facilitating shared decision-making, through being advocates for women’s autonomy and reminding women that they do have a choice in their care (Kloester et al 2022).

Shared decision-making is defined by Elwyn et al (2012 pg.1361) as:

“an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences”

When applying Charles et al’s (1997) characteristics of shared decision-making, as demonstrated in Table 18, it is clear how these align to the discussion described by women and midwives in relation to the 24-hour labour line.

Table 18 - Charles et al (1997) characteristics of shared decision-making as applied to the 24-hour labour line

Characteristic of shared decision-making	Applied to 24-hour labour line
Shared decision-making needs to involve at least two participants.	Most commonly the midwife and the woman, though sometimes extended to the birth partner.
Those involved in the shared decision participate in the process of decision-making. If either party is not willing, the consequence is that shared decision-making is not achieved (Charles et al 1997). This is neatly surmised as the idea that <i>“it takes at least two to tango”</i> (Charles et al 1997 pg. 686).	When applied to the decision of when to attend the birthing environment, both the midwife and woman (plus the birth partner if applicable) need to be invested in the process of decision-making.
Information sharing must occur before a shared decision can be made.	The midwife outlines the options available to the woman, and the risks and benefits of each, to enable the woman to deliberate her options and preferences. This may include to remain at home to reduce the likelihood of intervention, or the risk of being asked to return home if she opts to attend the hospital for assessment.
A decision is made, to which both parties agree. At this part of the process, it is important to recognise that both parties do not have to agree that the decision is the best one, but rather they have agreed together to this decision.	Both the woman and midwife share the responsibility of the decision. An example here may be that the decision is to attend for assessment in the absence of strong indications of established labour. The midwife may think the better decision would be for the woman to remain at home, but accepts the decision to attend for review and reassurance.

Despite better understanding of shared decision-making in recent years, some women were not interested in making a shared decision, instead their preference being to defer the decision to the midwife. There are many explanations for this, including different personality traits, previous experience of being excluded from the decision-making process by clinicians (Charles et al 1997), or poor levels of health literacy (Muscat et al 2020). Cultural variation in the adoption and acceptability of shared decision-making (Begley et al 2019) is also an important consideration. An example is provided by a meta-synthesis exploring Asian-American views on decision-making, which concluded that professional expertise can be questioned when people are presented with options, due to being more familiar with a paternalistic approach (Tan et al 2023). People of this demographic valued being involved in decisions, but ultimately preferred to defer the decision to the professional due to this being the cultural norm.

The lack of diversity in the socio-demographics of participants within this study must therefore be considered when assessing the transferability of findings. The majority of participants were White British and had high educational attainment. Research over the last twenty years has identified differences in the level of autonomy people seek over decisions made about their care. Although conducted in the USA, Levinson et al (2005) identified that Hispanic and Black participants were more likely to prefer the final decisions regarding their care to be made by healthcare professionals, when compared to White participants. Murray et al (2007) report similar findings, with Black people indicating they preferred a paternalistic approach to decision making when compared with White people. This translates to maternity care, where significantly fewer Black and Latina women reported shared decision-making than White women (Attanasio et al 2018), while immigrant women were found to be disempowered from being involved in decision making about their care altogether (Higginbottom et al 2019).

Moreover, research has also identified a link between increasing educational attainment and involvement in decisions about care (Levinson et al 2005), with women with lower educational attainment being less likely to report shared decision-making during pregnancy and childbirth when compared to those with higher educational attainment (Attanasio et al 2018; Hawke 2023). Murray et al (2007) identified that people of lower socio-economic status were also more likely to prefer a paternalistic approach to decision making, when compared with those of higher socio-economic status who preferred to engage in shared-decision making. Further research is necessary to better understand the impact cultural differences and educational attainment may have on people's perspectives around shared decision-making in order for clinicians to respond appropriately in practice (Resnicow et al 2022), however caution should

be applied to transferring the findings this study to people with demographics poorly represented within this study.

In circumstances where a paternalistic approach is preferred by service users models of shared decision-making can be adopted to promote the involvement of people in their care. This can also provide a framework to help ensure the philosophy of shared decision-making is consistently applied, in view of a few women within this study recalling instances where they were not in control of the decision to stay at home or attend the hospital. Elwyn et al (2012) refer to three steps to shared decision-making in clinical practice: choice talk, option talk and decision talk. This model can be utilised to create a proforma for midwives to work to (Table 19).

Table 19 - Application of Elwyn et al's (2012) shared decision-making steps

Step of shared decision-making	Process of step	Applied to decision whether to remain at home or attend for face-to-face assessment
Choice talk - ensuring women know the options available to them	Step back	Acknowledge the situation the woman describes through storytelling and explain that together you will think through what to do next.
	Offer choice	Provide reassurance that either option is appropriate and that it is important that each option is explored.
	Justify choice	Explain that two things may influence choice: Personal preference – not all women will make the same decisions in this point in their labour. The decision needs to be right for each individual. Uncertainty – the midwife cannot be certain how labour will progress for individuals, due to the unique nature of labour.
	Check reaction	Observe the woman's reaction to being given choice.
	Defer closure	If the woman wants to be told what to do, consider deferring closure by asking if you could describe the options available first.
Option talk – providing women with detailed information	Check knowledge	What does the woman already know about early labour and the progress of labour? What does the woman already know about coping mechanisms in early labour? What does the woman know about their options in early labour?
	List options	Provide a list of options:

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Step of shared decision-making	Process of step	Applied to decision whether to remain at home or attend for face-to-face assessment
about the options available		- Stay at home - Attend birthing environment for assessment - Continue at home until x time
	Describe options	Explain in further detail what is involved for each option.
	Harms and benefits	Explore pros and cons to each option such as: - Likelihood of being sent home following assessment - Benefits of remaining home during early labour - Benefits of face-to-face assessment during early labour
	Summarise	List options again and check understanding
Decision talk – supporting women in considering preferences and settling on what is best for them	Focus on preferences	Explore what their preferences might be, including what is important to them.
	Elicit a preference	Establish the woman's preference.
	Move to a decision	Ask if woman feels ready to make a decision.
	Offer review	Remind the woman that the decision can be reviewed at any time and confirm the open call and door policy of service.

Despite evidence of shared decision-making, the results of this study indicate that midwives are aware that they could be perceived by women, birth partners and colleagues in the birth environment as gatekeepers, though this was not an identity they held themselves. Instead, the midwives viewed themselves as the intermediary between the women and the hospital, perceiving that women had more choice, and therefore control, as a consequence of the organisation of the service. Participants felt able to advocate for the decision that was right for the woman based solely on her need and wishes. The situation of the 24-hour labour line away from the hospital setting supported the midwives in making collaborative plans of care with women, free of the influence of the competing demands of the hospital.

These findings do not align with those observed in earlier studies, whereby workload and social pressures were cited as influential factors for midwives when making decisions around care in early labour (Cheyne et al 2006; Spiby et al 2014; Shallow et al 2018). Cheyne et al (2006) first alluded to this, observing that midwives were concerned about the judgement from others related to their decision-making, particularly the midwife in charge. Conversely, midwives recruited in Spiby et al (2014) acknowledged that workload in the clinical setting should not take priority over caring for women in early labour, though still inferred this was customary practice through the delaying of women seeking to be admitted during early labour. Of particular importance was the idea that the co-ordinator of the birthing environment should take responsibility of telephone calls to exert control over decision-making and to support the management of workload demands (Spiby et al 2014). Later Shallow et al (2018) concluded that during discussions with women in early labour midwives conformed to social pressure within the work environment, which led them to delay admission due to organisational demands. Shallow et al (2018) proposed that *“organisational demands in the NHS exerted pressure on midwives to make organisational decisions to keep mothers out of hospital.”*

While at the time of these studies there was a shortage of midwives comparable or worse (RCM 2006; 2015) than that observed today, there was not the additional pressures that were challenging organisations during the timeline of this study. This includes the impact of the COVID-19 pandemic on maternity services, which furthered staffing challenges through the redeployment of staff to other clinical areas, the necessity to facilitate clinically vulnerable staff to shield, and the need for staff to isolate when experiencing symptoms of, or contact with, the virus. The latter led to a median staff shortage of 16% across NHS Trusts surveyed during this period (Brigante et al 2022). Further, systemic organisational changes ensued as a result of processes to try and contain the virus and manage staff shortages (Schmitt et al 2021). It is

therefore surprising that despite knowing the additional pressures facing their clinical colleagues, and demonstrating empathy towards the challenges they faced, midwives still felt able to make decisions without the consideration of organisational demands. Theories from previous literature may explain this, in that the midwives are providing the service free of competing responsibilities and without the spectacle of other clinicians, which have formerly been thought to influence decision-making (Cheyne et al 2006, Spiby et al 2014; Shallow et al 2018). The environment of the 24-hour labour line removes the midwife from the organisational pressures being experienced on the hospital sites, meaning they may be less acutely felt by them, in turn facilitating their role as advocate for the women.

9.4 Understanding and explaining tension

The role of advocacy was something considered important by the midwives within this study, viewing it as their role to represent the wishes of the women. As a result of advocating for women's choices, the 24-hour labour line experienced tension with the midwives working in the clinical setting. The midwife participants perceived that the criteria in the eyes of their colleagues was still that women should be showing signs of established labour prior to admission. Consequently, the 24-hour labour line midwives experienced resistance and questioning of their professional expertise from some midwives when trying to liaise women into the birth environment. This is a new finding, that has not been presented in previous research, and suggests the midwives at the labour line adopt a different ideology to those based at the birthing environment.

While this observation has not been made before in early labour, it has been acknowledged in research exploring the experiences of staff working in a midwifery continuity of carer model, who have interactions with hospital staff (Hunter 2004; Pace et al 2022). Continuity of carer midwives focused on person-centred and individualised care, while staff based in the hospital setting instead focused predominantly on medical care (Hunter 2004; Pace et al 2022). The differences in the philosophy of care led to tension between staff, and, similarly to in this study, necessitated midwives advocating for women's choices (Hunter 2005; Pace et al 2022).

Considering the findings of this research it is proposed that it is now the 24-hour labour line midwives that are the ones negotiating both their own and the woman's credibility when contacting midwives at the birthing environment. The structure of the service means that

women have become once removed from this part of the process, with the labour line providing them with protection from the more rigid criteria of the hospital setting.

While further insight could be gained by exploring the experiences of midwives working in the hospital environment, one explanation could be that these midwives have lost the control they once held over workload when they were responsible for triaging early labour calls themselves. This study identifies that the 24-hour labour line midwives felt a sense of control over arranging admission to the hospital environment, with some participants even forming a plan of care for after the woman's arrival. This results in a shift in control, from the midwives at the hospital, to the woman, with the 24-hour labour line midwife as the facilitator, as presented in Figure 7. This is a new observation, and as such there is negligible literature exploring midwives' experience of this phenomena, however further insight can be drawn from the wider literature exploring similar service designs as the 24-hour labour line.

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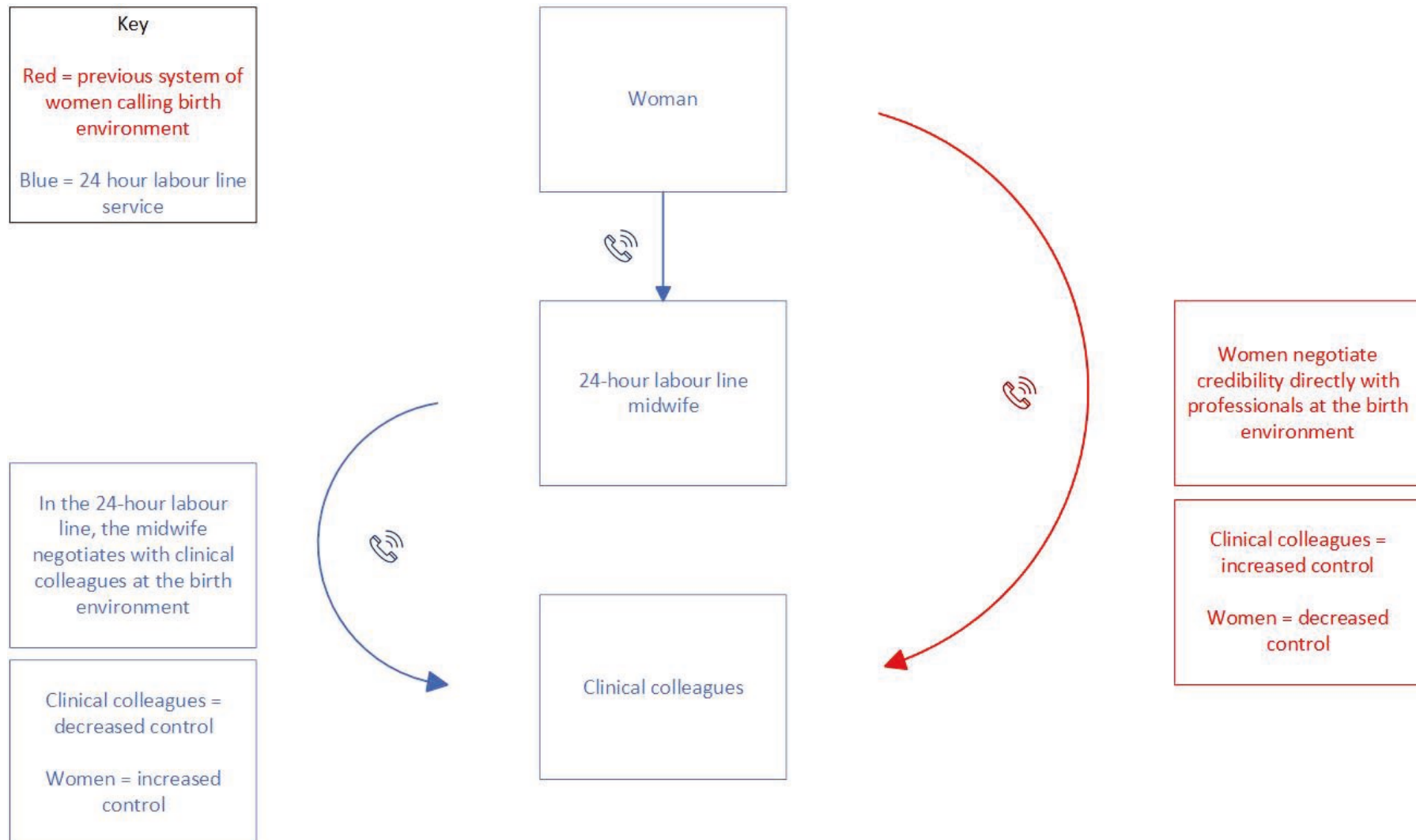


Figure 7 – Negotiating admission pre and post implementation of the 24-hour labour line

NHS 111 is a telephone triage service that provides assessment and, where necessary, referral to other NHS services such as Out of Hours GP services, Accident and Emergency Departments or Urgent Care Centres. NHS 111 and the 24-hour labour line are similar in that emergency care and labour care are unscheduled and as such there is no way of controlling the workload on any given shift. Similarly to the labour line, when calls were triaged and appointments arranged by the NHS 111 service, practitioners at Urgent Care Centres were found to have perceived a loss of control over their work (Turnbull et al 2014). While comparisons cannot be drawn between NHS 111, which uses a computer decision support system, rather than clinicians, such as on the 24-hour labour line, to assess risk and the need for face-to-face review, the concept of another system controlling who attends in person is similar and may help explain the reactions of midwifery colleagues in the hospital setting.

A challenge for staffing maternity services, particularly the birthing environment, is the lack of predictability regarding the number of people requiring care on any given shift. Comparisons can be drawn to emergency and urgent care services, whereby activity and acuity levels vary significantly between shifts, with historic data used to predict attendance levels (Turner et al 2020). Creswell et al (2023) examined the workload across maternity rosters at one hospital in Ireland, finding significant fluctuations between shifts, making it difficult to plan and manage demand. Workforce planning also necessitates consideration of skill-mix, which has been identified as a challenge for maternity services (RCM 2016). Specifically related to intrapartum care, services should facilitate one-to-one care during established labour - that is one midwife caring for only one woman during their labour and birth (NICE 2023). Through the implementation of the 24-hour labour line the midwives co-ordinating and managing care in the hospital environment have lost control over their workload at a time when staffing and acuity is challenging. While these organisational factors should not influence decision-making surrounding admission during early labour, they have no clear oversight over how many women may be in early labour at any one time, meaning they are unable to plan ahead and consider contingency plans to provide one-to-one care in labour in advance of women being referred into the hospital. Lack of control over workload may explain some of the interactions described by the 24-hour labour line midwives.

Another explanation could be misalignment between what hospital midwives and 24-hour labour line midwives consider an “appropriate” referral. From the accounts provided by the midwife participants, it appears midwives at the hospital were seeking for women to be admitted with signs of established labour, with them questioning the 24-hour labour line

midwives if the referral was for psychological support, analgesia or reassurance. Evidence from NHS 111 literature supports this idea, with clinicians at the Urgent Care Centres and Emergency Departments finding referrals into the service inappropriate (Turnbull et al 2014; MacLellan et al 2023). Clinicians perceived the NHS 111 system was risk adverse and consequently passed the responsibility of managing risk to clinicians at the Urgent Care Centre (Turnbull et al 2014). Thus, one explanation could be that the midwives at the hospital perceive the 24-hour labour line midwives to also be risk averse, and consequently women are referred inappropriately to avoid the risk of adverse incidents in the community, such as the baby being born before arrival at the hospital, or to prevent families being dissatisfied with the service. Exploration of their perception of the 24-hour labour line would provide the final perspective needed to fully evaluate the service.

The behaviour of the hospital midwives to the 24-hour labour line midwives may also be explained by existing literature exploring the stress and burnout of staff both before and during the COVID-19 pandemic. Pre-pandemic, a national survey of 1997 midwife members of the RCM was conducted, finding the workforce was experiencing significant emotional distress, personal and work-related burnout, stress, anxiety and depression (Hunter et al 2019). Coupled with the challenges of an unprecedented global pandemic and worsening staffing levels, the impact on midwifery staff was considerable. The 2021 NHS staff survey reported that less than 6% of midwife respondents said they had enough staff to be able to do their job properly, and more than 80% were unable to meet conflicting demands (RCM 2022c). It is thus unsurprising that the percentage of midwives reporting being emotionally exhausted at work was almost double that of NHS healthcare workers as a whole, with burnout at work being commonplace and work-related stress causing illness (RCM 2022c). These results are supported by research conducted during the pandemic exploring midwives' experiences of work. McGrory et al (2022) identified increasing levels of stress among midwife participants across a three-phase study spanning May 2020 – July 2021, due to a requirement to deal with increased workloads, staff shortages and fast changing guidelines. Indeed, the midwife participants in this study were empathetic to the challenges faced by their clinical colleagues working in the birthing environments and acknowledged that their calls referring women in for assessment contributed to these challenges. The 24-hour labour line midwives' recognition of the clinical climate was used to justify instances of unprofessional behaviour towards them from their clinical colleagues.

In return, this study identified that the 24-hour labour line midwives were not afforded the same empathy or understanding of the scope of the role and associated demands from clinical midwifery staff. The helpfulness of the 24-hour labour line in alleviating pressure on the birthing environment by taking calls and supporting families in early labour was not deemed appreciated. It seems possible that these results are due to the lack of visibility of the work undertaken on the service, with the midwives working in the hospital not being privy to the number of calls that ensue prior to the decision being made to attend hospital. Instead, each time they interact with the service it is to facilitate referral of a woman for assessment, adding to the workload of the hospital. Consequently, a large part of the work undertaken by the service remains invisible to the hospital.

Shorrock (2016) proposes four types of work: work-as-imagined, work-as-prescribed, work-as-disclosed and work-as-done. Table 20 outlines the four types of work and associated limitations with using them as a measure of the work a person undertakes.

Table 20 - Overview of Shorrock's (2016) "types" of work

Type of work	Description of type of work	Limitations of measure
Work-as-imagined	The work we imagine ourselves or others might do.	Simplified model of work. Likely to incompletely or incorrectly imagine work.
Work-as-prescribed	The formalisation of work through outlining procedures and processes.	Does not capture work that is not built into procedures and processes.
Work-as-disclosed	The way work is explained by the person undertaking the work to others.	Does not capture the work-as-done as the person has control over what they disclose. Impossible to capture all work undertaken.
Work-as-done	The actual activity that people do.	Not captured within imagined, prescribed or disclosed work.

The midwives in the birthing environments will likely use work-as-imagined to form a picture of the work of the 24-hour labour line midwives. Past experiences will be drawn on when imagining this work (Shorrock 2016). Without having experienced the work-as-done on the 24-hour labour line themselves, the work they imagine is likely to be inaccurate. While the hospital midwives

do not have experience of working on the 24-hour labour line, they likely have experience of taking early labour telephone calls before the implementation of the service. Midwives in this study identify that the design of the service allows more time to thoroughly explore options with women and provide support in early labour, something that they were not afforded before when calls were taken in the birthing environments. Consequently, if midwives at the hospital sites imagine the work of the 24-hour labour line midwives in the same way it was previously delivered, they will not accurately capture the work-as-done. Work-as-disclosed also forms part of the work-as-imagined, so depending on the extent to which the 24-hour labour line midwives explain the work they have done, such as the number of women they have supported that day in early labour or emergency scenarios in the community, the work-as-imagined is unlikely to be accurate. A result of the misalignment between the work-as-imagined and the work-as-done is that the work of supporting women to remain at home, as well as the additional responsibilities of responding to and supporting the work of 999 and 111 maternity related calls, is not visible to those on the hospital site. It is arguably the visibility of the work that becomes important. This explains the misconceptions of the 24-hour labour line work as recalled by midwife participants in this study. Consequently, a large part of the work undertaken by the service remains invisible to the hospital and the midwives become givers, rather than takers, of work.

In comparison, the interactions midwives in this study had with ambulance control staff, paramedics and NHS 111 services were reported more positively. When applying the same consideration to the visibility of the work undertaken, it could be argued that the effectiveness and efficiency of the 24-hour labour line was more visible for these groups. Prior to the implementation of the service the ambulance control staff, paramedics and NHS 111 clinicians did not have easy access to the advice and guidance of a qualified midwife. The implementation of the service results in the reduction of work for these professionals, making their working life easier, for example through the standing down of an ambulance. This is particularly pertinent due to limited resources available to dispatch to emergencies being a cause of work-related stress for employees of the ambulance control centre (Coxon et al 2016).

In addition to the tension experienced with hospital midwives, the 24-hour labour line also referred to the difficult experiences of bearing bad news to women, particularly when their birth choices could not be facilitated. The model of work can be further applied to the experiences of women and their response to being diverted to another birthing environment due to the closure of hospital units. When their choice is facilitated and they are provided reassurance by the

midwife, the work of the 24-hour labour line midwife is visible and valuable to them. When the midwife must bear bad news – that their planned choice regarding place of birth cannot be facilitated – they are instead given work by the midwife, to select their preference as to where to go instead.

Figure 8 provides visual representation of some of the potential explanations of the theme “Understanding and explaining tension” when considered in light of the wider literature, to help explain the experiences of the 24-hour labour line midwives. The figure shows the work undertaken by the midwives on the 24 hour labour line, and how this either gives, or takes, work from other professionals or members of the public. It draws out the idea that, according to the literature, this work was being given in the context of high levels of stress, and the loss of control over workload. To further explore the ideas discussed here, research is required to seek the experiences of the hospital midwives, ambulance control staff, paramedics, NHS 111, and women that were diverted to a different hospital during labour.

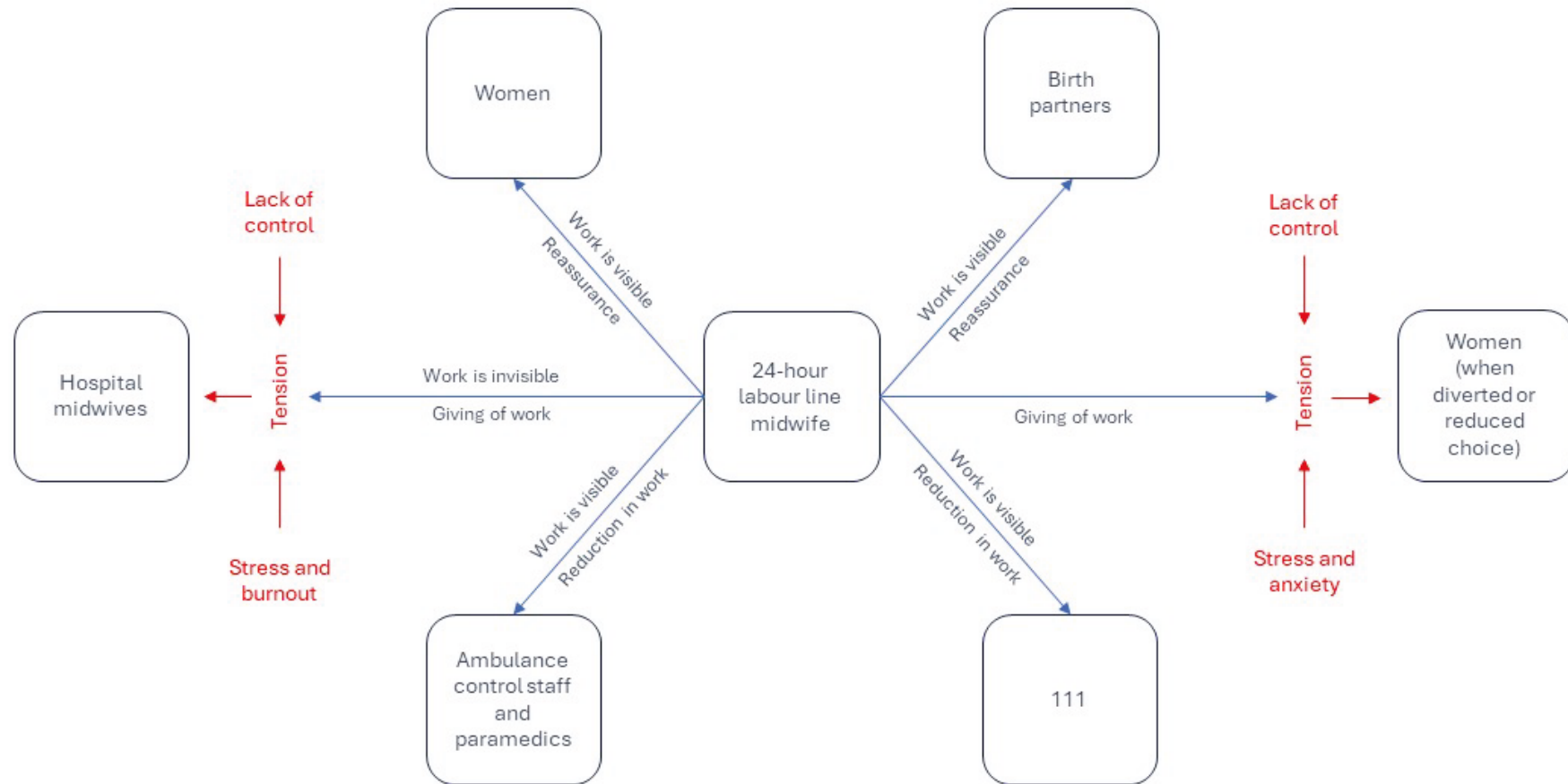


Figure 8 – Visual representation to explain the theme “Understanding and explaining tension”

9.5 Trust as a facilitator for reassurance and shared decision-making in early labour

One theme to emerge from the analysis was related to the trust women and birth partners had in the professional expertise of the midwives on the 24-hour labour line. Trust was built on the assumption that midwives had knowledge and previous experience of labour and therefore had the ability to keep them safe by detecting deviation from the norm. For some participants there was particular value in the professional registration of a midwife as a signal of expertise. This finding has long been observed, with Bluff and Holloway (1994) also identifying that women trust midwives due to their expertise in labour and birth, which has been gained through both formal training and experience. Similarly to women in this study, participants identified midwives and doctors as experts in childbirth and suggested that they knew better than them the appropriate decisions to take in labour (Bluff and Holloway 1994).

It seems obvious that literature generally suggests that the public are more likely to consider all healthcare professionals as trustworthy if they consider them competent in providing the required care (Anderson and Griffith 2022). Lewis et al (2017) refer to this concept as “initial” trust, based on the expectation that a midwife would be a competent professional. This initial trust in the midwife will later be tested to further assess their abilities.

Patient trust in healthcare professionals has been identified as a fundamental aspect for providing effective and person-centred healthcare (Rasiah et al 2020). The importance of public trust in registered nurses and midwives is highlighted in the NMC (2015) Code, which requires registrants to promote professionalism and trust through upholding the expected professional standards and maintaining integrity in their practice. Trust in midwives has consistently been identified as a facilitator to supportive relationships between women and midwives, which in turn promotes shared decision-making (O’Brien et al 2021; Almorbaty 2022). In this study, the women that trusted the midwives were the same women that felt involved in the decision-making process and had the strongest sense of reassurance following contact with the 24-hour labour line midwife. This suggests that trust is integral to the achievement of both reassurance and shared decision-making, and can encourage or jeopardise the presence of both during early labour.

Although initially designed to be applied to organisational trust in business, Mayer et al’s (1995) integrative model of trust could explain the relationship observed between women or birth partners and the 24-hour labour line midwives in this study. Mayer et al’s (1995) model

highlights the importance of ability, benevolence and integrity to trust, suggesting that when these were perceived by the trustor to be high, the trustee – in this case the midwife – would be considered trustworthy. Taking each aspect in turn and relating to the findings of this study demonstrates Mayer et al's (1995) model when applied to a telephone support line for early labour.

Firstly, participants in this study concurred that their trust in the midwife was directly associated with the midwife's expertise and regular exposure to women in labour. This aligns to Mayer et al's (1995) description of ability, in that the midwives have the relevant skills and competence to support decision-making in the context of early labour care. Secondly, participants generally believed that the midwife wanted to do what was best for them, demonstrating benevolence. Finally, in most cases the women described the integrity of midwives by them adhering to principles that they found acceptable, such as assessing their psychological wellbeing and handing over the final decision about their care to the women themselves.

Lewis et al (2017) also refer to the importance of women's control of, and choice in, their care in the development of trust between women and midwives. Trust was considered by women in this study to be two-way – that is the women's trust in the midwife and the midwife's trust in them. Multiparous women sought a two-way trusting relationship, which has been previously identified as a desire for women during pregnancy (Lewis et al 2017). For primiparous women and birth partners, the midwives' trust in them was of limited concern, instead the focus was on the midwives' expertise and trust they had in them. It could be argued that they didn't yet have experience of labour and birth, so were novices when compared to the midwife and multiparous women who also had prior experience to draw on.

The participants assessment of the integrity of the midwife may explain some of the differences identified between the experiences of primiparous and multiparous women. Mayer et al (1995) explains that trustworthiness is a continuum, rather than somebody either trusting a person, in this case the midwife, or not. Lewis et al (2017) agrees, concluding that while initial trust may be present, it is not absolute, and further trust develops over time, as women test the relationship to either gain or lose confidence in the midwife. While this research has demonstrated that trust in midwives is possible in the absence of continuity of carer, the idea that trust develops over time is strongly supported by research that recognises continuity of carer as a facilitator for trusting relationships (Boyle et al 2016; Perriman et al 2018) due to the time available for trust to develop (Perriman et al 2018; O'Brien et al 2021).

Multiparous women approached labour with the benefit of previous experience, and if this experience was negative, the trust in the midwife was lower, as also found in Lewis et al (2017). Two of the four multiparous women that indicated a lack of mutual trust were interviewed at the beginning of the research study, when the service was relatively recently established. It is possible that their previous experience of labour did not involve the same service, and as such their experience of telephone calls during early labour was tarnished by a previous experience. Scarlett, for example, was not advised to remain at home by the 24-hour labour line, but was asked what her preference was with regards to staying at home or attending for face-to-face assessment, however her perception was that women are not believed and routine advice is to remain at home. This may have been the experience of a previous pregnancy, which was then later applied to the 24-hour labour line service.

Maternity services in the UK are currently under close scrutiny following the publication of aforementioned independent investigations (Kirkup 2015 and 2022; The Independent Maternity Review 2022). Understandably, the findings of these investigations have been of great interest to media and families currently accessing maternity services or contemplating pregnancy within the UK, leading to the potential for public confidence and trust in maternity services to be diminished. The latest NHS surveys found that 78% of respondents reported that they “*definitely*” had trust in the staff caring for them during labour (Care Quality Commission 2024), a decrease from 82% in 2017 (Brader 2024). For women to continue to be reassured during early labour, and partake in shared decision-making, the maintenance of trust of pregnant women in maternity services must be prioritised.

9.6 Being a 24-hour labour line midwife

This study provides the first exploration of midwives’ experiences working in the ambulance control centre. At the outset of the study, it was presumed the themes identified through analysis of the midwives’ interviews would focus on their experience in supporting women during early labour. Instead, the majority of the interview centred on the additional roles and responsibilities the midwives undertake, which have previously been undocumented. Figure 9 succinctly captures all the roles of the 24-hour labour line midwife, before their role in assessing women in early labour, and working in the ambulance control centre are explored in further depth.



Figure 9 - The roles of a 24-hour labour line midwife

9.6.1 Assessing women in early labour

A key priority for 24-hour labour line midwives was assessing women during early labour. Midwives in this study used more than simply what was said by women and birth partners on the telephone to aid their assessment. These results reflect those of Spiby et al (2014) who also found that midwives wanted to speak to women themselves to enable them to hear a contraction and the sound of a woman's voice, inferring they were assessing more than the spoken words. For the midwives in this study, the quiet environment and time provided through the absence of other responsibilities facilitated this type of assessment, enabling them to focus on the sounds of the environment at home. In view of this being the first research to explore the experiences of midwives working on a dedicated telephone support line, this is a new observation.

Midwives used their listening skills to establish pieces of a jigsaw puzzle that they joined together to form an overall picture. The process of forming this picture has been recognised previously with midwives adopting a question-and-answer approach to obtain the information they needed, rather than focusing on other signals (Eri et al 2011). Comparatively, in this study

midwives described assessing the breathing pattern, ability to talk through a contraction, background noise and the tone of voice. In addition to these puzzle pieces, they also trusted their intuition during calls. The use of intuition has previously been identified by midwives as a way of assessing whether or not women need to attend the birth environment (Spiby et al 2014). Spiby et al (2014) observed this as an interesting finding considering previous literature, which predominantly refers to the use of intuition in midwifery practice when there is an existing relationship between women and the midwife before labour commenced. The finding of this study therefore offers further support for the idea that midwives are able to use intuition in the absence of previous rapport.

The midwives also spoke of visual tools they utilised to differentiate between reassuring signs of labour progression and indications of risks during labour. Some midwives also spoke with hope about the future implementation of a video-calling function to further support their assessment and address identified limitations to telephone contact.

Midwives' perceptions of using video-calling in early labour has been explored previously, concluding that most midwives were positive about the benefits of such a service being implemented, so long as perceived barriers could be addressed (Spiby et al 2018; Borrelli et al 2023b). Similarly to the midwives in this study, participants felt that video-calling could enhance the midwives' ability to conduct thorough assessment of women at home (Borrelli et al 2023b), without being physically present with them, while also being conducive to developing rapport and trust through a more personable interaction (Spiby et al 2018).

Midwives have previously suggested that video-calling may increase the level of reassurance felt by women (Borrelli et al 2023b), in turn giving them confidence to remain at home (Spiby et al 2018). It is questionable to what extent a video-call could provide additional reassurance when compared with a dedicated telephone support line. Women and birth partners in this study reported feeling reassured and did not comment on the inability to see the midwife as being problematic, whereas women have previously identified that being able to interact using video-calling was conducive to more individualised communication and rapport, leading to further reassurance (Borrelli et al 2023a; Faucher and Kennedy 2020). A reassuring feature of the 24-hour labour line is the availability of time offered by the midwife and the dedicated nature of their role, which ensures women in the birthing environment setting are not affected by their competing responsibility to take early labour calls. Perhaps it is the availability of the midwife to provide time to undertake a thorough assessment, offer advice and explore options that is reassuring, rather than the ability to see the midwife.

While the introduction of video-calling was presented positively by midwives in this study, challenges to implementation were not considered. Concerns regarding the ability of families to access care due to digital illiteracy has been reflected previously (Spiby et al 2018), and as such any implementation would need to assess whether video-calling becomes routine or is offered to families (Borrelli et al 2023b). Other concerns previously highlighted are negated by the current arrangement of the 24-hour labour line service. For example, the midwives already present themselves professionally by wearing uniform at the workplace, are familiar with their telephone calls being recorded, have a quiet space to receive calls, and are familiar with the technology utilised in the ambulance control centre. Therefore the 24-hour labour line offers the conditions sought by women and midwives to facilitate video-calling during early labour, lending itself to evaluation of this initiative.

9.6.2 Shaping a new identity

Despite the challenges, professional questioning and, in extreme cases, abuse from the public the 24-hour labour line midwives encountered, they still spoke highly of working on the service. A new finding in this study is the sense of satisfaction midwives get by being able to support the ambulance service, which contributed to their enjoyment of working in this role. Their role comprised either requesting or standing down an emergency response, and providing advice to paramedics and NHS 111 call-handlers. The ability to help in this way gave the midwives a sense of usefulness, while also valuing the opportunity to make a difference to the general public by redirecting emergency provision to those more in need. The meaningfulness of work has been identified as being associated with job satisfaction among midwives (Hansson et al 2022; Wangler et al 2022), suggesting that the opportunity to make a difference beyond traditional maternity services contributes to their satisfaction in the role.

Unsurprisingly, due to the unique nature of the 24-hour labour line, there is no previous literature exploring midwives' experiences of working within the ambulance control centre. Comparison could be drawn to secondary triage, which now regularly takes place in ambulance services. As outlined in section 7.7.1 calls from the public to the emergency 999 number are initially triaged by call-handlers (O'Cathain et al 2018) with no clinical training. Calls are categorised during triage before nurses or paramedics provide secondary triage for non-urgent calls, enabling patients to be appropriately redirected and to manage increasing demand for ambulance services (Eastwood et al 2015a; Eastwood et al 2015b; Roivainen et al 2020). Secondary triage has been shown to reduce the number of people presenting at emergency departments and being attended by ambulance services, while maintaining patient satisfaction with the service (Roivainen et al 2021). Despite interest in secondary triage as a mechanism for

responding to the increasing demands facing emergency services, and roles of healthcare professionals in non-traditional settings becoming increasingly common, there is limited literature exploring the experiences of the staff.

Turnbull et al (2014) reinforce the idea that locating multiple professionals and services within the emergency control centre encouraged interprofessional working relationships between different staff members, having observed this within the NHS 111 setting. The midwives in this study recalled the ease at which they could support NHS 111 and 999 services to work collaboratively for the benefit of the organisations and the public. This is a view that is mirrored by clinicians in this setting (Turnbull et al 2014) and the mechanisms for this in relation to maternity related calls warrants further exploration.

Midwives recalled being made to feel welcome and valued within the emergency control room, fostering a sense of belonging in the organisation. In view of the tensions they experienced from their own colleagues, it seemed the midwives had found what had been lost in their working relationships within maternity service. The emotional wellbeing and job satisfaction of midwives has been connected to relationships with colleagues (Cramer and Hunter 2019; Mharapara et al 2022), highlighting the importance of the 24-hour labour line midwives finding this connection elsewhere. Recognition within the workplace supports midwives to be satisfied (Mharapara et al 2022), and while the contribution participants in this study made to services was not deemed recognised by their peers at the hospitals, they valued being recognised as experts by colleagues in the ambulance control centre. Indeed, the idea of being “one big happy family”, where staff provide support to each other, was also identified in Turnbull et al (2014), suggesting the emergency control centre to be a satisfying, albeit stressful, environment to work in. A sense of belonging has been identified as a facilitator to retention of staff (Silver et al 2024) and therefore these relationships could be argued as essential to the longevity of the 24-hour labour line.

In summary, the role of the 24-hour labour line midwife appears to have two facets. The first is the midwives’ role in supporting and reassuring women during early labour, advocating for the shared decisions formed together. The second is the newly identified and emerging role they adopt within the ambulance control centre, which enables collaborative working, education and a sense of meaning to their work. Despite the challenges faced by 24-hour labour line midwives, they appear satisfied due to a perception of being valued and belonging within their environment, and excited for the innovation of the service to develop further into the future.

9.7 Conclusion

This chapter has situated the findings in the context of wider literature to provide consideration of the themes across the three participant sub-groups. The 24-hour labour line has been identified as a mechanism to provide support to women and birth partners during early labour, due to the easy access it provides to a trusted professional during a period of uncertainty. When trusting relationships are present, the 24-hour labour line also provides opportunity for shared decision-making between women and midwives, with the midwife defaulting to the role of advocate when negotiating admission with the birthing environment. The visibility of work in the context of stretched maternity services and differing ideologies between 24-hour labour line midwives and hospital midwives has been proposed as an explanation for the tensions experienced during interactions. Finally, the numerous roles of the 24-hour labour line have been summarised to explain the tools used to undertake assessment in early labour and importance of collaborative working with colleagues in the ambulance control centre.

The next, and final, chapter will surmise the contribution to knowledge made by this research, before the implications for practice and policy are explored. The limitations of the study will then be outlined, before recommendations for future research are proposed. Finally, a summary of the reflexivity engaged with throughout the research is provided.

Chapter 10 Conclusion

10.1 Introduction

This final chapter outlines the contribution of knowledge this research makes to the understanding of interactions during early labour between women, birth partners and midwives, of relationships between professionals, and of the role of midwives working in an ambulance control centre. The implications for clinical practice and policy are presented and the limitations of the study acknowledged. My role as a researcher, midwife and mother in the research process will be critically considered, before recommendations for future research are made. To conclude, final remarks will be given.

10.2 Contribution to knowledge base

The findings from this study make several contributions to the knowledge base by addressing the research questions identified in section 3.9. First, this thesis has provided further insight to the existing evidence base around women and midwives' experiences of telephone contact during labour. The findings shed new light on the experiences of women and midwives when delivery of care is provided in a different location to that which has been previously explored, centred around a dedicated telephone support line for labour. Existing literature exploring experiences of telephone contact during early labour also adopt a qualitative approach, so an IPA study appropriately offered the opportunity to compare findings.

At the conception of this study there was one poor quality quantitative research study exploring the experiences of fathers during early labour. This study, by Nolan et al (2011), did not focus on the interaction between birth partners and midwives before admission to the birth environment. During this study, research by Roberts and Spiby et al (2020) offered further qualitative insight into the experiences of fathers during early labour, with reference to contact with midwives. This research has therefore expanded the limited qualitative evidence base exploring birth partners' telephone interactions with midwives and enabled exploration of birth partners' experiences of a dedicated telephone support line during labour.

For the first time, this study has identified a remote model of care that provides reassurance to women and birth partners at home during early labour, which supports the navigation of uncertainty felt during this phase. The open-call policy of the service and calm conversations with the midwife provides women and birth partners with a virtual support service during their

time at home. This is the first time that early labour telephone support has been identified as an extension of the care of the hospital, rather than a perceived obstacle to accessing care, and offers a solution to provide women with support during early labour. The reassurance provided by the service comforted women and gave confidence that they could attend the hospital at the time that felt right for them, with the added benefit of empowering them to remain at home for longer.

Of specific interest was how decisions are made in early labour regarding the timing of face-to-face assessment. This study has provided new opportunity to examine decision-making processes from the perspective of women that contact a service, and the midwives that work on it. Corroboration of findings between women and midwives' experiences generally supports the idea that in this model of care shared decision-making is routine, with women usually being given the choice regarding the timing of assessment. This differs to the findings of previous literature and strengthens the idea that a dedicated telephone support line, situated away from the hospital setting, may facilitate more choice and control for women about their care in early labour. Midwives working in this model felt confident in their ability to make decisions free of the influence of organisational pressures, instead becoming advocates for women and adopting a newly observed role as 'negotiator' with their clinical counterparts.

As a result of this new role, the empirical findings in this study also provide novel understanding of the relationship between midwives working in a non-traditional setting to those working in the clinical setting. For the first time, tensions between clinicians has been identified as they navigate the differing priorities of advocating for women's choice and managing resources. Midwives also experienced tension with women, if their choice regarding place of birth was removed due to service demands. These tensions may be explained by the sense of control midwives or women have over either their workload or care and the visibility of and giving, rather than taking, of work.

Differing care ideologies and priorities for early labour care between 24-hour labour line midwives and hospital midwives may also be observed in this study, with 24-hour labour line midwives more focused on the emotional wellbeing of women than the risk of intervention. Moreover, this study provides useful understanding of the challenges faced by midwives working on a telephone support line, including the weight of responsibility and toll of being the bearer of bad news, for which there appears little acknowledgement of from their midwifery colleagues, leading them to find a sense of belonging with the ambulance control centre staff instead. This research will prove useful in expanding understanding of how professionals

interact when not physically present with each other and when working across multiple organisations.

This study becomes the first qualitative research examining the experiences of women, birth partners and midwives during the COVID-19 pandemic with a focus on early labour. This was not an initial aim of the study but has provided new understanding of the importance of a virtual support service in helping women achieve the right balance to ensure they arrive at the hospital at the right time, but with their partner present with them. Further, the collection of data both before and during the pandemic provided opportunity to capture differences in the perception of care during this period.

Finally, this is the first study to explore the experiences of midwives working in an ambulance control centre. As such, the findings of this study, which explore how they experience this, make a unique contribution to the evidence base. The insights gained from this study may be of assistance in expanding our understanding of how other health-professionals which are based in alternative organisations may experience their work. This includes mental health practitioners supporting the police service, or social workers supporting the ambulance service, for example.

10.3 Implications for clinical practice

The findings of this study have several important implications for future practice. Overall, this study strengthens the idea that a dedicated telephone support line for labour provides a positive experience for women and birth partners. Considering this new evidence, it may be timely for NHS Trusts to review their early labour service provision. While not all organisations may have the ability to collaborate with a local ambulance service, a reasonable approach could be to protect the role of the midwife while situated away from the intrapartum setting, but within the same building. Organisations should be sympathetic to the importance of the 24-hour delivery of such provision, and consider how best to name the service in a way that makes the round-the-clock availability clear to those that will use it.

In light of the tension identified between the 24-hour labour line midwives and their colleagues based at the hospital, attention should be given to improving the culture of communication between the two parties. Participants within this study identified that further education for midwives about the scope of role and responsibility of 24-hour labour line midwives is required to promote shared understanding of the demands faced. The opportunity to shadow the work of the 24-hour labour line midwife may also provide midwives that co-ordinate care within the birthing environment with greater understanding of the scope of the role. This activity should be

considered by senior leadership teams to ensure the psychological safety of staff across the service. Crucially, it is imperative that student midwives have the opportunity to work within the service, to aid their understanding of the role while simultaneously providing them with the telephone assessment skills necessary for clinical practice.

Consideration should be given to implementing a live dashboard in the hospital setting to give midwifery co-ordinators an overview of the number women in communication with the 24-hour labour line. This will support the birthing environments to feel more prepared for the number of women at home in early labour, who, in due course, will be presenting at the hospital for labour care, leading to a better sense of control over workload. This will also support the visibility of the work-as-done by 24-hour labour line midwives, by providing the number of calls already made to the service.

Efforts are needed to reduce the challenges the 24-hour labour line midwives face in undertaking remote assessments of labour. The implementation and evaluation of video-calling during early labour should be a priority to resolve the limitations identified in undertaking telephone assessments.

10.4 Policy implications

The following policy implications are to be considered:

The NHS England (2023) three-year delivery plan for maternity services identified the production of standardised information to aid decision-making during pregnancy and labour as a key aim. While early labour was not identified as a priority topic, the findings of this study, coupled with those of previous research, support the development of standardised information to guide families in early labour and encourage their involvement in decision-making. Current research is underway to evaluate a decision-making tool for early labour (Grylka-Baeschlin et al 2022), which could be utilised in this work.

Most participants in this study experienced control over decisions that were made regarding admission to the birthing environment, and all midwife participants identified giving the woman the final say on this decision as a routine part of their practice. Some multiparous women diverged from this experience, suggesting not all midwives working within the service adopt the same approach. Consequently, it is recommended that this question is integrated into the paperwork midwives use, to trigger clinicians to confirm with the woman their final wishes before ending the call. Further utilisation of Elwyn et al's (2012) three steps to decision-making,

as applied to the 24-hour labour line, will support consistent delivery of shared decision-making across calls.

The NICE (2014) intrapartum guideline included a recommendation for organisations to consider a dedicated midwife for early labour triage. This recommendation was based on the findings of the initial service evaluation by Mackenzie (2014) but was removed from the latest guideline in 2023. This study provides further evidence for this recommendation to be reviewed and, where appropriate, reinstated.

10.5 Study strengths and limitations

10.5.1 Study strengths

The study offers numerous strengths, related both to the original contribution of the research and the methodological design of the study.

First, the study offers several original contributions to the evidence base, as outlined in detail in section 10.2. For the first time, the findings provide insight into the experiences of a dedicated telephone support line for labour, based in an ambulance control centre, for three participant groups. The methodological decision to triangulate experiences provided opportunity to analyse across the three groups for areas of congruence and difference in the interpretation of experience. This enabled a deeper level of analysis, where findings could be strengthened, or challenged, by the experience of another group, to offer a more nuanced understanding of the strengths and limitations of the service. The study also contributes to the limited evidence base exploring birth partners experience of early labour, enabling greater understanding of the importance of a birth partner prior to admission to the birthing environment, and for the first time offers insight into the experiences of midwives working in a non-traditional maternity environment.

The completion of the study during an unprecedented global pandemic is a further strength. The nature of the context at the time meant fast paced changes, which complicated the research methods and triggered the need to navigate changes to the design to ensure compliance with evolving restrictions. To enhance the dependability of the research a clear description of the necessary amendments have been outlined. Successful navigation of these processes led to an accidental strength of the research, which provided opportunity to examine the experience of participants during the COVID-19 pandemic, again contributing new knowledge to the evidence

base of women, birth partners and midwives experiences of early labour in the context of a global pandemic.

IPA was a good choice of methodology to provide rich insight into the lived experience of a dedicated telephone support line for labour, while also appreciating the individual nature of labour and birth. IPA provided in-depth, qualitative insight into the experiences of women, birth partners and midwives of the 24-hour labour line, enabling new recommendations for clinical practice to be formed, while also offering deeper understanding of the meaning of early labour to women and birth partners more broadly.

For the participant group of women, a very good sample size was achieved, which was in line with the recommended number of participants made by Smith et al (2022) for a doctoral study. The sample size was sufficient to provide insightful information of a phenomena from the perspective of those that have experienced it (Gauci 2019). Achieving an adequate sample size afforded opportunity to find similarities and difference in experience, including identifying some participants with outlying experiences, which will be useful in considering further development of the service.

10.5.2 Study limitations

Despite careful consideration to the methodology, as to be expected, there are some limitations to this study. Firstly, this study explored the experiences of the women, birth partners and midwives at a particular point in time, in the context of a service organised in a particular way, limiting the transferability of the research to other settings or other telephone support lines for labour. Intricate differences in the organisation of the service could yield different findings. This has been mitigated by the rich description of the service provided within this thesis, allowing organisations to assess the transferability of the findings to their setting or to support the design of new services.

Arguably, the research also examined two different phenomena – experience of the 24-hour labour line, and experience of the 24-hour labour line during a global pandemic. In view of the COVID-19 pandemic being an unprecedented time, whereby the way in which people usually lived their lives was redesigned (Cornejo et al 2023), and considering the majority of data was collected during this time, there will be some findings that will be less transferable outside of the context of a pandemic. Since the time of data collection there is greater understanding of the impact of the pandemic on people's mental health, with multiple research studies identifying an increase in psychological morbidity for people in the UK (Jia et al 2020; Daly and Robinson 2022; Paul and Fancourt 2022). The increase in mental health conditions was also

reflected in the pregnant population (Kasaven et al 2023), with increasing prevalence of depression, anxiety, stress (Filippetti et al 2022; Tauqeer et al 2023), loneliness and worry (Dib et al 2020) identified among women during the data collection period. Data was not collected during this study to indicate the prevalence of mental health conditions of participants, however in view of the extraordinary global context participants were dealing with at the time, and evidence of the impact of this on mental wellbeing, the transferability of the findings may be affected.

Some findings are also explicitly linked to the context of the pandemic. Examples of this include reference to the comfort of home being related to restrictions on birth partners attendance during labour and isolation requirements. For the midwives, this research was conducted during a period of exceptional demand on clinical staff, as discussed in section 9.4, and therefore the relationships between midwives working in the hospital, and those working on the 24-hour labour line, may not be transferable to post-pandemic clinical practice. To enhance the credibility of the research, it is explicit which participants were recruited before, and which during, the pandemic, which will support readers in assessing the transferability of the findings to their setting.

While necessary to enable the continuation of the research, the change from face-to-face interviews, to remote video interviews, also had the potential to impact the credibility of the findings. There has been little evaluation of the use of video interviewing within the literature (Chandratre and Soman 2020; Roberts et al 2021), however concerns regarding the effectiveness and efficiency of remote video interviews have been noted. Concerns include the ability of researchers to detect non-verbal cues when conducting interviews remotely, even when video functions are utilised, due to the visibility of such cues being limited by what is available on screen (Varma et al 2021; Cornejo et al 2023). Although this has been reflected on in section 4.7, and provisions put in place to mitigate the impact, there is potential that interviews lacked insight that could have been gained by observing and analysing the non-verbal cues gained in face-to-face interviews (Denham and Onwuegbuzie 2013).

Although adequate for IPA, I achieved a small sample size for the birth partners and recruited fathers only. This is unsurprising due to most data being collected during the COVID-19 pandemic, when, due to Government restrictions, contact with wider family members and friends was limited, and hospitals permitted only one birth partner to attend with the woman. Consequently, women tended to attend the birthing environment with their partner, rather than additional family members or friends. In hindsight, the advertisement of the research study on maternity based social media sites may have reduced the likelihood of birth partners being

exposed to the advert when compared to social media sites aimed at this target sample. Even so, there was no locally available social media site specifically for fathers or birth partners that may have been more suitable. Further, while I co-produced the advertising materials with the MNVP, it may have been beneficial to have included service user input from birth partners to yield a greater response from this target population. The initial recruitment strategy included face-to-face signposting by midwives, which was ceased due to the COVID-19 pandemic and was likely to generate a greater response from potential participants. Unfortunately, due to the pandemic, alternative methods of advertising the study away from social media were prevented.

Despite a homogenous group of participants being considered beneficial in an IPA study (Smith et al 2022) the findings of this study will be limited in their transferability to other settings, due to the lack of diverse sociodemographic characteristics within the sample. Participants from the women and birth partner groups were almost exclusively White British people, who spoke English as a first language and had achieved high educational attainment. This results in the lack of representation of people of the global majority, people with lower educational attainment and people for whom English is not their first language, to which the findings of this study are less transferable.

It is particularly important to consider the experiences of women and birth partners who are not fluent in the English language, who are unlikely to recall the same experiences of the 24-hour labour line described in this study. Previous research has acknowledged that language barriers have impeded telephone contact during early labour between midwives and families, resulting in a question and answer approach to the call (Vik et al 2022), as opposed to the more discussion based conversation described within this study. When considering maternity care more broadly, literature concludes that ineffective communication can result in women feeling isolated, fearful or ignored (Higginbottom et al 2019) and unable to understand the information provided to them by healthcare professionals (Henderson et al 2013; Bains et al 2021). Further, within this population there is an increased likelihood of communication via an interpreter, arguably an entirely different phenomenon in itself. Consequently, while the decision to exclude those that were not fluent in English language was necessary for the remit of this study, it is not possible to apply the findings of this study to this demographic, and so when considering service design and development this limitation must be considered, to ensure the needs of those requiring interpretation services are met. How maternity services design early labour support for women may in part depend on the local demographic, as the number of women requiring an interpreter ranges from between 1-25% of women depending on the NHS Trust (MacLellan et al 2024).

The limited diversity in sociodemographic characteristics within the sample may be explained by the design of the study, particularly in relation to the recruitment of participants and data collection methods. Adopting convenience sampling with recruitment via social media may have restricted exposure to those from diverse backgrounds. Literature has consistently identified that health research recruitment using social media results in the over-representation of White people within samples when compared to the general population (Whitaker et al 2017; Benedict et al 2019; Johnson et al 2019; Farr et al 2022). In addition, the aforementioned limitation of the use of remote video interviews may also have discouraged or prevented women and birth partners from broader socio-demographic backgrounds from participating, including through excluding those without digital literacy or the economic ability to access and engage with virtually conducted research (Cornejo et al 2023). It is accepted that these methodological decisions, which were unavoidable in the context of the pandemic, likely led to limited diversity in the sample, and make the findings less transferable to people with different sociodemographic characteristics.

Despite IPA being a good choice of methodology, for reasons outlined in section 10.5.1, the volume of data generated by using this methodology was challenging to manage and time-consuming to analyse within the required timeframe. As previously explored, Smith et al (2022) offers limited guidance on an appropriate number of participants for a doctoral IPA study, while recognising that ten appears to be gaining traction as a large enough sample to manage the idiographic nature of IPA and achieve analysis to the required depth. This study has the added complexity of exploring multiple perspectives, which with a collective sample size of twenty, made following the idiographic steps of analysis time-consuming and the process of looking for patterns across cases and sample groups more complex. Consequently, as predicted by Smith et al (2022), this resulted in less idiographic detail within the write up of the findings, instead with focus on the shared experiences within the Group Experiential Themes. This may have led to greater breadth rather than depth, as sought in IPA (Smith et al 2022), and as foreseen by Larkin et al (2019), the inclusion of multiple perspectives led to difficult decisions regarding what to bring to the foreground and what to omit. To help demonstrate the idiographic element of IPA I have chosen to highlight within the findings examples and storytelling from certain participants, particularly when their experience was divergent to that of other participants. An example of this would be Francesca's experience in relation to decision-making regarding the timing of admission. In hindsight, achieving such a good sample size may have warranted justification for the adoption of a different type of analysis, such as thematic analysis.

My own lived experience of the service could be considered both a strength and limitation to the study. As discussed in section 4.11 and 10.6, this experience and the potential for influence upon the analysis process has been mitigated as far as reasonably possible.

A final limitation is that the 24-hour labour line evolved in 2022 into the Maternity Triage Line. While the location of the service has not changed, and the staffing numbers have increased, the scope of calls has also expanded to include non-labour related called from 20 weeks' gestation. Suspected labour calls and queries regarding spontaneous rupture of membranes now make up on average between 40-50% of all activity in the service, which takes on average 100 calls per day (Maternity Triage Line 2023). While the service still serves a purpose in supporting women in early labour, it is difficult to measure the impact on women's experiences or the potential for increased pressure on midwives which may hinder the transferability of this study to the current organisation of the service.

10.6 Reflexivity – my role as researcher, midwife and mother

As previously explained, I am approaching this research through the lens of researcher, midwife and mother, and as such reflexivity has been especially important to identify my assumptions, and their possible influence on the data, as far as possible. I have a unique perspective as I am an insider in both the woman and midwife participant groups - that is, I am studying a group, to which I also belong.

Firstly, while developing the research proposal for this project in 2013 I worked as a midwife on the 24-hour labour line. This was a conscious decision to enhance the credibility of the research through prolonged engagement. A consequence is that it is possible that some of the midwife participants may have known this, though the likelihood of this is reduced due to the amount of time that passed between my experience and data collection. If they were cognisant, it is possible they may have tried to portray their practice as fully aligned to the initial ethos of the service, knowing I would be aware of it.

Take the theme about decision-making as an example – my findings suggest that midwives gave women the choice regarding whether to stay at home or attend the clinical environment for face-to-face assessment. This is what you would expect of a “good” midwife, who is working in line with their professional code of conduct and the philosophy of the service. When viewed critically, it could be suggested that the midwives engaged in “identity performance” – that is they wanted to portray the best possible identity of a midwife to me during the interviews, rather than reflecting the complete truth of what may happen in practice. A limitation of any research

is response bias, the idea that participants may perform for the researcher, and tell them what they want to hear, but this may be furthered when they are interviewed by an “insider”. The use of triangulation, through exploring the experiences of multiple perspectives, helped as most women in this study corroborated this finding, increasing the trustworthiness of the conclusions drawn. In comparison, the women have less reason to present their experience of decision-making as anything different to that it was, increasing the credibility of the finding.

When I reflect on my experiences of working on the 24-hour labour line, I note that I did not experience many of the challenges that the midwives did. Rather, in my reflective diary, I am surprised during the data analysis process how challenging the role appeared to be. This may be telling of the evolution of the service since 2013, with the role of the midwives developing further than simply providing support to women in early labour. One aspect that was particularly important to consider was my interactions with clinical colleagues at the hospital sites. The midwives in this study experienced questioning of their professional judgement, and while this is not something that I recall from my personal experience, I do remember frequently being apologetic to clinical colleagues when referring women into the unit and feeling partly intimidated by the reaction I may receive. This could be considered a sign of empathy for their workload pressures, as is found in this study.

Next, I consider my role as a mother. All participants were aware of my professional qualification as a midwife, but in hindsight I considered it important to reflect on whether they knew I was a mother and whether they realised I was pregnant at the time of the interviews. To preserve professionalism, I do not recall telling them this before the interview, and a benefit of the interviews being conducted on Microsoft Teams™ meant it was not physically noticeable, as it would be in person. I may have discussed this afterwards, in view of the question of whether I was a parent myself being a frequent one, though this would not have influenced the data collected. Had they known, it may have impacted the data in that they may have tried to protect me from poor experiences of the service, or labour, to reduce my own personal concerns about an impending experience. Further, knowing my role as a midwife, they may have been less inclined to be critical of a service that they saw me inherently part of.

My own experience of the service as a mother is also worth contemplating. I needed to consider my assumptions about the service as a midwife, and later as a parent. From referencing my thoughts on the 24-hour labour line, I do not see an obvious difference in my view from before or after accessing the service. My ideas of the service before I became a mother was that, while valuable to women, it may not be the best use of a midwife’s time to provide the service. This

was a view I maintained after having contacted the service myself – it was a nice-to-have and functional aspect of care, but not a critical part of my labour journey.

An area of further development for me professionally will be experience in making field notes during face-to-face interviews. My ability to develop this skill and navigate the challenge of listening to the participant with making my own notes, was hindered by the pandemic moving the interviews onto Microsoft Teams™. Having the recording of the interview to replay was valuable in considering how the tone of voice coupled with body languages or gestures by the participants conveyed meaning. I found this particularly difficult to capture in the face-to-face interviews and wonder the extent of which this impacted the analysis for these participants. Equally, the interviews conducted online also removed the ability to assess the language of the participants whole body, as it was common for only their faces and shoulders to show.

10.7 Recommendations for future research

After concluding the contribution made by this research study, recommendations to develop this work further include:

1. Due to the complications posed by the COVID-19 pandemic I was unable to undertake the dyadic aspect of my study, examining the same episode of care from the perspective of both the pregnant woman and the midwife she spoke to. As described, the interview of Nathan and Mabel together in this project led to further insight that may not have been explored had they been interviewed separately. Now restrictions related to the pandemic are lifted, the recording of conversations on the Maternity Triage Service provides opportunity for this research and would contribute valuable understanding of the perspectives of women and midwives of the same conversation. This may enable further exploration of the differing perspectives of women and midwives highlighted in this, and other, studies. Further triadic interviews with the woman, birth partner and midwife would be uniquely insightful in exploring the decision-making processes in early labour from multiple perspectives.
2. The final piece of the puzzle in exploring experience related to the 24-hour labour line would be to interview midwives within the birthing environments, particularly in view of the tension between them and the 24-hour labour line midwives that has been identified in this study. It may also be valuable to explore the experiences of ambulance control centre staff, paramedics and NHS 111 staff, to form an overall picture of the interactions between 24-hour labour line midwives and other professionals.

3. There is a paucity of recent research exploring women and birth partners' experiences of early labour, particularly related to telephone interaction with midwives, however the experiences of people from diverse socio-demographic backgrounds are more lacking. Further research exploring the experiences of people of a range of ethnicities, sexual orientation and socio-economic backgrounds will enhance the evidence base in this area. Only one study (Vik et al 2022), which explores the experiences of migrant Somali women in Norway, explores the experiences of women from a particular demographic. If maternity services plan to further advance their telephone triage and support systems, attention must be paid to the experiences of those who are non-native English speakers or speak and/or understand little or no English language. Research exploring the experiences of using telephone interpretation services is pertinent in ensuring the design of future services. This is especially important in view of Vik et al (2022) concluding that interpretation services need strengthening.
4. The findings of this study suggest the 24-hour labour line is evolving to offer video-calling. Existing research has explored the perspectives of women (Borrelli et al 2023a) and midwives (Spiby et al 2019 and Borrelli et al 2023b) of video-calling during early labour. The 24-hour labour line provides a convenient opportunity to launch and evaluate the implementation of video-calling for early labour support and assessment, complimenting the existing evidence-base. This research has identified the role of the 24-hour labour line in supporting families that have contacted either NHS 999 or 111 services with a maternity related health concern. A consideration for future research is how women and their birth partner experience the support provided in these circumstances, and that of BBA. In addition, midwife participants in Borrelli et al (2023b) expressed that emergency services should continue to deal with emergency calls if video-calling was implemented, so the evaluation of this aspect of the 24-hour labour line midwives role is also advised if video-calling is executed.
5. Further exploration of the experiences of birth companions, such as mothers, sisters or friends, of supporting women in labour, may be beneficial in further expanding the evidence base around birth partners' experiences of early labour.
6. In view of challenges to the cost effectiveness and efficiency of the 24-hour labour line, a priority should be thorough cost-benefit analysis prior to national or international implementation of a service, especially considering the current constraints on staffing within the NHS. This would include evaluation of the Maternity Triage Line, including any impact on the provision for support in early labour.

10.8 Final remarks

This is the first research study that, using IPA, explores the experiences of women, birth partners and midwives of using a dedicated telephone support line for labour, including exploration of the decision-making process undertaken to determine the timing of admission. The findings have broadened understanding of the experiences of women and birth partners when early labour care is provided in this way. Midwives' experiences have been explored, and the challenges to the role they undertake identified.

For the first time, this research has observed and documented positive experiences of women and birth partners using a dedicated telephone support line during early labour. These findings provide evidence that this service offers reassurance, and more control to women during early labour, with midwives acting as an advocate for their choices. This sense of control promotes a better experience for women in early labour, enhancing their emotional wellbeing and creating a more positive birthing experience. Paired with the increased acceptability of remote or virtual support services as a result of the pandemic, this new evidence offers valuable insights to NHS Trusts and policy makers when considering the implementation of such a service.

Further, the study has revealed and documented the role of the midwife within the 24-hour labour line as a negotiator and advocate for women, and the resulting tensions with clinical colleagues in the hospital setting. It highlights a lack of visibility and understanding of the work undertaken by midwives on the 24-hour labour line, and recommends that improved education around the scope of the role and responsibilities of these midwives would help alleviate these tensions. Recommendations include the opportunity to shadow 24-hour labour line midwives and the implementation of a live dashboard within the hospital setting to provide better oversights of potential incoming workload.

Finally, this study is the first of its kind to identify that a dedicated telephone support line enables midwives to deliver a holistic, woman-centred model of care in early labour, free from organisational pressures within a hospital setting. While this has also highlighted tensions between clinical teams, it evidences the value of a dedicated telephone support service for achieving women-centred care during this uncertain period, as families start their labour journey to meeting their baby.

Appendix A Overview of databases

Database	Description
CINAHL	Bibliographic database hosting over 4,900 journals from the nursing and allied health field (EBSCO Health n.d)
EMBASE	Bibliographic database containing over 32 million global references, published since 1947, from the biomedical field (Elsevier 2017).
MEDLINE	Bibliographic database containing over 25 million global references, published since 1966, from the life sciences and biomedical field (U.S. National Library of Medicine 2018).
PsycINFO	Bibliographic database containing over 4.5 million references from almost 2,000 journals from the behavioral and social science fields (American Psychological Association n.d)
SCOPUS	Bibliographic database containing over 71 million global references from over 23,000 journals, from the health sciences, social sciences, life sciences and physical sciences field (Elsevier 2018).
Web of Science	A platform providing access to 33,000 journals (Clarivate Analytics 2018)

Appendix B Combination searches

	MEDLINE	CINAHL	Web of Science	PsycINFO	EMBASE	Scopus	
S1: Latent AND phase AND labo?r	83	34	66	3	343	27	
S2: Latent AND stage AND labo?r	39	14	26	5	187	4	
S3: Early AND labo?r	2432	528	4552	502	14964	553	
S4: S1 OR S2 OR S3	2500	555	4598	506	15274	579	
S5: Telephon* OR phon* OR call* OR triag* OR contact* OR communicat*	1,133,762	257,469	2,436,345	562,984	1401861	2,160,746	
S6: S4 AND S5	216	86	351	61	895	17	TOTAL: 1,626
Limit to 1998-2017	188	84	321	56	768	16	TOTAL: 1,433

Appendix B

	MEDLINE	CINAHL	Web of Science	PsycINFO	EMBASE	Scopus	
S1: Latent AND phase AND labo?r	83	34	66	3	343	27	
S2: Latent AND stage AND labo?r	39	14	26	5	187	4	
S3: Early AND labo?r	2432	528	4552	502	14964	553	
S4: S1 OR S2 OR S3	2500	555	4598	506	15274	579	
S5: midwife OR midwives OR midwifery OR maternity	68025	48,990	23439	12,013	53221	84,654	
S6: S4 AND S5	307	147	233	18	887	60	TOTAL: 1,652
Limit to 1998-2017	257	139	216	18	792	52	TOTAL: 1,474

Appendix C Example Critical Appraisal Skills

Programme critique

Critical Appraisal Skills Programme (n.d) - Checklist for Qualitative Research

Paper for appraisal: Eri, T.S., Blystad, A., Gjengedal, E., and Blaaka, G. (2010) 'Negotiating credibility: first-time mothers' experiences of contact with the labour ward before hospitalisation', Midwifery, 26(6), pp. e25-e30. Available at: https://doi.org/10.1016/j.midw.2008.11.005		
Was there a clear statement of the aims of the research?	Yes	Comments: Clearly identifies that the objective is to explore nulliparous women experiences of contact with labour ward prior to admission in Norway. The research was justified due to the absence of previous research exploring women's experiences of encounters with hospital midwives during early labour. It was not explained thoroughly why this is important - more because there is a gap in the lit
Is a qualitative methodology appropriate?	Yes	Comments: A qualitative methodology is appropriate as the research was interested in exploring experience.
Was the research design appropriate to address the aims of the research?	No	Comments: There is no underpinning methodology identified in this study and no justification for the methods included. This provides little insight into the researcher's ontological and epistemological view of the world.
Was the recruitment strategy appropriate to the aims of the research?	Yes	Comments: The paper clearly explained how women were recruited to the study at antenatal classes. It is arguably not best to recruit prior to labour as knowing experiences are being explored may change the experience/heighten senses. This was required for diaries however this was not

Appendix C

		reported on within this paper. There is no information regarding why some women chose not to participate. The inclusion criteria was appropriate in addressing the aims of the study.
Was the data collected in a way that addressed the research issue?	Yes	Comments: 3 methods were used (diaries, observation and interview) though paper only reports findings from interviews. A good background to interview was provided – women were encouraged to tell their story and the researcher then revisited areas of interest. No example of follow up questions were provided. The use of interviews was not justified, however are an appropriate form of data collection for the aim of the study. Interviews were recorded, the length and location was included and appropriate. Partners were present for some interviews which could impact findings but this was not acknowledged. There was no mention of data saturation.
Has the relationship between researcher and participants been adequately considered?	No	Comments: No consideration. No methods of reflexivity were reported, impacting the credibility of the study.
Have ethical issues been taken into consideration?	Yes	Comments: Ethical approval was gained. Consent was gained and confidentiality maintained. Oral and written information was given to enable women to provide informed consent. Good ethical consideration observed.
Was the data analysis sufficiently rigorous?	Yes	Comments: Thorough description of data analysis was provided. A large sample size for qualitative research was achieved. No examples of data analysis provided. Verbatim quotes support themes and align to the conclusions drawn.

Appendix C

Is there a clear statement of findings?	Yes	Comments: Findings are explicit. The credibility of the research is discussed and no adoption of methods such as participant validation or analysis by more than one researcher. No mention of strategies to improve trustworthiness. Findings are discussed in relation to original research question.
How valuable is the research?	Valuable	Comments: It addresses a gap in knowledge. It does not identify areas for future research, but provides understanding of women's experiences at home during early labour, including of their interactions with midwives at the hospital.

Appendix D CASP Checklist Summary Table

	Cheyne et al (2006)	Cheyne et al (2007)	Barnett et al (2008)	Carlsson et al (2009)	Eri et al (2010)	Nolan and Smith (2010)	Eri et al (2011)	Carlsson et al (2012)
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes – though very little information provided	Yes	Yes – however the ethics of recruiting on the telephone during labour is not considered	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes – would benefit from justification for telephone interviews	Yes	Yes

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Has the relationship between researcher and participants been adequately considered?	No – not acknowledged	No – not acknowledged	No – not acknowledged	No – not acknowledged	No – not acknowledged	Yes	No – not acknowledged	No – not acknowledged
Have ethical issues been taken into consideration?	Yes - though no discussion around the ethics of offering a financial incentive to participants	Yes	Yes	Yes	Yes	Yes – however questions over the ethics of recruiting via telephone during labour	Yes	Yes
Was the data analysis sufficiently rigorous?	Yes	No - little information provided on method of analysis	No - method identified but limited information on process provided	Yes	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable

Appendix D

	Larkin et al (2012)	Spiby et al (2014)	Shallow et al (2018)	Roberts and Spiby (2020)	Myhre et al (2021)	Vik et al (2022)	Mueller and Grylka-Baeschlin (2023)	
Was there a clear statement of the aims of the research?	Yes	Yes	No – clear aims are not stated and it was unclear throughout whether the focus was on women or midwives	Yes	Yes	Yes	Yes	
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Was the recruitment strategy appropriate to the aims of the research?	Yes	Can't tell – recruitment strategy not outlined	Can't tell – multiple methods outlined, unclear if all were adopted or different methods were	Yes	Yes	Yes	Yes	

Appendix D

			used to target different groups. The recruitment processes for women are outlined despite paper focusing on midwives perspectives.					
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Has the relationship between researcher and participants been adequately considered?	Yes	No – not acknowledged	Yes	No – not acknowledged	No – not acknowledged	No – not acknowledged	No – not acknowledged	
Have ethical issues been taken into consideration?	Can't tell – some ethical issues considered, but no approval from an ethics committee was noted and no discussion around the	Yes – limited information provided besides ethical approval	Yes	Yes	Yes	Yes	Yes	

Appendix D

	ethics of offering a financial incentive to participants							
Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
How valuable is the research?	Somewhat valuable due to limited focus on early labour	Valuable	Valuable	Valuable	Valuable	Valuable	Valuable	

Appendix D

RCT CASP tool	Janssen and Desmarais (2013b)	Systematic Review CASP tool	Beake et al (2018)	Eri et al (2015)
Did the trial address a clearly focused issue?	Yes	Did the review address a clearly focused question?	Yes	Yes
Was the assignment of patients to treatments randomised?	Yes	Did the authors look for the right type of papers?	Yes	Yes
Were all of the patients who entered the trial properly accounted for at its conclusion?	Yes	Do you think all the important, relevant studies were included?	Yes	Yes
Were patients, health workers and study personnel 'blind' to treatment?	No – this was not possible due to the nature of the intervention.	Did the review's authors do enough to assess quality of the included studies?	Yes	Yes – though no discussion about the quality of literature.
Were the groups similar at the start of the trial?	Yes	If the results of the review have been combined, was it reasonable to do so?	Yes	Yes
Aside from the experimental intervention, were the groups treated equally?	Yes	What are the overall results of the review?	18 synthesised findings were identified to answer the primary and secondary research questions.	5 emergent core concepts; • Finding out if labour has started is absorbing • Dealing with labour at home • Trying to arrive at the labour ward at the right time • There is always a risk of being sent home

Appendix D

				Encountering health professionals arouses strong emotions These core concepts were synthesised as “A balancing act in an unknown territory”
How large was the treatment effect?	Treatment effect not measured – objective of study was to compare experience. Women’s experience of early labour care was significantly more positive for women that received a home visit (p=0.01). Perceptions of Nursing Care was significantly higher for the home visit group (p=0.001). No significant difference was noted in emotional wellbeing or emotional distress.	How precise are the results?	Thorough process for synthesising the literature outlined.	Thorough process for synthesising the literature outlined.
How precise was the estimate of the treatment effect?	Treatment effect not measured– objective of study was to compare experience. Measures were mean score and standard deviation.	Can the results be applied to the local population?	Yes	Yes
Can the results be applied to the local population, or in your context?	Yes – to note that women returning the questionnaire were more likely to be educated and have attended antenatal education.	Were all important outcomes considered?	Yes	Yes

Appendix D

Were all clinically important outcomes considered?	Yes – other clinical outcomes are reported in separate publication (Janssen et al 2003). This study appropriately considered the outcome of experience.	Are the benefits worth the harms and costs?	n/a for systematic review concerned with experience.	n/a for metasynthesis as concerned with experience.
Are the benefits worth the harms and costs?	Can't tell – further literature required exploring outcomes and experience to establish if the cost is worth the benefit of home assessment. This study suggests women in home visit group are more satisfied, but not why, and does not find that women in the telephone group were dissatisfied.			

Appendix E Information sheet - signposting midwives

Information Sheet for Signposting Midwives

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 03.06.2018

Version: 2

Thank you for supporting this research study taking place at [Trust name]. The research explores the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour (the 24 hour labour line). **Please ensure you read this sheet prior to signposting women or birth partners to the study.**

Women and their birth partners will be signposted to the study by [NHS Trust] midwives, and this information sheet aims to provide you with further information about signposting.

- You can signpost women and their birth partners to this research study during the postnatal period.
- You can hand the woman and/or birth partner the information pack and inform them that the research is taking place.
- The inclusion criteria state that women and birth partners can be included in the study if 'signposting midwives consider them to be psychologically and physiologically able to participate'. Please use your professional discretion regarding whether or not the woman or birth partner is able to participate and how appropriate it is for you to give them the information pack.
- Included in the information pack is a leaflet with basic information about the study, a more detailed participant information sheet and a contact detail slip.
- **You are not recruiting potential participants to the study. You are not able to talk through the participant information sheet with the woman or her birth partner, answer questions about the study, attempt to consent a potential participant or give guidance regarding whether or not a woman/birth partner should participate.**
- You simply need to give the information pack and a brief sentence explaining what it relates to, for example 'This study is taking place at this NHS Trust, if you have any questions or are interested in participating please contact the research team, or complete the contact details slip attached'

- The participant information sheet provides women and birth partners will contact details to have any questions answered.
- You are able to accept the contact detail slips from women or their birth partners if they complete them. Please place these in the dedicated envelope ready for collection by the research team.
- Once you have given a woman and/or the birth partner the information, please ensure you place a dedicated sticker in her notes so that this information is not given to her multiple times. The stickers are located with the information packs.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Midwifery Programme Lead / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email: E.L.Kitson-Reynolds@soton.ac.uk

Appendix F Leaflet for birth partners

UNIVERSITY OF
Southampton

Did you phone the 24 hour labour line for your partner / friend / family member during labour?

**If so – would you be interested in
taking part in a research study?**

We are looking for birth partners to take part in research about their experience of phoning the 24 hour labour line while supporting their partner / friend / family member during labour. You can take part if;

You are aged 18 or over and contacted the '24 hour labour line' in the last 12 weeks while supporting a friend or family member during their labour

**Taking part aims to help us improve care for
women and birth partners in the future.**

To find out more about the research or to take part please contact Marie Naish on the contact below or complete a contact details slip and hand to a midwife;

**men1v07@soton.ac.uk
02380 597851**

Ethics reference number: 168418 Version: 2 Date: 03.06.2018

Appendix G Leaflet for women



Did you phone the 24 hour labour line in labour?

If so – would you be interested in
taking part in a research study?

We are looking for women to take part in research about
their experience of phoning the 24 hour labour line at home
during labour. You can take part if;

- You are aged 18 or over
- You had a baby in the last 12 weeks
- You phoned the '24 hour labour line' during your labour

Taking part aims to help us better understand women's
experience and improve care for women and their families
in the future.

To find out more about the research or to take part please
contact Marie Naish on the contact below or complete a
contact details slip and hand to a midwife;

men1v07@soton.ac.uk
02380 597851

Ethics reference number: 168418 **Version:** 2 **Date:** 03.06.2018

Appendix H Participant information sheet - birth partners

Participant Information Sheet

(Birth Partners)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 03.09.2018

Version: 4

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a practicing midwife with over 4 years of clinical experience. This research will form my PhD at the University of Southampton. My supervisors at the University of Southampton are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [Trust name] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. This research aims to explore the experiences of birth partners that have called the 24 hour labour line. It is important that health professionals understand how birth partners experience the service because they are an important source of support for women at home during labour. Having a better understanding about birth partners experience means midwives can improve the care women and their birth partners receive and help better prepare birth partners for labour. Another part of the study will explore the experiences of women and midwives of the service.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to take part in this research because:

- You are aged 18 or over
- You supported a friend or family member at home during labour in the last 12 weeks

- You contacted the '24 hour labour line' while supporting a friend or family member during their labour while they were at home

Do I have to take part?

No. It is your decision whether to take part in the study and this decision will not affect your current or future health care.

What will happen to me if I take part?

If you decide to take part in the research the researcher (Marie Naish) will interview you once about your experience of contacting the 24 hour labour line while supporting your friend or family member at home during labour. You can choose if the interview takes place at your home, [Hospital name], [Hospital name] or [Hospital name]. The interview will last for between 30-60 minutes. The interview will be digitally recorded.

The researcher will also collect some demographic data (such as your relationship to the woman, age and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Are there any benefits in my taking part?

There may not be any direct benefits to you in taking part; however the findings from the study will help healthcare professionals understand and improve care for women and their birth partners in the future.

Are there any risks involved?

There are no direct risks involved in taking part in the study. Although unlikely, some participants may become upset during the interview. If this happens the researcher will offer to stop the interview and recommend you contact an appropriate healthcare professional, such as your GP, for further support.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Any information that could identify you, such as your name will not be included on any research reports and an alternative name will be chosen for you. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously with other researchers. The data will later be destroyed following University guidelines.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future health care.

What happens if I have a question or concern?

If you have a question or concern about the study at any time, you should speak to the researcher, Marie Naish, who will answer your questions (Address: Building 45 Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you have a concern or a complaint about this study you should contact the Research Governance Office (Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ; Tel: +44 (0)23 8059 5058; Email: rgoinfo@soton.ac.uk. If you remain unhappy and wish to complain formally the Research Governance Office can provide you with details of the University of Southampton Complaints Procedure.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and University of Southampton ethics committee.

What do I need to do next?

If you are interested in taking part, or would like further information, you can complete the contact detail slip attached and hand it to a midwife. The researcher (Marie Naish) will contact you using the information provided. The researcher will try and contact you twice (two-three weeks and five-six weeks after birth). On the second occasion, if there is no answer, the researcher will either leave a message or email you, and will not contact you again unless you phone/email back. The contact detail slip will be destroyed two weeks after leaving the message.

Alternatively, you can contact Marie to register your interest in the research using the contact details below.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 45
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851
Email: men1v07@soton.ac.uk
2) Dr Ellen Kitson-Reynolds

Midwifery Programme Lead / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email : E.L.Kitson-Reynolds@soton.ac.uk

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at <http://www.southampton.ac.uk/assets/sharepoint/intranet/Is/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf>

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for

the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix I Participant information sheet - women

Participant Information Sheet

(Women)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 03.09.2018

Version: 4

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a practicing midwife with over 4 years of clinical experience. This research will form my PhD at the University of Southampton. My supervisors at the University of Southampton are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [Trust name] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. My research aims to explore the experiences of women that call the 24 hour labour line during labour and their experience of talking with the midwife. It is important that health professionals better understand how women experience the service so that the care of women at home during labour can be improved in the future. Another part of the research will look at the experiences of birth partners and midwives.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to take part in this research because:

- You are aged 18 or over
- You had a baby in the last 12 weeks
- You contacted the '24 hour labour line' during your labour

Do I have to take part?

No. It is your decision whether to take part in the study and this decision will not affect your current or future health care. Participating in the research will not change your current plan of care.

What will happen to me if I take part?

If you decide to take part in the research, there will be two stages. You do not have to take part in both stages of the research. Both stages involve having an interview with the researcher (Marie Naish) and you can choose if this takes place at your home, at [Hospital name], [Hospital name] or [Hospital name]. Each interview will last for between 30-60 minutes. The interview will be digitally recorded.

The researcher will also collect some demographic data (such as your type of delivery, age and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Stage I

The researcher (Marie Naish) will interview you about your experience of contacting the 24 hour labour line during labour. At the end of the interview, you will be asked if you would be interested in taking part in stage II of the research.

Stage II

The researcher (Marie Naish) will interview you about the conversation you had with the midwife on the telephone during labour. All calls to the '24 hour labour line' are recorded. The researcher will use the recordings of the conversation you had with the midwife to transcribe (type up and print out) part of the conversation and will bring this to the interview. The researcher will ask you questions about how you felt about what the midwife said, how this helped you at home and how you wanted the midwife to interpret what you said to them.

Not all women will be asked to take part in stage II. This is because the research is interested at looking at the conversation from the point of view of you *and* the midwife. Whether you are contacted to take part will depend on whether the midwife you spoke to has chosen to take part too. You will be contacted if you have been chosen to take part.

The midwife will not be told what you have said during your interview. The interviews will only be concerned about what was discussed during the telephone call and no additional information about you will be shared.

Are there any benefits in my taking part?

There may not be any direct benefits to you in taking part; however the findings from the study will help healthcare professionals understand and improve care for women in the future.

Are there any risks involved?

There are no direct risks involved in taking part in the study. If you are affected by talking to Marie about your experience you can phone the [Trust name] Birth Reflections service for further support. The Birth Reflections service helps you talk through your experience and have any unanswered questions addressed. Birth Reflections can be contacted on: [redacted telephone number]. The researcher can stop the interview at any time if you do not want to continue.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Any information that could identify you, such as your name will not be included on any research reports and an alternative name will be chosen for you. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously with other researchers. The data will later be destroyed following University guidelines.

If you decide to, and are chosen to participate in stage II of the research this means the midwife you spoke to has decided to participate too. There is a possibility that you may remember the name of the midwife you spoke to, and that she may remember you. This means that the midwife may know that you are participating in the research. As you will both be given an alternative name this will reduce the likelihood that the midwife could identify what you said during the research, and that you could identify what the midwife said. It is important that you understand that participating, even if the midwife remembers you, will have no impact on your current and future healthcare.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future health care.

What happens if I have a question or concern about the research?

If you have a question or concern about the study at any time, you should speak to the researcher, Marie Naish (Address: Building 45, Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you have a concern or want to make a complaint, you should contact the Head of the Governance Office, at the Research Governance Office (Address: Building 37, University of Southampton, Highfield, Southampton, SO17 1BJ; Tel: +44(0)2380 595058; Email: rgoinfo@soton.ac.uk) who will provide you information about the University of Southampton Complaints Procedure.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and the University of Southampton.

What do I need to do next?

If you are interested in taking part, or would like further information, you can complete the contact detail slip attached and hand it to a midwife. The researcher (Marie Naish) will contact you using the information provided. The researcher will try and contact you twice (two-three weeks and five-six weeks after birth). On the second occasion, if there is no answer, the researcher will either leave a message or email you, and will not contact you again unless you phone/email back. The contact detail slip will be destroyed two weeks after leaving the message.

Alternatively, you can contact Marie to register your interest in the research using the contact details below.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 45
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Bachelor of Midwifery Programme Lead / Supervisor of Midwives / Lecturer in
Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email: E.L.Kitson-Reynolds@soton.ac.uk

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This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

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Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

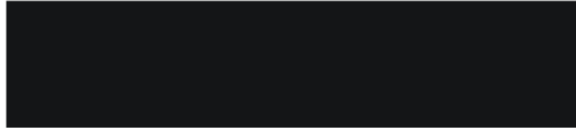
To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix J Contact details slip



UNIVERSITY OF
Southampton

Ethics reference number: 168418

Version: 3

Date: 03.06.2018

An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Thank you for taking the time to read about this research. If you would like to learn more or you are interested in taking part and would be happy for the researcher, Marie Naish, to contact you, please fill in the details below and hand it to a midwife. Please note: filling out this form does not mean you have to take part.

Name:

Birth date of baby:

Email address:

Telephone number:

If you are a birth partner delete as appropriate:

Relation to woman: Partner / Family member / Friend / Other

Appendix K Recruitment social media post



24 HOUR LABOUR LINE STUDY

**HAVE YOU OR YOUR PARTNER GIVEN BIRTH WITHIN THE
LAST 12 WEEKS?**

DID YOU CALL THE 24 HOUR LABOUR LINE DURING LABOUR?

**IF THE ANSWER TO BOTH THESE QUESTIONS IS 'YES', WE
WOULD LOVE TO HEAR FROM YOU!**

▼

We are looking for women and birth partners to take part in research about their experience of phoning the 24 hour labour line at home during labour. This would involve taking part in a remote interview.

If you are interested in hearing more about the study, please follow this link:

<https://www.isurvey.soton.ac.uk/38697>

or contact Marie Naish on men1v07@soton.ac.uk
02380 597851

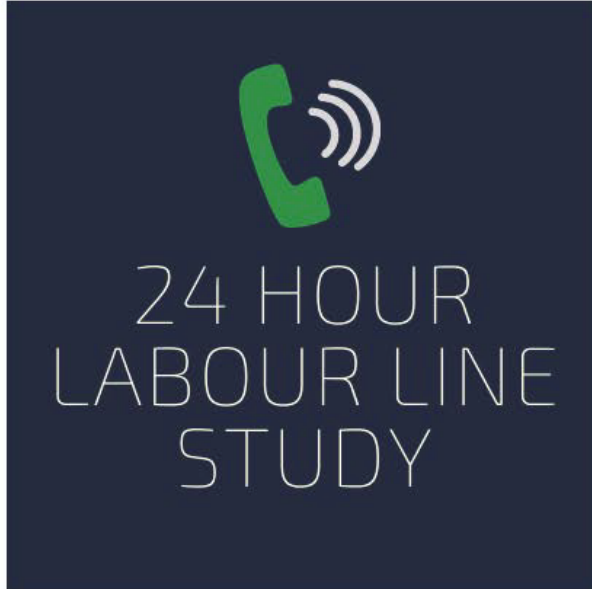
Thank you. We look forward to hearing from you!

Ethics number: 168418 Version 1 12.11.2020

Appendix L Recruitment survey

12/11/2020

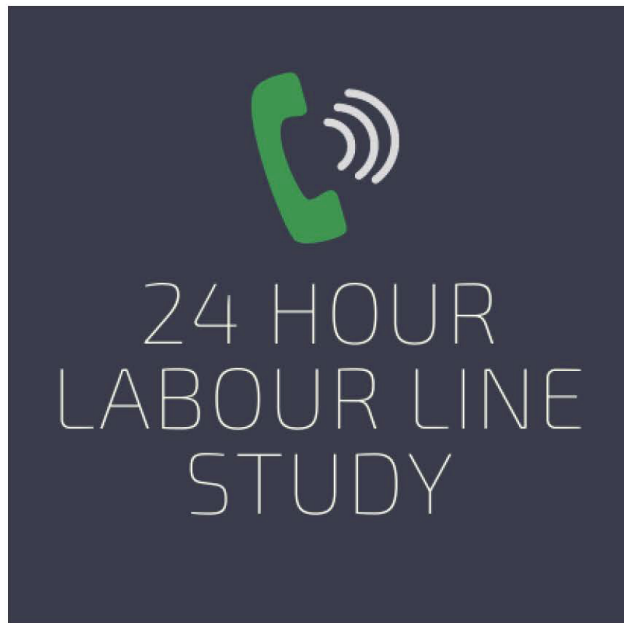
iSurvey - Online Questionnaire Generation from the University of Southampton



24 Hour Labour Line Research Study

☐ Thank you for your interest in the 24 Hour Labour Line Research Study. My research aims to explore the experiences of women and birth partners that call the 24 hour labour line during labour and their experience of talking with the midwife. It is important that health professionals better understand how women and birth partners experience the service so that the care of women, and support of birth partners, at home during labour can be improved in the future. The researcher (Marie Naish) will interview you about your experience of contacting the 24 hour labour line during labour. This survey will ask you some questions to enable the researcher, Marie Naish, to contact you to talk more about the study and what would be involved if you decided to participate. Please tick (check) the box to the left to indicate that you consent to providing this information.

[Click here to start this survey](#)



24 Hour Labour Line Research Study

1. About you

Thank you for your interest in the 24 Hour Labour Line Research Study. My research aims to explore the experiences of women and birth partners that call the 24 hour labour line during labour and their experience of talking with the midwife. It is important that health professionals better understand how women and birth partners experience the service so that the care of women, and support of birth partners, at home during labour can be improved in the future. The researcher (Marie Naish) will interview you about your experience of contacting the 24 hour labour line during labour.

This section will ask you some questions to enable the researcher, Marie Naish, to contact you to talk more about the study and what would be involved if you decided to participate.

You do not have to participate if you complete this survey, you are simply expressing an interest about hearing more.

For information about how the University of Southampton collects and uses your personal information when you take part in one of our research projects, please see our Privacy Notice [using this link](#).

Ethics number: 168418 - Version 1 - 12/11/2020

Question 1.

What is your name?

Question 2.

Appendix L

02/12/2020

iSurvey - Online Questionnaire Generation from the University of Southampton

What date was your baby born?

1 / January / 2021

Question 3.

Where did you/your partner birth your baby?

Please select one of the following options, using the information below to help you:

Please select

Question 4.

Are you aged over 18 years?

Please select

Question 5.

What is your telephone number?

Question 6.

What is your email address?

Question 7.

If you are a birth partner, please select your relationship to the woman

Please select

Survey Progress

Start  Finish

Save and Finish

Once this button is pressed you will not be able edit your responses
You haven't answered all the questions on this page

Save and Finish Anyway

Once this button is pressed you will not be able edit your responses

<https://www.isurvey.soton.ac.uk/questions.php>

2/2

Appendix M Revised participant information sheet - birth partners

Participant Information Sheet (Birth Partners)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 10.11.2020

Version: 5

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a practicing midwife. This research will form my PhD at the University of Southampton. My supervisors at the University of Southampton are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [NHS Trust] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. Later, [NHS Trust] collaborated on the project. This research aims to explore the experiences of birth partners that have called the 24 hour labour line. It is important that health professionals understand how birth partners experience the service because they are an important source of support for women at home during labour. Having a better understanding about birth partners experience means midwives can improve the care women and their birth partners receive and help better prepare birth partners for labour. Another part of the study will explore the experiences of women and midwives of the service.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to take part in this research because:

- You are aged 18 or over
- You supported a friend or family member at home during labour in the last 12 weeks
- You contacted the '24 hour labour line' while supporting a friend or family member during their labour while they were at home

Do I have to take part?

No. It is your decision whether to take part in the study and this decision will not affect your current or future health care.

What will happen to me if I take part?

If you decide to take part in the research the researcher (Marie Naish) will interview you once about your experience of contacting the 24 hour labour line while supporting your friend or family member at home during labour. The interview will take place remotely, via a video or telephone call, at a time convenient to you. The interview will last for between 30-60 minutes. The interview will be digitally recorded. This recording will be destroyed after the researcher has transcribed (typed up) the recording and quality checked this.

The researcher will also collect some demographic data (such as your relationship to the woman, age and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Are there any benefits in my taking part?

There may not be any direct benefits to you in taking part; however the findings from the study will help healthcare professionals understand and improve care for women and their birth partners in the future.

Are there any risks involved?

There are no direct risks involved in taking part in the study. Although unlikely, some participants may become upset during the interview. If this happens the researcher will offer to stop the interview and recommend you contact an appropriate healthcare professional, such as your GP, for further support.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Any information that could identify you, such as your name will not be included on any research reports and an alternative name will be chosen for you. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously with other researchers. The data will later be destroyed following University guidelines.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future health care.

What happens if I have a question or concern?

If you have a question or concern about the study at any time, you should speak to the researcher, Marie Naish, who will answer your questions (Address: Building 67 Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you have a concern or a complaint about this study you should contact the Research Governance Office (Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ; Tel: +44 (0)23 8059 5058; Email: rgoinfo@soton.ac.uk). If you remain unhappy and wish to complain formally the Research Governance Office can provide you with details of the University of Southampton Complaints Procedure.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and University of Southampton ethics committee.

What do I need to do next?

If you are interested in taking part, or would like further information, you can contact the researcher, or the researcher will contact you, depending what you have agreed at initial contact.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851 / [redacted telephone number]
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Midwifery Programme Lead / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email : E.L.Kitson-Reynolds@soton.ac.uk

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at <http://www.southampton.ac.uk/assets/sharepoint/intranet/Is/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf>

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information – may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix N Revised participant information sheet - women

Participant Information Sheet (Women)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 10.11.2020

Version: 5

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a practicing midwife. This research will form my PhD at the University of Southampton. My supervisors at the University of Southampton are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [NHS Trust] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. Later, [NHS Trust] collaborated on the project. My research aims to explore the experiences of women that call the 24 hour labour line during labour and their experience of talking with the midwife. It is important that health professionals better understand how women experience the service so that the care of women at home during labour can be improved in the future. Another part of the research will look at the experiences of birth partners and midwives.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to take part in this research because:

- You are aged 18 or over
- You had a baby in the last 12 weeks
- You contacted the '24 hour labour line' during your labour

Do I have to take part?

No. It is your decision whether to take part in the study and this decision will not affect your current or future health care. Participating in the research will not change your current plan of care.

What will happen to me if I take part?

If you decide to take part in the research, you will have an interview with the researcher (Marie Naish) about your experience of contacting the 24 hour labour line during labour. The interview will take place remotely, via a video or telephone call, at a time convenient to you. The interview will last for between 30-60 minutes. The interview will be digitally recorded. This recording will be destroyed after the researcher has transcribed (typed up) the recording and quality checked this.

The researcher will also collect some demographic data (such as your type of delivery, age and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Are there any benefits in my taking part?

There may not be any direct benefits to you in taking part; however the findings from the study will help healthcare professionals understand and improve care for women in the future.

Are there any risks involved?

There are no direct risks involved in taking part in the study. If you are affected by talking to Marie about your experience you can phone the [NHS Trust] Birth Reflections service or [NHS Trust] Birth Afterthoughts for further support. The Birth Reflections/Afterthoughts services helps you talk through your experience and have any unanswered questions addressed. Birth Reflections can be contacted on: [telephone number] and Birth Afterthoughts on: [telephone number]. The researcher can stop the interview at any time if you do not want to continue.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Any information that could identify you, such as your name will not be included on any research reports and an alternative name will be chosen for you. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously with other researchers. The data will later be destroyed following University guidelines.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future health care.

What happens if I have a question or concern about the research?

If you have a question or concern about the study at any time, you should speak to the researcher, Marie Naish (Address: Building 67, Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you have a concern or want to make a complaint, you should contact the Head of the Governance Office, at the Research Governance Office (Address: Building 37, University of Southampton, Highfield, Southampton, SO17 1BJ; Tel: +44(0)2380 595058; Email: rgoinfo@soton.ac.uk) who will provide you information about the University of Southampton Complaints Procedure.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and the University of Southampton.

What do I need to do next?

If you are interested in taking part, or would like further information, you can contact the researcher, or the researcher will contact you, depending what you have agreed at initial contact.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851/ [redacted telephone number]
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Bachelor of Midwifery Programme Lead / Supervisor of Midwives / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email: E.L.Kitson-Reynolds@soton.ac.uk

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take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at <http://www.southampton.ac.uk/assets/sharepoint/intranet/Is/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf>

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information – may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix O Poster for midwives



**Are you a midwife working
on the 24 hour labour line?**

Ethics reference number 168418 Version:3 Date: 12.11.2020

**We are looking for midwives to
participate in research about their
experience of working on the 24 hour
labour line.**

What is in it for you?

- An opportunity to help improve care for women
and their families in the future
 - A £30 voucher
- Learn more about and contribute to research
 - Reflect on your own clinical practice

To find out more about the research please contact
Marie Naish on:

- **men1v07@soton.ac.uk**
- **02380 597851**

Appendix P Participant information sheet - midwives

Participant Information Sheet (Midwives)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 03.09.2018

Version: 4

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a midwife with over 4 years of clinical experience. This research will form my PhD at the University of Southampton. My supervisors are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [Trust name] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. This research aims to explore the experiences of midwives working on the 24 hour labour line and how they understand and process the communication between them and women. It is important that we understand how midwives experience working on the 24 hour labour line so that we can improve the care provided to women and birth partners at home during labour and better support midwives in their role.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to participate in this research as:

- You are a qualified midwife working at [NHS Trust]
- You have worked on the '24 hour labour line' in the last 12 weeks

Do I have to take part?

No. You are under no obligation to take part in the study and this decision will not affect your current or future employment or promotion.

What will happen to me if I take part?

If you decide to take part in the research, there will be two stages. You do not have to participate in both stages of the research. Both stages involve having an interview with the researcher (Marie Naish) and you can choose if this takes place at your home, [Hospital name], [Hospital name] or [Hospital name] or [Ambulance Trust name] offices. You can choose whether you would prefer to have two separate, shorter interviews, or one longer interview. Two separate interviews will last for between 30-60 minutes each. One longer interview will last for up to 90 minutes. The interview will be recorded.

The researcher will also collect some demographic data (such as the length of time you have been qualified, your age range and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Stage I

The researcher (Marie Naish) will interview you about your experience of working on the 24 hour labour line.

Stage II

The researcher (Marie Naish) will interview you about the conversation you had with a woman on the telephone that was at home during labour. The researcher will have transcribed (typed up and printed out) the conversation you had and will bring this to the interview. The researcher will ask you questions about how you felt about what the woman said, how you interpreted what the woman said and how you wanted the woman to interpret what you said.

Not all midwives will be asked to participate in stage II. This is because the research is interested at looking at the conversation from the point of view of both you and the woman. Whether you are invited to take part will depend on whether a woman you spoke to has chosen to participate too. You will be informed if you have been chosen to take part in stage II.

The woman will not be told what you have said during your interview. The interviews will only be concerned about what was discussed during the telephone call and no additional information about you will be shared.

Are there any benefits in my taking part?

There may not be any direct benefits to you in taking part; however the findings from the study will help healthcare professionals understand and improve care for women in the future and further understand the communication between midwives and women at home during labour.

Are there any risks involved?

There are no direct risks involved in taking part in the study. Although unlikely, some participants may become upset during the interview. If this happens the researcher

will offer to stop the interview and recommend you contact an appropriate healthcare professional for further support.

Will my participation be confidential?

Yes. Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Your colleagues or manager will not be informed of your participation in the study. Any information that could identify you, such as your name will not be included on any research reports. You will be given an alternative name so that you cannot be identified. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously with other researchers. The data will later be destroyed following University guidelines.

If you decide to, and are chosen to participate in stage II of the research this means a woman you spoke to has decided to participate too. There is a possibility that you may remember the woman you spoke to, and that she may remember you. This means that the woman may know that you are participating in the research. As you will both be given an alternative name this will reduce the likelihood that the woman could identify what you said during the research, and that you could identify what the woman said.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future employment or promotion.

What happens if I have a question or concern?

If you have a concern about the study at any time, you should speak to the researcher, Marie Naish, who will answer your questions (Address: Building 45, Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you continue to be concerned or want to make a complaint, you should contact Head of the Governance Office, at the Research Governance Office (Address: Building 37, University of Southampton, Highfield, Southampton, SO17 1BJ; Tel:

+44(0)2380 595058; Email: rgoinfo@soton.ac.uk) who will provide you information about the University of Southampton Complaints Procedure.

The researcher (Marie Naish) is a midwife registered with the Nursing and Midwifery Council. In the unlikely event that she has any concerns about the clinical care provided by you to women she has a duty to respond to this and '*act without delay if you believe that there is a risk to patient safety or public protection.*' (Nursing and Midwifery Council 2015 pg 12). In this unlikely scenario the researcher will encourage you to speak personally to your Professional Midwifery Advocate. If you feel unable to do this, you will be supported by the researcher in making contact.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and University of Southampton ethics committee.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 45
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Midwifery Programme Lead / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email: E.L.Kitson-Reynolds@soton.ac.uk

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This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

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Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix Q Revised participant information sheet - midwives

Participant Information Sheet (Midwives)

Study Title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher: Marie Naish (PhD student and midwife)

Ethics number: 168418

Date: 10.11.2020

Version: 5

I would like to invite you to take part in my research study. Please read this information carefully before deciding to take part. I will go through this information sheet with you to help you decide and answer any questions you may have. If you are happy to take part you will be asked to sign a consent form.

What is the research about?

My name is Marie Naish and I am a midwife with over 4 years of clinical experience. This research will form my PhD at the University of Southampton. My supervisors are Dr Ellen Kitson-Reynolds and Dr Jane Prichard.

In 2013 [NHS Trust] launched an advice and support telephone line for women and their birth partners to call from home during labour. The telephone line is called the '24 hour labour line'. Later, [NHS Trust] and [NHS Trust] collaborated on the project. This research aims to explore the experiences of midwives working on the 24 hour labour line and how they understand and process the communication between them and women. It is important that we understand how midwives experience working on the 24 hour labour line so that we can improve the care provided to women and birth partners at home during labour and better support midwives in their role.

Service users have helped develop the research design and reviewed the participant information sheets.

Why have I been chosen?

You have been chosen to participate in this research as:

- You are a qualified midwife working at on the 24 hour Labour Line
- You have worked on the '24 hour labour line' in the last 12 weeks

Do I have to take part?

No. You are under no obligation to take part in the study and this decision will not affect your current or future employment or promotion.

What will happen to me if I take part?

If you decide to take part in the research you will have an interview with the researcher (Marie Naish) about your experience of working on the 24 hour labour line. The interview will take place remotely, via a video call, at a time convenient to you. The interview will last up to 60 minutes. The interview will be recorded. This recording will be destroyed after the researcher has transcribed (typed up) the recording and quality checked this.

The researcher will also collect some demographic data (such as the length of time you have been qualified, your age range and ethnicity) at the interview. This data will be anonymised so that it cannot be linked back to you. You do not have to give the researcher this information if you would prefer not to.

Are there any benefits in my taking part?

If you participate in either stage of the research you will be given a £30 shopping voucher. This will be provided to you after the interview. The voucher aims to compensate you for the time you provide giving insight into your experiences.

The findings from the study will help healthcare professionals understand and improve care for women in the future and further understand the communication between midwives and women at home during labour.

Are there any risks involved?

There are no direct risks involved in taking part in the study. Although unlikely, some participants may become upset during the interview. If this happens the researcher will offer to stop the interview and recommend you contact an appropriate healthcare professional for further support.

Will my participation be confidential?

Yes. Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Your colleagues or manager will not be informed of your participation in the study. Any information that could identify you, such as your name will not be included on any research reports. You will be given an alternative name so that you cannot be identified. Short quotes from the interview may be included in publications and you may be able to recognise yourself from this, however others will not be able to recognise you. The data recorded during the study will be stored on a password protected computer or in a locked filing cabinet. The data will be stored and may be used to support other research in the future. The data may be shared anonymously

with other researchers. The data will later be destroyed following University guidelines.

What happens if I change my mind?

You can withdraw from the study at any time, without giving a reason. If you withdraw we will destroy any identifiable information you have provided, but we would need to use the data collected up to your withdrawal if this had already been anonymised. Withdrawal from the study will not affect your current or future employment or promotion.

What do I need to do next?

If you are interested in taking part, or would like further information, please contact Marie Naish on men1v07@soton.ac.uk or [redacted telephone number].

What happens if I have a question or concern?

If you have a concern about the study at any time, you should speak to the researcher, Marie Naish, who will answer your questions (Address: Building 67, Faculty of Health Sciences, University of Southampton, Highfield, Southampton, SO17 1BJ; Telephone: 02380 597851 Email: men1v07@soton.ac.uk)

If you continue to be concerned or want to make a complaint, you should contact Head of the Governance Office, at the Research Governance Office (Address: Building 37, University of Southampton, Highfield, Southampton, SO17 1BJ; Tel: +44(0)2380 595058; Email: rgoinfo@soton.ac.uk) who will provide you information about the University of Southampton Complaints Procedure.

The researcher (Marie Naish) is a midwife registered with the Nursing and Midwifery Council. In the unlikely event that she has any concerns about the clinical care provided by you to women she has a duty to respond to this and '*act without delay if you believe that there is a risk to patient safety or public protection.*' (Nursing and Midwifery Council 2015 pg 12). In this unlikely scenario the researcher will encourage you to speak personally to your Professional Midwifery Advocate. If you feel unable to do this, you will be supported by the researcher in making contact.

Who has reviewed the study?

The study has been approved by the NHS ethics committee and University of Southampton ethics committee.

Where can I get more information?

For more information about the study, or to ask any questions, please contact a member of the team below:

1) Marie Naish
PhD Student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851 / [redacted telephone number]
Email: men1v07@soton.ac.uk

2) Dr Ellen Kitson-Reynolds
Midwifery Programme Lead / Lecturer in Midwifery
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597846
Email: E.L.Kitson-Reynolds@soton.ac.uk

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at <http://www.southampton.ac.uk/assets/sharepoint/intranet/Is/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf>

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change,

or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (<https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page>) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix R Recruitment email - midwives

Dear Midwives,

I am looking for midwives that work on the 24 hour labour line to participate in my research. I am interested in your experience of working on the 24 hour labour line and talking to women and partners at home during labour.

If you decide to take part in the research you will have an interview with the researcher (Marie Naish) about your experience of working on the 24 hour labour line. The interview will take place remotely, via a video call, at a time convenient to you. The interview will last up to 60 minutes. The interview will be recorded.

If you participate in the research you will be given a £30 shopping voucher. This will be provided to you after the interview. The voucher aims to compensate you for the time you provide giving insight into your experiences.

For further information about the research please see the attached 'Participant Information Sheet'.

If you are interested in participating, or would like more information about the research please do not hesitate to contact me on the contact details below;

Marie Naish
men1v07@soton.ac.uk (preferable email address)
02380 597851

Ethics number: 168418
Version: 3
Date: 12.11.2020

Best wishes,

Marie Naish
Midwifery Lecturer / PhD Student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
Telephone: 02380 597851
Email: men1v07@soton.ac.uk

Appendix S Interview schedule

Phase I – Interviews

- Welcome participant
- Offer participant a drink (dependent on interview location) and ensure they are comfortable (for remote interviews: Ensure they are comfortable and have everything they may need/want, for example a drink)
- Revisit the participant information leaflet and explain the aim of the research and what particular aspects the research is interested in
- Explain that the interview will be digitally recorded
- Sign the consent form (for remote interviews: Ensure the signed consent form has been received and revisit the consent form to ensure consent is still given)
- Ensure participant is aware they can withdraw or withdraw their data at any stage of the study
- Explain the purpose of note taking during the interview

Phase I – Stage I - Prompts for women

These prompts do not need to be in this order – but are present for the researcher as a memory aid. Further notes will be made during the interview when the researcher wants to return to a point a participant has touched on.

- ‘Tell me about your experience at home during labour’.
- ‘Tell me about your experience contacting the 24 hour labour line at home during labour’
- ‘Tell me about the decision to go to the hospital/birth centre/get the midwife to come to your home’
- ‘Tell me about how involved you felt in making the decision to go to the hospital/birth centre/get the midwife to come to your home’
- Did you want to make the decision to go to the hospital/birth centre/get the midwife to come to your home?’

At the end of the interview with women they will be reminded of the process for phase II of the study and asked if they consent to be involved. If so, phase II

consent form will be signed (this is completed at this point to confirm consent for transcription of the tapes). The women will be informed that the researcher will contact them to inform them if they have been selected for phase II.

Phase I – Stage II - Prompts for birth partners

These prompts do not need to be in this order – but are present for the researcher as a memory aid. Further notes will be made during the interview when the researcher wants to return to a point a participant has touched on.

- ‘Tell me about your experience of supporting your partner/friend/relative at home during labour’
- ‘Tell me about your experience contacting the 24 hour labour line for your partner/friend/relative’s home during their labour’

Appendix T Ethical approval



28 May 2015

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.
REC reference: 15/SC/0175
Protocol number: 12863
IRAS project ID: 168418

The Research Ethics Committee reviewed the above application at the meeting held on 12 May 2015. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant, Miss Lidia Gonzalez on nrescommittee.southcentral-hampshirea@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Research Ethics Committee established by the Health Research Authority

1. In reference to the Participant Information Sheet (Birth Partners), under the heading "What will happen to me if I take part?" please amend the sentence, "Both interviews..." as earlier in the paragraph it states that participants will only be interviewed once.
2. In reference to the participant information sheet, please state that the participant will be contacted twice and specify the approximate time frame.
3. Please provide an approximate maximum number for the sample size of the study.
4. Please provide reassurance that once the study is reported there would be no way to identify individual midwives with regards to demographics.
5. In reference to Participant Information Sheet (Women), under "Why have I been Chosen?" please amend the sentence so it reads, "You had a baby in the last..."
6. Consent Form for Birth Partners, statement 5 asks for permission to access data collected during the study. It is not clear why access is needed to the companions/birth partners' health records. This should be revised if it is a cut and paste error, if not then an explanation should be provided as to why the health records of partners will be accessed.
7. The PIS for participants mentions that the research team will be contacting GPs for further information. The Committee agreed that the participants should also be informed that their companions/partners may also be approached for further information over the next 2 years. There should also be some guidance provided with regards to the kind of information that might be collected.
8. As discussed at the meeting, if mothers who had experienced traumatic births are to be included, then there should be formal process to handle a situation if after the interviews the mother is distressed or if any other problems are highlighted.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

The sponsor is asked to provide the Committee with a copy of the notice from the MHRA, either confirming no objection or giving grounds for objection, as soon as this is available.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Summary of discussion at the meeting

Social or scientific value; scientific design and conduct of the study

The Committee noted that question A59 of the IRAS application form mentioned the sample size as 5>, which could include a very large number.

You replied that you were reluctant to give a number as you weren't sure and requested to get back to the Committee with more details.

Favourable risk benefit ratio; anticipated benefit/risks for research participants (present and future)

The Committee noted (as mentioned in the application form question A6-2) recordings would be used for quality and training purposes. The Committee asked if the research would interfere with the normal use of the recordings in this study.

You clarified that there was no ongoing audit of the calls and they were very rarely listened to.

The Committee noted that the demographic information of the midwives may also be collected. The Committee asked whether this was necessary.

You replied that demographics might be valuable in setting the scene in regards to the experience the midwives. It was however not an urgent requirement.

The Committee asked you whether there was a robust method to screen out mothers who had experienced traumatic births.

You explained that the midwives would choose appropriate mothers to be included in the study, and in addition you would also make a decision as to whether they were suitable. However the as researcher, you were keen to hear from mothers with a range of experiences, and experiencing a traumatic birth would not necessarily be an exclusion criteria if the mother was otherwise willing to participate.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Committee asked you to clarify whether the midwives would have to participate in their own time given that the research had been commission by their employer.

You replied that there had not yet been any in-depth discussions as to whether it would be from the midwives own time or work time. You mentioned that the initial discussions suggested that using their own time not being an issue.

With reference to information provided under question A-31 of the IRAS application form, the Committee requested clarity on how many times the research team would try to make contact with the potential participants.

You clarified that they would be called twice before they were excluded or alternatively they would be able to contact the research team if they were interested.

Suitability of the applicant and supporting staff

The Committee asked whether you were prepared to offer clinical advice or support as new parents would have a host of questions not related to the study.

You stated that you would make it clear that you were there only in a research capacity and would direct them back to the clinical care team who would be in a better position to answer their questions. However, if there were any general queries then those would be dealt with on case by case or individual basis.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Copies of advertisement materials for research participants [Leaflet for women]	1	25 March 2015
Copies of advertisement materials for research participants [Leaflet for birth partner]	1	25 March 2015

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Copies of advertisement materials for research participants [Poster for Midwives]	1	25 March 2015
Copies of advertisement materials for research participants [Contact detail slips]	1	25 March 2015
Covering letter on headed paper [Covering Letter]	1	02 March 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Insurance]	1	05 March 2015
Interview schedules or topic guides for participants [Interview schedule]	1	24 February 2015
IRAS Checklist XML [Checklist_25032015]		25 March 2015
Letter from sponsor [Copy of letter of sponsorship email]	1	05 March 2015
Other [Peer Review Evidence]	1	07 November 2014
Other [Proof of Enrolment at University of Southampton]	1	27 January 2015
Other [University of Southampton Risk Assessment Documents]	1	16 December 2014
Other [Timeline for project]	4	24 February 2015
Other [Data Management Plan]	1	24 February 2015
Other [Ellen Kitson-Reynolds Research CV]	1	24 December 2014
Other [Sticker for notes]	1	25 March 2015
Participant consent form [Consent form Women Phase I]	1	25 March 2015
Participant consent form [Consent form Phase II Women]	1	25 March 2015
Participant consent form [Consent form Midwives Phase I]	1	25 March 2015
Participant consent form [Consent form Phase II Midwives Stage II]	1	25 March 2015
Participant consent form [Consent form Birth Partners]	1	25 March 2015
Participant information sheet (PIS) [Participant Information Sheet Women]	1	13 February 2015
Participant information sheet (PIS) [Participant Information Sheet Birth Partner]	1	12 February 2015
Participant information sheet (PIS) [Participant Information Sheet Midwives]	1	14 February 2015
REC Application Form [REC_Form_06032015]		06 March 2015
Research protocol or project proposal [Research Proposal]	1	25 March 2015
Summary CV for Chief Investigator (CI) [Marie Nott Research CV]	1	03 February 2015
Summary CV for student [Marie Nott Research CV]	1	03 February 2015
Summary CV for supervisor (student research) [Dr Nicola Jarrett Research CV (Supervisor)]	1	24 December 2014

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

Research Ethics Committee established by the Health Research Authority

- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/SC/0175

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Simon Kolstoe
Chair

E-mail: nrescommittee.southcentral-hampshirea@nhs.net



Health Research Authority

NRES Committee South Central - Hampshire A

Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1381
Fax: 0117 342 0445

09 July 2015

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

REC reference: 15/SC/0175

Protocol number: 12863

IRAS project ID: 168418

Thank you for your letter of 09 July 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 28 May 2015

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Contact detail slips]	2	26 June 2015
IRAS Checklist XML [Checklist_09072015]		09 July 2015
Other [REC Response Letter]	1	26 June 2015
Participant consent form [Consent form Birth Partners]	2	29 May 2015
Participant consent form [Consent form Women Phase I]	2	26 June 2015
Participant consent form [Consent form Phase II Women]	2	26 June 2015
Participant consent form [Consent form Midwives Phase I]	2	26 June 2015
Participant consent form [Consent form Phase II Midwives Stage II]	2	26 June 2015
Participant information sheet (PIS) [Participant Information Sheet Women]	2	29 May 2015

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Participant information sheet (PIS) [Participant Information Sheet Birth Partner]	2	29 May 2015
Participant information sheet (PIS) [Participant Information Sheet Midwives]	2	26 June 2015
REC Application Form [REC_Form_09072015]		09 July 2015
Research protocol or project proposal [Research Proposal]	2	26 June 2015

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Leaflet for women]	1	25 March 2015
Copies of advertisement materials for research participants [Leaflet for birth partner]	1	25 March 2015
Copies of advertisement materials for research participants [Poster for Midwives]	1	25 March 2015
Copies of advertisement materials for research participants [Contact detail slips]	2	26 June 2015
Covering letter on headed paper [Covering Letter]	1	02 March 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Insurance]	1	05 March 2015
Interview schedules or topic guides for participants [Interview schedule]	1	24 February 2015
IRAS Checklist XML [Checklist_09072015]		09 July 2015
Letter from sponsor [Copy of letter of sponsorship email]	1	05 March 2015
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Other [Data Management Plan]	1	24 February 2015
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Other [REC Response Letter]	1	26 June 2015
Participant consent form [Consent form Women Phase I]	2	26 June 2015
Participant consent form [Consent form Phase II Women]	2	26 June 2015
Participant consent form [Consent form Midwives Phase I]	2	26 June 2015
Participant consent form [Consent form Phase II Midwives Stage II]	2	26 June 2015
Participant consent form [Consent form Birth Partners]	2	29 May 2015
Participant information sheet (PIS) [Participant Information Sheet Women]	2	29 May 2015
Participant information sheet (PIS) [Participant Information Sheet Birth Partner]	2	29 May 2015
Participant information sheet (PIS) [Participant Information Sheet Midwives]	2	26 June 2015
REC Application Form [REC_Form_09072015]		09 July 2015

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Research protocol or project proposal [Research Proposal]	2	26 June 2015
Summary CV for Chief Investigator (CI) [Marie Nott Research CV]	1	03 February 2015
Summary CV for student [Marie Nott Research CV]	1	03 February 2015
Summary CV for supervisor (student research) [Dr Nicola Jarrett Research CV (Supervisor)]	1	24 December 2014

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/SC/0175	Please quote this number on all correspondence

Yours sincerely



Maxine Knight
Rec Manager

E-mail: nrescommittee.southcentral-hampshirea@nhs.net



Health Research Authority

South Central - Hampshire A Research Ethics Committee

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Whitefriars
Lewins Mead
Bristol
BS1 2NT

Tel: 0117 342 1381
Fax: 0117 342 0445

27 December 2015

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.
REC reference: 15/SC/0175
Protocol number: 12863
Amendment number: 1
Amendment date: 19 November 2015
IRAS project ID: 168418

The above amendment was reviewed the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP) [168418 887667 13 989 47284 AmendmentForm_snapshot]	1	19 November 2015
Other [168418 V1 Demographic information of birth partners]	1	19 November 2015
Other [168418 V1 Demographic information of midwife participants]	1	19 November 2015
Other [168418 v1 Demographic information of woman participants]	1	19 November 2015
Other [168418 V1 Information sheet for signposting midwives]	1	02 October 2015
Other [168418 V1 Recruitment Email to Midwives]	1	19 November 2015

Participant information sheet (PIS) [168418 V1 Letter for birth partner participants]	1	02 October 2015
Participant information sheet (PIS) [168418 V1 Letter for women participants]	1	02 October 2015
Research protocol or project proposal [168418 V3 Research Proposal Highlighted, superceded]	3	13 November 2015

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/SC/0175:	Please quote this number on all correspondence

Yours sincerely



pp

Vice Chair
Dr Ronja Bahadori

E-mail: nrescommittee.southcentral-hampshirea@nhs.net



South Central - Hampshire A Research Ethics Committee

Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT
Tel: 020 7104 8049

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

12 July 2018

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

REC reference: 15/SC/0175

Protocol number: 12863

Amendment number: 3

Amendment date: 11 June 2018

IRAS project ID: 168418

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date

Appendix T

Copies of advertisement materials for research participants [168418 V2 Poster MIDWIVES HHFT.pdf]	2	03 June 2018
Notice of Substantial Amendment (non-CTIMP) [AmendmentForm_ReadyForSubmission.pdf]	3	11 June 2018
Other [168418 V1 Letter for birth partner participants HHFT logo.pdf]	1	02 October 2015
Other [168418 V1 Letter for women participants HHFT logo.pdf]	1	02 October 2015
Other [168418 V2 Data Management Plan.pdf]	2	03 June 2018
Other [168418 V2 Information sheet for signposting midwives .pdf]	2	03 June 2018
Other [168418 V2 Leaflet Birth Partners HHFT.pdf]	2	03 June 2018
Other [168418 V2 Leaflet women HHFT.pdf]	2	03 June 2018
Other [168418 V2 Recruitment Email to Midwives.docx]	2	03 June 2018
Other [168418 V3 Contact detail slips HHFT logo.pdf]	3	03 June 2018
Participant consent form [168418 V3 Consent form Birth Partners .pdf]	3	03 June 2018
Participant consent form [168418 V3 Consent form Midwives Phase II stage I Interview .pdf]	3	03 June 2018
Participant consent form [168418 V3 Consent form Midwives Phase II Stage II .pdf]	3	03 June 2018
Participant consent form [168418 V3 Consent form WOMEN .pdf]	3	03 June 2018
Participant consent form [168418 V3 Consent form Women Phase II .pdf]	3	03 June 2018
Participant information sheet (PIS) [168418 V3 Participant information sheet for BIRTH PARTNER.pdf]	3	03 June 2018
Participant information sheet (PIS) [168418 V3 Participant information sheet for MIDWIVES.pdf]	3	03 June 2018
Participant information sheet (PIS) [168418 V3 Participant information sheet for WOMEN.pdf]	3	03 June 2018
Research protocol or project proposal [168418 V4 Research Proposal.pdf]	4	03 June 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/SC/0175:	Please quote this number on all correspondence

Yours sincerely
PP



South Central - Hampshire A Research Ethics Committee

Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT
Tel: 020 7104 8049

26 March 2019

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.
REC reference: 15/SC/0175
Protocol number: 12863
Amendment number: 4 07.03.2019
Amendment date: 07 March 2019
IRAS project ID: 168418

The Sub Committee considered an amendment as the Chief investigator is due to maternity leave on 25th March 2019 and for this reason has suspended their studies from this date, until 23rd March 2020.

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP) [15 SC 0175 Substantial Amendment 15-03-2019]	4 07.03.2019	07 March 2019
Other [M.Naish Spec_Cons_suspension_approved]		19 December 2018
Other [MNSpec_Cons_extension_candidature]		23 January 2019

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

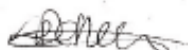
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

15/SC/0175:	Please quote this number on all correspondence

Yours sincerely
PP



Dr Ronja Bahadori
Vice Chair

E-mail: nrescommittee.southcentral-hampshirea@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Miss Marie Nott*

South Central - Hampshire A Research Ethics Committee

Temple Quay House
2 The Square
Temple Quay
Bristol
BS1 6PN

Tel: 0207 104 8019

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

22 December 2020

Miss Marie Nott
University of Southampton, Faculty of Health Sciences
Building 67
Southampton
SO171BJ

Dear Miss Nott

Study title:	An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.
REC reference:	15/SC/0175
Protocol number:	12863
Amendment number:	12863.A8
Amendment date:	22.12.2020
IRAS project ID:	168418

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Completed Amendment Tool [168418_12863.A8_17Nov2020_Locked01Dec20_112315]	1	01 December 2020
Copies of materials calling attention of potential participants to the research [168418 V3 Poster MIDWIVES]	3	12 November 2020
Copies of materials calling attention of potential participants to the research [168418 V3 Leaflet Birth Partners]	3	12 November 2020
Copies of materials calling attention of potential participants to the research [168418 V3 Leaflet women]	3	12 November 2020
Copies of materials calling attention of potential participants to the research [168418 V3 Recruitment Email to Midwives]	3	12 November 2020
Copies of materials calling attention of potential participants to the research [168418 V1 Social Media Post]	1	12 November 2020
Other [168418 V3 Letter for women participants]	3	10 November 2020
Other [168418 V1 iSurvey]	1	12 November 2020
Participant consent form [168418 V4 Consent form WOMEN]	4	12 November 2020
Participant consent form [168418 V4 Consent form Midwives]	4	12 November 2020
Participant consent form [168418 V4 Consent form Birth Partners]	4	12 November 2020
Participant information sheet (PIS) [168418 V5 Participant information sheet for MIDWIVES]	5	10 November 2020
Participant information sheet (PIS) [168418 V5 Participant information sheet for BIRTH PARTNER]	5	10 November 2020
Participant information sheet (PIS) [168418 V5 Participant information sheet for WOMEN]	5	10 November 2020
Research protocol or project proposal [168418 V5 Research Proposal]	5	15 November 2020

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

IRAS Project ID - 168418:

Please quote this number on all correspondence

Yours sincerely



Dr Simon Kolstoe
Chair

E-mail: hampshirea.rec@hra.nhs.uk

Enclosures:

List of names and professions of members who took part in the review

Copy to:

Miss Marie Nott

Appendix U Overview of study suspension timeline

	J	F	M	A	M	J	J	A	S	O	N	D
2013												
2014												
2015												
2016												
2017										employment		
2018	employment											
2019			maternity leave									
2020	maternity leave			COVID-19								
2021						maternity leave						
2022	maternity leave											
2023												

Appendix V Consent form - birth partners

CONSENT FORM

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher name: Marie Naish

Date: 12.11.2020

Study phase: Birth Partners

Version: 4

Ethics reference: 168418

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (10.11.2020/version 5) and have had the opportunity to ask questions about the study which have been answered satisfactorily. I have been given a copy of the information sheet to keep.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study and educational purposes.	
I understand my participation is voluntary and I may withdraw at any time without this affecting my medical care or legal rights.	
I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers	
I understand that relevant sections of data collected during the study, may be looked at by regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access.	
I understand that the researcher may use direct quotes I make in publications about the research, but that I will not be able to be identified through these quotes.	
I know how to contact the research team if I need to.	

I understand that taking part in the study involves audio and/or video recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	

Name of participant (print name).....

Signature of participant.....

Name of Researcher (print name)

Signature of Researcher..... Date.....

Appendix W Consent form - women

CONSENT FORM

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher name: Marie Naish

Date: 12.11.2020

Study phase: Women

Version: 4

Ethics reference: 168418

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (10.11.2020/version 5) and have had the opportunity to ask questions about the study which have been answered satisfactorily. I have been given a copy of the information sheet to keep.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study and educational purposes.	
I understand my participation is voluntary and I may withdraw at any time without this affecting my medical care or legal rights.	
I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers	
I understand that relevant sections of my medical notes and data collected during the study, may be looked at by regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I understand that the researcher may use direct quotes I make in publications about the research, but that I will not be able to be identified through these quotes.	
I know how to contact the research team if I need to.	

I understand that taking part in the study involves audio and/or video recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	

Name of participant (print name).....

Signature of participant.....

Name of Researcher (print name)

Signature of Researcher.....Date.....

Appendix X Consent form - midwives

CONSENT FORM

Study title: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Researcher name: Marie Naish

Date: 12.11.2020

Study phase: Midwives

Version: 4

Ethics reference: 168418

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (10.11.2020/version 5) and have had the opportunity to ask questions about the study which have been answered satisfactorily. I have been given a copy of the information sheet to keep.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study and educational purposes.	
I understand my participation is voluntary and I may withdraw at any time without this affecting my medical care or legal rights.	
I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers	
I understand that relevant sections of data collected during the study, may be looked at by regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access.	
I understand that the researcher may use direct quotes I make in publications about the research, but that I will not be able to be identified through these quotes.	
I know how to contact the research team if I need to.	

I understand that taking part in the study involves audio and/or video recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	

Name of participant (print name).....

Signature of participant.....

Name of Researcher (print name)

Signature of Researcher..... Date.....

Appendix Y Letter for participants – birth partners

Dear

Re: Research study: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Thank you for participating in the above research study. As discussed, your participation in this research will be anonymous, and therefore your healthcare providers will not be aware of your participation.

You may feel that your participation in this research is relevant to your current or future healthcare, and therefore you are welcome to present this letter confirming your participation to your healthcare providers (such as your GP), now or in the future. Please note that if you give this letter to your healthcare provider, they will know that you have participated in the study, but not what you have said.

Thank you again for your participation in this study.

Yours sincerely,

Marie Naish
PhD student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
02380 597851
men1v07@soton.ac.uk

Ethics number: 168418

Date: 03.06.2018

Version: 2

Letter for participating birth partners

Appendix Z Letter for participants - women

Dear

Re: Research study: An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.

Thank you for participating in the above research study. As discussed, your participation in this research will be confidential, and therefore your healthcare providers will not know that you have participated.

You may feel that your participation in this research is relevant to your current or future healthcare, and therefore you are welcome to present this letter, which confirms your participation, to your healthcare providers (such as your midwife or your GP), now or in the future. Please note that if you give this letter to your healthcare provider, they will know that you have participated in the study, but not what you have said.

If you are affected by talking to the researcher (Marie Naish) about your experience you can phone the [NHS Trust] Birth Reflections, [NHS Trust] Birth Afterthoughts service, or your local maternity service, for further support. The Birth Reflections/Afterthoughts service helps you talk through your experience and have any unanswered questions addressed. Birth Reflections can be contacted on: [telephone number] and Birth Afterthoughts on: [telephone number].

Thank you again for your participation in this study.

Yours sincerely,

Marie Naish
PhD student
Building 67
Faculty of Health Sciences
University of Southampton
Southampton SO17 1BJ
United Kingdom
02380 597851
men1v07@soton.ac.uk

Ethics number: 168418

Date: 10.11.2020

Version: 3

Letter for participating women

Appendix AA Data management plan

Data Management Plan	
Chief Investigator	Marie Naish
Project Title	An exploration of the experiences of women, birth partners and midwives of using a dedicated, midwife-led telephone support line for labour.
Sponsor	University of Southampton
Academic Supervisors	Dr Ellen Kitson-Reynolds and Dr Jane Prichard
NHS Trust	[Trust name]
Data Custodian	Business Relationship Manager for the Faculty of Health Sciences at University of Southampton (currently [name])
Version	2
Date	03.06.2018
<u>Main features of data management plan</u> This data management plan has been produced with input and guidance from the Information Governance team at [NHS Trust] and Research Data Management team at the University of Southampton. The data management plan for this doctoral research project follows the University of Southampton Research Data Management Plan available at: http://www.calendar.soton.ac.uk/sectionIV/research-data-management.html	
Type of data	

Appendix AA

What data will be collected?	Qualitative data • Digital recordings of semi-structured interviews with 3 sample populations (women, midwives and birth partners) • Transcripts of the above interviews with 3 sample populations (women, midwives and birth partners) • Digital recordings of telephone conversations between women and midwives • Transcripts of the above telephone conversations between women and midwives • Field notes from interviews • Contact detail slips – including name, email address and telephone number Quantitative data • Demographic data
What format will the data be in?	• Contact detail slips will be collected in paper form and transferred into a digital version (MS Excel) on return to the office at the University of Southampton. • Demographic data will be collected in paper form at the site of the research and transferred into a digital version (MS Excel) on return to the office at the University of Southampton. • Digital recordings of interviews will be held initially on a University provided and approved digital recording device at the site of the research. This digital recording will be transferred into a secure folder on a University computer and stored here until transcription is complete. Original recordings will be destroyed (see below) following transcription and quality checking processes. • Transcripts of the interviews will be in MS Word processed form • Transcribed telephone recorded conversations will be in MS Word processed form • Field notes from interviews will initially be in hand written form and converted to MS Word on return to the University of Southampton office. • Transcripts from interview will also be held on NVivo, a qualitative data analysis platform. The digital telephone conversation recordings will not be stored as part of the research – please see data transportation section of this document.
Will existing data be used?	No

Data transportation	
What data will be transported?	Events in which transportation of data may occur includes; • Contact details slips being transported from the [NHS Trust] sites to the University of Southampton for storage • The anonymised transcripts of the telephone conversation being transported via email to the researcher • The anonymised transcripts of the telephone conversation being transported to the interview with the woman and midwife and then back to storage • The anonymised field notes taken by the researcher during interview being transported from interview back to storage. The decision was made in collaboration with the information governance manager at [NHS Trust] that the original, digital telephone recordings of conversation between women and midwives would not be transported from their routine holding place at [Ambulance Trust Name] to the University of Southampton for transcription. The researcher will transcribe and anonymise the recordings on the [NHS Trust] site, prior to transportation to the University of Southampton for storage. These digital MS Word files will be transported securely and will not contain any identifying information such as name, DOB, address, birth partners name etc. This reduces the likelihood of identifying recordings containing patient details being lost during transportation.
How will data be transported?	Paper hard copies will be transported in sealed envelopes with 'Private and Confidential' written on the envelope. The hard copies will be transported directly between locations and storage and will not be left in view of the public or in motor vehicles. Digital copies will be transported using NHS Mail.
Data storage	

Appendix AA

Storage at [NHS Trust]	The contact detail slips for women and birth partners to complete if they are interested in being contacted by the researcher will initially be stored at [NHS Trust]. Potential participants will hand the contact detail slip to a midwife, who will put it in a sealed envelope, and place it into a larger envelope stored in an unlocked filing cabinet in the postnatal midwives office on the ward. Both envelopes will have 'Private and Confidential' written on them. This office is not locked but is for staff only, and contains all inpatient notes for the ward. The process for storing these contact detail slips in this location has been discussed and approved by the information governance manager at [NHS Trust]. Every 1-2 weeks the researcher will visit each site and collect the contents of the envelope personally, transporting them following the process outlined above. Once they are on University of Southampton premises they will be stored as outlined below.
Storage and back up at University of Southampton	The data will be stored and backed up by the University of Southampton iSolutions department. iSolutions provide secure data storage, which is regularly backed up securely both on and off site to ensure there is no loss of data. Stored data will be held on University approved, password protected and encrypted devices. The researcher has applied for 500GB of data storage space for the purpose of this research. It is not anticipated that this amount of storage space will be required due to the nature of this research.
Who will have access to data storage?	Only the doctoral researcher (Marie Naish) and her academic supervisors will have access to the data storage for the duration of the study, in line with the University of Southampton Research Data Management Policy. After the study is completed the data will be made available in the capacity outlined below.
Ensuring anonymity and confidentiality during data storage	As the research is using pseudonyms to protect the identity of the participants there must be a process for ensuring that the pseudonym is not matched to the participant. Transcripts will be anonymised, with the names of places, people and dates removed and inserted with alternatives such as 'labour ward' or 'birth partner'. Until data collection and analysis is complete the researcher is required to store certain personal details to facilitate

Appendix AA

	communication between themselves and the participants. This includes the participants first name, contact number and address (to communicate the findings of the study). All other data will be anonymised, with personal details such as age or mode of delivery being aggregated, rather than stored with identifying information. To ensure the participant is not matched to the pseudonym the researcher will store the data managed under the pseudonym in a separate location to the personal details of the participant. Only the researcher and her two supervisors will have access to this information, which will be stored as outlined above. The researcher will be able to match the participant to the pseudonym following the process below: Rachel is the pseudonym chosen for a participant. The participant's real name is Kathryn. '0001' will be the file name storing anonymised transcripts, using the pseudonym Rachel, from the interview stored in a folder. '0001' will be the file name of another document containing Kathryn's details. This file will be stored in a separate location and in folder with an unrelated name, such as 'Publications 2015'. This reduces the likelihood that, in the unlikely event that access was gained to an unauthorised person that the two documents could be located and the link between them identified. Once the research is complete and the findings have been communicated to the participants, remaining personal details such as first name, address and contact number will be destroyed and participants will only be known by the pseudonym.
Data sharing	
Depositing	Anonymous transcripts and data-sets will be deposited using the University of Southampton eprints depository following doctoral submission and publication. This will ensure data is securely stored for a minimum of a rolling 10 years from last access, as per the University of Southampton Research Data Management Policy. Eprints allows global access to publications, theses and data, though systems are in place to restrict access to certain content.

Appendix AA

Disposal of confidential information	The disposal of information, such as the name, address, contact details and hand written demographic data, will be destroyed as soon as possible. The demographic data will be aggregated as soon as the data is at the University of Southampton site. The paper version will be destroyed as soon as possible, following the University of Southampton guidance for destruction of confidential material.
How will data be disposed of?	The University of Southampton Research Data Management Policy will be followed in relation to disposal of data. At the time of disposal the current recommendations of the University for disposal of data will be followed to ensure the most thorough and up to date process is followed. The current process can be found at: http://library.soton.ac.uk/rdmresources/destruction

Appendix BB Diary excerpts

A critical reflection on a novice researcher's first interview

Following the first interview with a woman participant as part of my pilot study I reflected critically on the process of interviewing and the influence I may have had as an interviewer on this process. As somebody with a tendency to be very self-critical and self-deprecating it is important for me to actively engage with my achievements in this process, and thus I will begin with reflecting on the things I consider I did well.

My demeanour throughout the interview was very professional whilst, in my opinion, not being too formal for the participant to relax in my company. The interview did take place in a relatively chaotic environment, and throughout I showed patience, being considerate of the interruptions made and the woman's role and responsibility as a mother. This included interacting with children; even when this may have interrupted my thought processes. In future interviews, while I will continue these traits, I could use my field notes book to retain this thought process. I surprised myself throughout the interview process, from travelling to the location, introducing myself and facilitating the interview at how calm I remained. This has given me confidence and enthusiasm in facilitating more interviews.

Throughout the interview I was suspicious that the participant might have made assumptions about my role. I interpreted that the participant assumed that I was there to find positive things about the 24 hour labour line, rather than seek lived experiences, positive or negative. This became apparent through the participant stating that the service was 'really good' and 'fine', before explaining her own negative experiences and interpretation of friends and family also having negative experiences of midwives not 'believing' women. While this woman was forthcoming in sharing these less favourable experiences, it has encouraged me to reflect on my process of discussing of both my role and the participant information sheet prior to interview. In future I will ensure I clearly outline that my role is to find out more about participants lived experiences of this period of their lives, and state that this is not to determine and conclude that the service is either 'good' or 'bad' and with this explain that we are seeking honest experiences from participants.

During the interview I became aware that in places towards the middle and end of the interview I had started helping the participant to finish her sentences. This was confirmed following initial transcription of the interview. While the participant either verified the end of the sentence through either agreeing, offering an alternative ending or finishing the sentence in unison with me, this could be considered to reflect my interpretation of her experience, rather than her

interpretation. In future interviews I will be much more aware of this, and avoid the natural conversational instinct to contribute myself.

The phrasing of my questions also required further consideration prior to the next interview. In places my questions could be perceived as putting words into the participant's mouth. An example of this is when I asked 'So did you feel like ultimately you made the decision to go in?'. While the participant had alluded to this, and I was seeking clarification, it would have been more appropriate to ask 'so who do you feel ultimately made the decision to go in?' Furthermore, my 'thinking time' pauses often involved me making comments such as 'OK lovely' or 'Great'. This could be interpreted by the participant as me stating that their experience was lovely, or great, when it may not have been their lived experience that it was so. I must be conscious to use more generic language in these pauses.

For me, the aspect of interviewing I need to work on further is the juggling of writing, listening and thinking of and asking questions. Due to the conflicts between these things, I do not feel I explored the woman's experience in as much depth as I could have. An example is the woman's experience of making the decision to phone the 24-hour labour line in the first place. While the participant covered this briefly, through discussing pain thresholds, it could have been explored by me in further depth through asking additional questions.

Reflection after first Microsoft Teams interview

This interview went so much better than I expected. I was so worried about the technology working, but actually it was arguably more smooth than using the portable recording device. During the face-to-face interviews I found it really difficult to make field notes at the same time as concentrating on what the participant was saying. Here I felt much less pressure to do this as the body language was recorded, though I could not see the whole of the participants body so I may have missed out on observations that would have been detected when interviewing face-to-face. I will need to consider this within the data analysis process.

I also felt really aware of my face as the lack of ability to make eye contact made me feel like I may not seem as interested in what the participant was saying. I tried to be encouraging by nodding so as to seem engaged but then started to overthink whether this looked like I was agreeing with what was being said and therefore validating the experience for them to tell me more. I also wasn't sure whether to look at the camera, so it appeared to them I was trying to make "virtual" eye contact, or if I should continue to look at them on my screen. I suppose this is an adjustment we are all making during these uncertain times as we adapt to online working, and the participant may have felt similarly? One thing I did notice is that I found it so much less tempting to interrupt during this interview when compared to the face-to-face interviews.

Perhaps being conscious that there could be a delay in them hearing me or vice versa helped with this?

Overall a good experience and I am looking forward to the next!

Reflection after interview with one birth partner participant

I found this interview really challenging. I found it so hard to get further insight from the participant about their experience and the interview ended after a short amount of time. I feel deflated about it after having had a run of really positive interviews. I keep reflecting on what I could have done differently, but I still can't identify anything. He just seemed very matter of fact about the whole thing and didn't have more to add. Perhaps it was as simple as that for him and actually the interaction with the labour line didn't have more significance than that? I haven't had this problem before, so perhaps it isn't a case of me having done anything wrong, but just that this is how it goes sometimes.

Reflection after interview with birth partner and woman

Feeling totally elated this evening. I really, really enjoyed that interview. It was a completely different dynamic interviewing them both together and I found it so engaging to try and manage the task of exploring both their experiences. I think that this interview is going to give me further insight as they helped each other to make sense of their experience. I think this is the way forward for understanding experiences of the service – I really felt I got more insight from interviewing them both together and loved being an observer to the interaction between them. Slightly dreading the transcription though!

Appendix CC Reflection on personal experience of 24-hour labour line

Experience one - Arthur

I vividly remember having so much confidence in my body. My family had generally experienced relatively quick, “easy”, first labours and births. I had genetics on my side, birth affirmations in my Pinterest folder, and I was ready to ride. I was booked for induction of labour the next morning as I’d experienced a hind water leak. I was elated to be in labour naturally. I had spent the previous evening sobbing at my dining room table regarding the induction, but I wouldn’t need it now. I had gotten lucky, my birth affirmations had worked, and here I was, about to become a mother.

I had been laid in bed around 10pm in discomfort. I had experienced almost 7 days of on and off tightening’s and period pain but they’d usually settle down by bedtime and I had been sleeping well. This time I was uncomfortable, I couldn’t lay right, I was unsettled and the period pain remained. Chris was snoring next to me, and I laid there for a good few hours trying to dose, as gradually the tightening’s crept in. In the end I got up for a bath, and I stayed in there until I felt I needed some emotional support and analgesia. At this point I woke Chris, and asked him to put the TENS machine on. The hours passed in the dark, warm bedroom and occasional visit to the toilet, the TENS machine was fantastic and I became a big fan of the boost button during contractions. I felt in control, I was breathing, I was supported. I remember our cat, Smudge, coming to see why we were up in the night, and among it all we took a selfie of the three of us sat on the bed. I thought I had prepared mentally for the life change that was coming, but I don’t think it is until now, looking back that I realise the enormity or significance of that night.

In time, I felt I wanted to return to the bath. The weight of my uterus felt heavy. I kept shaking. I felt like it wouldn’t be too long until I would want to see a professional, to check my precious baby was okay and coping, but I knew that they would ask if I’d had a bath, so I thought it would be another thing to tick off the list and would provide me some relief.

I found it increasingly difficult to get comfortable in the bath. Everything in me was telling me to be upright, on all fours, anything but semi-recumbent. I had this dreadful feeling that baby was in the occipito-posterior and for this reason I kept putting off making the phone call for as long as I could. In my head I was thinking “just do x more contractions”, “just get through x more songs on the playlist”. If I’d had any true concerns about myself or the baby, I would have called sooner. I felt like instinctively I knew they were okay. I could feel movement and between the

contractions we would speak to the baby. But as time went on, around 4.30am I felt I needed to be seen.

Chris made the call to the labour line initially, but I had already warned him that they would likely want to speak with me. I really did not want to speak to them, I was worried I would know the midwife, and that they would have to tell me that it was not yet time to go in. I dislike making telephone calls at the best of times, so I was nervous about having to speak with somebody while experiencing what by this point were strong contractions. I felt like calling the labour line was such a big step on our journey to meet our baby – it was the way we would advance, graduate, move physically and emotionally to the next stage in what may be a long process.

I felt as though I was going to be humiliated. I couldn't stop thinking "I am going to be that midwife who is researching the latent phase that goes in at 1cm and gets sent home". I wanted to be at home, so it wasn't that I wanted to wind away hours of the latent phase in a hospital setting – I had just attached a sense of embarrassment to the idea that I would be "that midwife", that I would be talked about, felt sorry for and that my pride would be damaged.

I don't remember much of the conversation now. I remember the midwife being pleasant and kind, but not memorable or overly encouraging. The key thing I remember is there not being any kind of a battle to go in. They simply took the information and asked what I would like to do. My personality is such that I wouldn't have called had I not felt I had needed to go in. I wasn't seeking advice or comfort, I was simply engaging in a process to access the hospital. My knowledge of the labour line helped. I didn't think that I would have to convince anybody that I did need to go in, but I didn't know I wouldn't have to, I couldn't be sure. On reflection I think this is why I needed to try and stay at home for as long as I could, try and push through a few more songs, a few more contractions, try the bath. I wanted to be the person that had tried everything, before the call, to make the call as simple and as short as possible. There wasn't really a focus on the frequency or length of the contractions. My husband offered this information in the initial call, but it wasn't questioned and at no time did I feel that my discussion with the midwife was to "check" that they were that frequent or how I was coping with them. I didn't feel under scrutiny, I just felt like it was a process for admission.

The midwife asked what I wanted to do, so I said, albeit sheepishly, that I wanted to go in. There was no problem with this, the midwife was nice and said she would inform the hospital we would be on our way in shortly. I felt so relieved. I still had an underlying sense of anxiety about being the midwife that arrives at 1cm and is immediately sent home, but for now I had passed the test, I was eligible, I was worth a check over.

On arrival – I was examined and found to be in established labour and Arthur was born around six hours later.

Experience two - Edith

I didn't make the call personally, but I have reflected on it anyway. What I came to see here was that actually women have an experience of the labour line, even if they do not speak to the midwives themselves.

With Edith I had so much uncertainty – I really did not know at what stage of the process I was in. Labour manifested itself in a different way to with Arthur. Coincidentally I emailed my supervisors around 6.15am saying there was still no sign of the baby, yet by 7am I had sent my husband to the hospital to collect a TENS machine, and was arranging childcare for Arthur. All I could think at this point was “get him some childcare”. My mother was en route, but she was over an hour away and I knew too many women in my line of work who had been waiting for childcare and had their baby at home. I gave him a custard crème, put the television on, bounced on the birthing ball and we waited.

By 8am I needed Arthur to be cared for by somebody else. My husband took him to a friends, and arrived back to me in the bath. I didn't feel contractions in the way that I expected – the waves of feeling just came over my whole body. I had no concept of how frequently they were coming and my husband, looking concerned after I had been saying second babies tend to arrive quickly for months, thought we should call labour line. I said it hadn't been going on long enough, and that the contractions weren't frequent enough. As a midwife, I still felt like I needed to “get it right”. It still felt like going in too early would be a mistake, a problem. I was surprised to feel this way with my second child, I thought after having my first and arriving at the “right” time, I would feel confident in my decision-making and trust the signs my body were giving me. Chris decided to time them, and shortly after (I had no concept of time, except that nothing felt like long!) he said they were coming every 60-90 seconds. I felt this gave me some sort of validation to call, I also noticed that I had begun making a classic “moo” sound, which confirmed to me that I wouldn't be making a mistake in calling. This time I was more uncertain about what was happening, but much less phased about the phone call. On reflection, I am unsure why. Perhaps I felt more confident that labour progresses more quickly for a multiparous woman. Perhaps I instinctively knew she was coming. Perhaps I just knew I was unable to speak to the midwife myself, so I wouldn't have to do the dreaded speaking on the phone!

Waiting for the call felt like an age – I was still in the bath and waiting for the green light to go in gave me reason to stay there. I felt like the baby could come any time, I remember having visions of Chris needing to deliver the baby, yet I felt confident that everything would be okay. I could

Appendix CC

hear the pre-recorded schpeal and it felt like it was never ending, but as soon as the midwife answered the phone I felt a wave of relief across my whole body. I knew the midwife. I recognised the voice straight away and I felt safe and confident that I was going to be going in. I remember the tone of her voice being so cheerful, so exciting, enthusiastic and reassuring. After a few questions to collect some simple details the midwife said she could hear me in the background, and to go in. I was feeling so shocked this was happening – surely if two hours ago I had no signs of labour, I couldn't already be in established labour?

This baby was coming, I was excited, nervous and couldn't wait to meet them and find out if they were a girl or a boy. I couldn't stop thinking about Arthur, was he okay? Did he feel abandoned? He was going to become a big brother and he had no idea about the gravity of the situation. A phone call with labour line essentially sent me a message that this was happening, the baby was coming, our family would be extended, it would change forever. As Chris said goodbye to the midwife and hung up the call, I was immediately filled with dread. I had to leave this bath, get dressed and try and make the car journey, in rush hour. I was gearing myself up to get out, working out as I was breathing through the contractions what was the quickest way to get to the hospital at this time of day.

Needless to say, Edith was born within a few minutes of arriving at the birth centre.

Appendix DD Women Group Experiential Themes – Supported by Personal Experiential Themes and key quotes

Group Experiential Theme: “...I didn't really know what to expect” – Navigating uncertain waters during early labour	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quotes
Scarlett - Navigating chartered waters	44 - I sort of thought maybe! [exclaims] Maybe not! [exclaims] and then we walked back home about I dun- it must have been about 530 and I thought yeah maybe I am [laughs] 66 - I feel like ‘Oh well maybe I’m wrong then’ It gives me that feeling that I am not right that I’m not...
Sara	
Julia - Processing the shock of labour	106 - I don't know if I was expecting anything really I didn't really know what to expect I was just we were both a bit scared I think it was erm yeah we were both quite just unsure of everything didn't know what to expect 21 - I honestly thought I'd wet myself and then erm got up and my water's broke no sign nothing no symptoms Well I had sort of Braxton hicks but it turns out that was early labour and I just didn't nobody knew
Nora - Balancing expectations	17 - I'd read that you know your waters tended to break later 119 - most of the material I'd read talked about um the waters breaking once labours underway rather than you know them breaking you know before labour begins and friends who've had babies um quite a few of them actually had to have their waters broken for them so yeah it was kind of like ‘oh is this is this the right thing?

Group Experiential Theme: “...I didn't really know what to expect” – Navigating uncertain waters during early labour	
Dorothy - Managing the uncertainty of labour	120 - but I was thinking this really doesn't hurt very much at all so if this is it then you know this [laughs] this really isn't that bad but of course it got worse [laughs] 44 - I don't know what quite what I was expecting because with my eldest I never got to calling labour line because it was a little bit more dramatic 31 - we had a bit of a discussion about oh do we need to get our childcare kind of going now or kind of what do we need to do and we were thinking or well yeah we probably need to get people on standby but let's let's call the labour line first and see what they say 52 - [speaking of first pregnancy] I ended up staying for couple of days and then getting induced so I never called labour line so I never went into labour so I didn't really know what to expect
Eliza - Managing expectations in the uncertainty of labour	106 - I guess it's funny cos you are very much told that oh it's really it's I certainly I was told it's really unusual for your waters to go first that that normally happens much later so I think that in that initially was quite a shock cos um yeah the not really what I expected as such 81 - although you kind of have the theory from the course I'd done and things like that it's hard to know um it's kind of hard it's hard to know when you're kind of going through it you know what the right kind of thing to do is? 126 - I didn't really know what that sort of meant for whether I could stay at home or whether I'd need to go in and that sort of thing... so the fact my contractions started really quickly I I did equally I didn't know if that was a good thing a bad thing [laughs] um so yeah it was that sort of um unknown 558 – I think to be honest I thought well whatever will be will be you know there's not again it's out of your control so I think worrying about it just seemed pointless

Group Experiential Theme: “...I didn't really know what to expect” – Navigating uncertain waters during early labour	
Mabel - The uncertainty of unmet expectations	17 - it was all in my back all the pain was in my back but it was it was um spread out it wasn't very close together there was nothing that made me think it was contractions until I got to about eight o'clock and I thought uh it would be fun to track these and you know bit of practice for when it's the real thing 59 - again I was like it's all in my back don't think it's I think I'm gonna be here for a while it doesn't even feel like a proper contraction should yet cos it's supposed to all be at the front isn't it? you know everything says 443 - you know you don't know do you as the first time Mum you don't know if you've got it right or not
Annabel - The need to know amid the uncertainty	172 - obviously from that point on as well you then get to see a midwife you get to be examined and things like that whereas before you are just going off your gut feeling erm and obviously that can be influenced by a whole bunch of other things [laughs] 90 - I was a bit worried in general obviously because I didn't know like how far along in my labour I was and I was in pain and I was worried I'd forgotten things but I think that that wasn't a case of labour line at all I think that was just like second pregnancy kind of panic 149 - maybe I'd forgotten everything erm and hadn't remembered cos then obviously that's the classic thing of it's obviously a big deal and you give birth to this baby and you almost like instantly forget what's happened beforehand [laughs] so yeah so I thought maybe I had forgotten
Camilla - Managing broken expectations among the uncertainty	498 - I hadn't had a kid before and I didn't know what what I was looking at really 67 - I always thought that erm contractions would be like I'd feel them like all over my whole bump so when they started quite low down I was like oh this will be I'll wait until they're over the whole bump and then that's the proper contraction but no so [laughs]

Group Experiential Theme: “...I didn't really know what to expect” – Navigating uncertain waters during early labour	
	307 - it surprised me because yeah because I thought they would want to then check even as even as in the end when they said you know you may be sent home I I thought they might want to see how far along I was erm just because you do hear about people who have really quick labours and everything else and you think well I don't really want to have this baby at home erm but I thought well it maybe this is just going to be a very very long labour I thought it's probably not gonna be today and and I didn't have any idea where I'd be in the process so I thought well they're they're the experts they know better than I do so I'll just go with whatever they say
Francesca - Seeking reassurance among the uncertainty	462 - I think it's a general stigma around it that you're supposed to phone midwives or labour line when when you feel like you need to but you I don't think you really know when you need to erm it's you know when you're when you're going into labour or something you're thinking well am I going into labour? have my waters broken? did I just wet myself? [laughs] 565 - I was panicking because when when they were close together and then they'd do five minutes then they do three minutes and then the next one wouldn't come for fifteen I'm like why what's happening? what isn't happening is he getting distressed like [child's name] did? what what's going on? Erm because they're coming and then they're not coming but I know they're real I can feel them they're painful so why isn't it happening properly? what what's going wrong? Erm you know is he gonna be ok? 174 - I'd have one every three minutes and then it would be half an hour or an hour and it would be so it was very much like right well its stopping now and then its starting and it stopped so I was getting a little bit scared by that point
Lucy - The journey into parenthood that is impossible to prepare for	189 - yeah it was a little bit nerve wrecking cos obviously I didn't expect it to happen that quickly obviously being the first time mum you kind of hear stories and things that it can take almost like days almost like early labour erm so yeah it was a little bit overwhelming but also I guess like comforting that I would well I just hoped that it would be soon [laughs]

Group Experiential Theme: “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quotes
Scarlett	
Sara	
Julia - Reassurance of midwives - Virtual presence of midwives at a point in time	160 - that reassurance it meant it meant yeah it did mean a lot to us both of us 95 - and she said well they might theres lots of options and you'll just have to discuss with them it might not be giving birth but if it is there's this don't worry and erm yeah it was all it was just it was nice to know that there were options
Nora - A sense of reassurance	69 - they were like 'no you'd be able to feel it so you you don't need to worry' and that was really reassuring to hear' 213 - so just the fact that rather than having to resort to Google or whatever you can erm or even ring 111 you can talk to someone and um and get the kind of the reassurance that it's it's all OK and what you should be doing um I found that really really invaluable
Dorothy	
Eliza - Taking comfort in easy access to reassurance and advice	115 - that's where actually having the line to phone to to speak to some you know speak to someone about was really was really helpful because um yeah I I think it gave you a bit more reassurance 285 - it just adds to that feeling that someone cares and that um there's someone there to help...it was nice to know that if anything changed there was something to call to um to kind of work out next stages if anything changed

Group Experiential Theme: “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line

Mabel - Reassurance of 24-hour labour line	126 - I said it doesn't feel like contractions it's all in my back and she said oh that's probably because baby's back to back with you um and that's really common I was like oh that's what it is 399 - I think talking to them it was really reassuring and helpful erm and it made me feel better about being at home erm and I mean I was never scared I was never scared erm and talking to them definitely reaffirmed that I thought you know I felt like I knew what I was doing 781 - it was just very calming the way that they spoke the language that they used there was no rush no panic and and therefore you didn't feel like there was anything to worry about either 768 - in your mind you're going excuse my my language shit shit shit shit shit shit you know like oh my god oh my god there's a baby coming like a duck you know the legs are going underneath and inside you're going ok you're already ten hours ahead or a day ahead erm whereas when you ring the labour line and you say ok this is what's happening I think it was just that [brightly] ok alright well let's have a you know have you tried this? have you tried that? there was no panic from their side there was none of this oh gosh well you need to get to the hospital then 911 - they are the midwives at home aren't they but through the phone...that is very clear when you say labour line what's it for? It's a ok well it's your midwives before you go to hospital it's the people looking after you before you get there so it is it's an extension of the care that you get at the hospital
Annabel - Keep calm and leave as soon as possible	45 - they recommended that we come in as soon as possible erm but it wasn't it didn't feel like it was like it was important to come in as soon as possible but it didn't feel like it was like panicked or like anything like that it was just like you know don't waste any time just make sure you get in as quick as you can that kind of thing 254 - it (calling LL) definitely made a difference in terms of just like listening taking a minute erm rather than kind of going you know where's your pillow? where's this? where's that? is [sisters name] on her way? like sorting out everything else

Group Experiential Theme: “...they put me at ease straight away” - Finding reassurance in the 24-hour labour line	
Camilla - Finding reassurance in the comfort of the 24-hour labour line	110 - the team were really really comforting and reassuring erm they put me at ease straight away 545 - it took any anxiety of whether to call or not away if I thought I'm going to call them I just called them I didn't think oh should I? shouldn't I? should I just wait a bit? so yeah it just took any questioning away 226 - even though I'm at home there's still support so it felt like there was sort of a link then between the home space and the hospital that didn't matter that I wasn't there I could still get support from here 119 - they were very very clear that it didn't matter how quickly I phoned them back erm whether I phoned them back in two minutes literally put the phone down and picked it back up again and said I need pain relief or I've got more questions or anything like that or whether it was another two three days before they heard from me again erm and that was really comforting 117 - it was great to be able to have that central hub and know that they knew they could tell the hospital and that there was sort of then it was kind of on the radar that at some point I might be going in
Francesca - Seeking reassurance among the uncertainty	544 - if they'd said you know I think you're in prolonged labour you might have a few more hours yet before you can it might have just calmed me down a bit of what why is this happening? and it actually has a term and this is what is gonna happen and you will get there eventually but your body's just taking a bit longer
Lucy - Space to be calmly heard and reassured	266 - I think just the way she was really like calm like she wasn't like wasn't panicking or wasn't asking us loads of questions erm like I had a couple of contractions while I was on the phone to them and she just kind of like paused and just let me have the contraction

Group Experiential Theme: “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Scarlett - Safety first	128 - I think some midwives are very concerned about strep b and others aren't so concerned about the strep b and where I very very very very tiny risk I'd rather have those antibiotics 145 - because of the wanting to get in to have those drugs four hours before, which we didn't in the end because it was too far down the line but [...] that was why there was sort of a need for me personally I wanted to get in sooner
Sara - Being in a safe place	180 - I should have been in the hospital earlier than this critical stage because I got scared that's it [laughs] 220 - it was I would say it was very in the nick of time I was scared that I was gonna deliver in the car that was really the only thing I was thinking
Julia - Managing fear and anxiety about safety of fetus	284 - it did really help it really helped cos I think then it confirmed it for him that I wasn't in any sort of danger cos you know you always think awful things 82 - yeah I thought we kinda thought that we would have to go in to the hospital er because I just I just thought there was a problem'
Nora - Prioritising reducing risk	190 - you know having got to 39 weeks and 4 days or whatever it was you know just really keen to you know for it to be a happy ending' 67 - which is the reason I rang the labour line pretty quickly is because now its gone and you know is there anything I should be doing?
Dorothy	505 - I didn't want to go in too early but I obviously wanted to make sure that I made it rather than giving birth at home or in the car

Appendix DD

Group Experiential Theme: “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	
- Timing it right in murky waters	523 - just being in a different environment it's not that relaxing and much better to stay at home 555 - but I certainly knew I didn't want to be hanging around in the hospital for a lot longer than I needed to be
Eliza - Balancing risk with comfort during early labour	94 - I'm not a massive fan of hospitals and so as much as I was I really like I absolutely did not want a home birth but I also didn't want to find that yeah I was kind of stuck in hospital for hours and hours and hours just going through those early stages of labour I'd much rather be at home where I can or I could get myself some food more easily and like you know being a bit more of a familiar environment 141 - they set you up with the appointment as kind of a backstop so if nothing had changed prior to then you've got that sort of security of knowing that someone was gonna I was going to be able to see someone to be assessed regardless 451 - they sort of say you could come in later but you you may then not have the option of going home where as you know if you come in now you're almost certainly going to be sent home but that but I then knew actually by the time I went home I could have some dinner and I could have that bit more time at home whereas if I went in later there might be a risk that I would like you know I wouldn't go home again
Mabel	
Annabel	
Camilla - Balancing the comfort of home with the safety of hospital	54 - I wanted to be in my house er and just my own surroundings if I wanted a snack I I could just get a snack you know things like that just just creature comforts I guess um and hospitals generally speaking in most people's lives are a negative association so it was nice to just even though the the maternity hospital didn't have that negative association

Group Experiential Theme: “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	
	erm my husband really doesn't like hospitals so it was nice that he then felt more comfortable as well and yeah just made the whole thing a bit easier to cope with 349 - it was nice to know that all the facilities were in one place they had all the best equipment all the best care and that you know we had accessibility to that and that they had the birth pools and they had everything that we would ideally like 415 - I knew that we would have to wear masks at some stage have a test at some stage and the comfort of being at home for longer meant that we didn't have to concern ourselves with any of that 398 - with covid again where you know I hadn't even barely left the house for months so to to be going into an environment where there's not only the risks associated with the labour er but there's also other medical risks for the pandemic erm I would have hated to go in and and feel worried
Francesca - Prioritising safety	290 - so I felt like I needed to get in just in case anything like that happened again 302 - I wanted to be in hospital so that if anything went wrong I was where it would be okay 575 - well you're you're in labour you're already got hormones rushing around and you're stressed and you're worried and then for you to not know why your contractions aren't happening or somebody not say to you potentially why [laughs] it is a bit like [high pitched] ahh I just wanna get seen now I just wanna know he's okay
Lucy - Seeking safety and security	302 - yeah just more safe like being with like the medical professionals I guess erm yeah not that I felt unsafe at home it was just everything's there isn't it in hospital [laughs] 286 - which is why I chose to go into hospital rather than like have a home birth or anything like that erm yeah just the reassurance I guess and the safety

Group Experiential Theme: “...the security of knowing that I was in the hospital” – Balancing the comfort of home with the safety of hospital	
	280 - obviously the midwives were there and I could have pain relief if I needed it and just obviously they're professionals aren't they they know exactly what they're doing they do it every day 45 - I kind of wanted to stay at home as long as I could erm to obviously make sure that [partners name] could come with me

Group Experiential Theme: “...for them it is very bread and butter, isn't it?” - The significance of trust in self and others	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Scarlett - Power of trust in mind and body - Intuition	111 - 'you'll go home' I'm like 'um I don't think ill be going home but OK' and that was before she examined me again 120 - I think they're just accepting of if you tell them you're going in you're going in and im not im not somebody that you could push over right I will 164 - yeah I mean because I was going in whatever they said [laughs]
Sara - Following intuition - Importance of not labouring alone	92 - and then I just thought that no I should go now so I didn't call the labour line again and I just went to the hospital 283 - this is a situation where you wa- you need someone who in which you can put your trust in
Julia	111 - I mean we were regardless we were gonna go straight up to [hospital name]

Group Experiential Theme: “...for them it is very bread and butter, isn't it?” - The significance of trust in self and others	
- Handing over responsibility to trusted experts	340 - then I felt right ok well this lady she's obviously an expert she obviously knows whats or she has a rough idea of what is going on we are going to go with what she said you just trusted her trusted what she was saying so that was that made me feel a lot better you know
Nora - Putting trust in experts	225 - it was my first thought to talk to someone who was a professional [laughs] rather than anybody else
Dorothy - Confidence in self - Being believed	500 - I was confident that the first couple of times that I'd called that I shouldn't have been going in and that it was too early erm by the time I'd called the last time I knew I definitely did need to be going 510 - I was like right well I need to go even though I hadn't reached what I thought was the three in ten because I was lying down I'd made that decision I can't cope with this anymore so I'm gonna need to go 599 - there wasn't any question about it I just explained that it was like just a slow trickle erm yeah I didn't feel like that was being questioned at all
Eliza - Respecting professional expertise and guidance	178 – the fact that you know they've seen so many people that um they're probably a lot better judge as much as I can tell them what my symptoms are there a lot better judge then of whether that's kind of in that category of being like relatively normal and in keeping with what they've seen or whether actually it's something to that needs looking at or um needs a second opinion 465 - I think um if they'd said no you're coming in at your original appointment time regardless of how you're feeling and [...] you know while I would have respected there I would I would have like respected their decision 666 - in a circumstance where you're in a lot of pain you've possibly never been through this before um or even if you have this is potentially very different to how it was before it's really nice to know you've got someone that can actually

Group Experiential Theme: “...for them it is very bread and butter, isn't it?” - The significance of trust in self and others	
	provide you with some advice as well as just rather than just simply being a um yeah a referral mechanism as such if that makes sense
Mabel - Trust in professionals alleviated underlying fear	804 - Also what's new and exciting or scary or unknown for us you know [frantically] should it be like this? should be like that? for them is very bread and butter isn't it? 990 - those thoughts were gone it was a case of she's gonna get here one way or another these amazing ladies and midwives cos I know you've got male midwives too but erm you know these amazing midwives they're gonna they're gonna look after us 781 - it was just very calming the way that they spoke the language that they used there was no rush no panic and and therefore you didn't feel like there was anything to worry about either
Annabel - Confidence in self-diagnosis of labour	58 - I was pretty sure that they going to tell us come in... I was kind of sure this time round that actually I was in enough pain that I I warrant I didn't have a doubt as much doubt that I should be calling if that makes sense 191 - like I talked about being worried that I had forgotten but at the same time like I knew it was a big deal and I knew it had gotten to the point where it was painful enough for me to think no I can't like I don't think my body can cope with this like long term without actually being looked out or checked or whatever
Camilla - Putting faith in professionals	254 - I just kept an eye on it then but once it got to once it got to once it got to the point where the Freya app said I was in established labour but then they said that it wasn't then I stopped monitoring on the app 313 - I thought well they're they're the experts they know better than I do so I'll just go with whatever they say 382 - all my experiences through the whole pregnancy with midwives were positive and I had no reason to to doubt them

Group Experiential Theme: “...for them it is very bread and butter, isn't it?” - The significance of trust in self and others	
	386 - I mean it was it was my plan to let them deliver the baby so [laughs] but you know I was I was happy that I trusted them
Francesca - Dismissal derailed the experience	350 - I don't think they'd really taken me seriously on the phone when I said they're really strong they're lasting at least a minute and they are really really strong they're not those little ones you have to start with it wasn't Braxton's they were proper contractions
Lucy	

Group Experiential Theme: “...it's your labour” - Being empowered to take control (with hints of occasional autocracy)	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Scarlett - Autonomy to be in control	120 - I think they're just accepting of if you tell them you're going in you're going in 163 - Interviewer: OK so did you feel like ultimately you made the decision to go in? 164 - Participant: Um yeah I mean because I was going in whatever they said [laughs] so yeah but I think maybe they they probably would have probably would have said go in anyway but I dunno – I just phoned to say I am going in 296 - like I say it doesn't really matter with me because I'll do what I chose to anyway 72 - and no you must be wrong but I suppose begrudgingly we'll take you in n' tha- tha- that's what I feel for both of them
Sara	65 - they said it'll be some time at the moment so you have to wait

Group Experiential Theme: “...it’s your labour” - Being empowered to take control (with hints of occasional autocracy)	
- Midwife holds the key to admission - Transient control	376 - I think it [being asked by midwife if she wanted to go in] it might have changed because I wanted I might have gone to the hospital if they asked me 92 - and then I just thought that no I should go now so I didn't call the labour line again and I just went to the hospital... cos I thought they they they they going to say again [laughs] that there’s still time and that’s why I just went there
Julia - Authentication by midwives	148 -she said yeah it does sound like your waters broke and the plug so she we were sort of agreeing on the same sort of lines if that makes sense? We were sort of she just confirmed what I was thinking already and then yeah then more like reassuring the decision you know 60 - so I thought I’d have to go up the hospital but she really did right you you know she confirmed it for me if that makes sense? 111 - I mean we were regardless we were gonna go straight up to [hospital name]
Nora - Happily complying with midwives advice	158 - oh right ok well if you want me to come in to [place name] I’ll just um get in the car 198 - I wasn’t looking to make a joint decision I was looking for an expert to you know tell me
Dorothy - Navigating varied approaches to decision-making	142 - she explained that I should be looking for definitely like three ideally in ten minutes and they need to be properly painful lasting a minute each so I was like okay well I'm clearly not there yet so then I was like well you know how how long should I keep monitoring this for and was sort of told yeah you just need to kind of wait until you've got to that point and then call us back again 659 - I think the second lady that I spoke to was um very much this is like the this is the measurements you need

Group Experiential Theme: “...it’s your labour” - Being empowered to take control (with hints of occasional autocracy)	
	510 - that's when I was like right well I need to go even though I hadn't reached what I thought was the three in ten because I was lying down I'd made that decision I can't cope with this anymore so I'm gonna need to go 491 - so she was almost kind of leaving the ball in my court I suppose and had kind of said as long as you feel OK then kind of stay there whereas the second midwife I spoke to was very much like yeah it needs to be three in ten and for a minute each before you come in 531 - I kind of just wanted someone to tell me what to do at that point I think 254 - so I had a contraction while I was on the phone and so I think who I'd spoke to was like okay yeah this is the real deal and was basically like yeah do you wanna come in now
Eliza - Feeling empowered to take control of the decision	463 - I-I-I was grateful that they gave you all the information that you needed to make that choice and then let you actually decide it 491 - equally if I'd had the choice and I'd gone for the later one at least would have felt like it would have been my decision rather than feeling kind of forced into a set of circumstances that I potentially didn't have as much control over 606 - they're so intent on trying to do whatever is best for you and trying to accommodate what you want as far as they possibly can in this system it yeah just makes you really grateful for it 444 - I guess you know within reason they were sort of saying actually we can accommodate we can accommodate that and so yeah I that's that's why I mean they weren't necessarily just saying no your appointments at this time you're not very far dilated therefore nothing's going to change they were very much listening to how I was feeling and not just kind of the facts of the facts of it

Group Experiential Theme: “...it’s your labour” - Being empowered to take control (with hints of occasional autocracy)	
	546 - I sort of thought in my head like well it would be it's nice to let them know if we can but fundamentally if we needed to go we needed to go
Mabel - Seeking to hand over control	515 - [laughs] I think I probably needed somebody to say ok it's time to come in now [laughs] whereas they were they were reluctant to do that 554 - I needed someone to take me in because I wasn't going to make that decision solely on my own It's your labour 523 - I think [pause] I needed the push I think I wanted to go in and I think Nathan said we're going in and I think that was a bit of a relief to me because it was ok it's not my decision we're going in and I think I gave in at that point
Annabel - Appreciating verification of the decision to attend	83 - we were all kind of in agreement that that sounded like the right like next step 123 - it was nice to know that even though I didn't know what stage of labour I was at erm that that I was told I could go to the next step 292 - if she had said no I would have said something [laughs] 305 - I think the first time around we maybe didn't we'd not not have a positive experience but I think we were put off by our first call to labour line so obviously I think that possibly was in the back of our heads the second time round 310 - I think maybe in some way I was kind of pre-empting like obviously when you call you don't know whether they're going to say yes or no you're a bit I was kind of pre-empting that maybe I would have to say actually no you know I'm not I'm not perky actually I'm just doing whatever you know the best I can for where I'm at kind of thing so I think maybe in some way I was kind of preparing for that

Group Experiential Theme: “...it’s your labour” - Being empowered to take control (with hints of occasional autocracy)	
Camilla - Being in control of the decision to attend	317 - still completely involved in making the decision because I know that if they [repeated word x 2] did say if I wanted to talk about any other pain relief or if I wanted if so if I wanted to go in for more pain relief then that's still something that I could do it wasn't just you can't come in it was just you know you don't need to come in yet 460 - they said you know we can once you find out where abouts what sort of situation you're in then we can we can look at what pain relief options are available and and what you want to do from there so yeah the decision making process was still put into my court 28 - by about three I was like no you know what? let's let's call them back let's let's tell them I think we're gonna go in let's see what other pain relief 504 - we knew that we we would have the skills to make an informed decision no matter what sort of situation came along so I felt like it was it was great to be able to utilise that tool and make the decision between myself and my husband
Francesca - Midwives as gatekeepers to control	21 - cos I just I I wanted to be seen but they kept saying that you know they're not close enough blah blah blah 88 - she just said no you're gonna have to wait erm cos they're not close enough together you wouldn't you wouldn't get seen they're not close enough together there's no point you going in erm so that that wasn't a great [laughs] that wasn't a great phone call 186 - and then she said if you can't cope with the pain go in they can assess you and they can give you some form of painkiller erm which would have been nice to been told that before [laughs]

Group Experiential Theme: “...it’s your labour” - Being empowered to take control (with hints of occasional autocracy)	
	196 - and she just listened and then you know said to me that it was up to me whether I wanted to go in or whether I wanted to stay at home and try for a couple of hours to not go in erm so she sort of made it my decision then which was nice 423 - I think it was definitely the second lady who put me off calling again until my husband was saying you need to call you need to call and I said no cos I’ll just get another lady like that who’ll just tell me that I have to wait and won't won't listen to me erm so yeah I think she put me off 20 - I ended up at the hospital because I phoned again and said that I didn't feel him kicking as much cos I just I I wanted to be seen 441 - when you're in the situation of thinking you're in labour and getting a bit worried bit stressed you need somebody else to take that charge
Lucy - Being empowered by others to make decisions - Space to be calmly heard	64 - so they said that I could either stay at home until I was three in ten or I could go in and be assessed if I wanted to 144 - I think I wanted to make the decision so and covid has kind of changed things obviously I knew if I wasn't in in established labour that [partners name] would be sent home erm so obviously that's impacted so yeah it was it was nice to be able to make the decision to go in yeah 241 - well it's just that really just to say that I could go in and be assessed if I wanted to or I could try and stay at home a bit longer erm yeah they kind of just left up to me and I made the decision to go in 134 - they listened to what I had to say on the phone and then kind of gave me the option erm and I felt it would be best for me to go in so

Appendix EE Birth Partner Group Experiential Themes – Supported by Personal Experiential Themes and key quotes

Group Experiential Theme: “...we will listen to what we’re told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Bernard - Delegating to trusted professionals and following their advice - Seeking the security of professionals in the face of anxiety	158 - it was sort of erm well its over to the labour line now so kind of tell us what to do as such, we’ll follow you know, you tell us what to do and we’ll do it essentially er I think that's certainly how I felt from my perspective 166 - I think we were sort of er I don't want to use the word happy but we understood enough that then it was kind of over to the labour line, these are the guys who it’s kind of an everyday business for them, its new for us, but it isn’t for them so we will listen to what we’re told to do as such and obey instructions er under advisement 286 - I don't think there was any sort of, they weren’t waiting for an acknowledgement on that, the instructions were given, I’d understood, that was probably the end of it 324 - but also perhaps comforted that people are aware, people that are much more er savvy and much more educated on such things are aware of such, so we’re sort of now giving ourselves over to the advice of others as such 216 - there was nothing that they told me that surprised me erm it all seemed to be relatively logical 120 - we weren’t overly concerned certainly concerned enough to get it verified by an expert
Nathan	159 - they sort of gave us the choice they kept on using the phrase um it’s your pregnancy you know what would you like to do?

Group Experiential Theme: “...we will listen to what we’re told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	
- Unwanted control	324 - I think the frustrating term for us that was a bit like it's it's your pregnancy you know it's up to you to decide which again I wholeheartedly understand but I think as sort of first time parents we were a little bit like but we need someone to make a decision and tell us that this might not be well this might be the time this might not be the time 896 - but [laughs] I think I wanted them to just say to you you need to come in now my love [laughs] but they weren't having any of it it was like you know what do you think is best it's like [in despair] I don't know [laughs] 854 - regardless of what their internal kind of monologue might be in their own head thinking oh this this lady probably should come in early or this lady should stay at home for another couple of hours it was very much you were they allowed you supported you to make your choice yourself so we were in control of that 162 - its your labour and I'm like [with urgency] we're coming in [laughs] I'm making the decision now this is scaring me 538 - I think had I have not said I really think you need to go in now I I wouldn't say it was one hundred percent my decision but I think you know probably sort of seventy thirty that I was at that point going oh I'm I'm I'm gonna take you into the hospital you know
Charlie - Being led by the professional	65 - we were quite happy to kind of follow their advice 130 - she said I think it would be wise that you go and have your assessment done at this point and we were on the same page with that so it was kind of a mutual decision I suppose but I think mid midwife led no less
Anthony	557 - it sounds bad doesn't it but I don't know whether necessarily [partners name] would really say that she was involved in it because I was kind of like taking the advice from the labour line telling labour line what was going on and

Group Experiential Theme: “...we will listen to what we’re told to do...and obey instructions” – Seeking and trusting the professional recommendations of the midwife	
- Following professional advice above the wants of the partner in labour	taking their advice erm and then kind of like hanging up and then telling [partners name] what the labour line had said so [partners name] was kind of like taken out of any decisions 382 - she kind of like almost made the decision for us cos I was [partners name] was very much like ‘we need to go in’ and I was very much like ‘well I don't think like we should necessarily go in straight away’ so it kind of made the decision for us really 202 - they kind of like just took the details and then kind of like gave me instructions on what to do next 346 - I don't think I said ‘we want to come in’ cos [partners name] was a bit like yeah I think we should go in now but no I kind of rung up to say ‘what do you suggest we do?’

Group Experiential Theme: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	
Personal Experiential themes leading to Group Experiential Theme	Line number and key quote
Bernard - Taking comfort in the availability of the labour line	41 - it was very clear for us that that we should be using that er that was er recommended numerous times by midwives er etc etc during any every visit that that was sort of the number once you started thinking things were going to happen calmly call the number 532 - I was grateful that it was there, it was like a safety net to a certain extent, because you know we knew that ok at this point we call this line

Group Experiential Theme: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	
- Taking comfort in being on the radar	535 - it struck me that it is something that didn't have to be there, if we weren't organised as such as a an entity as the NHS is as a sort of an organism as such erm it doesn't have to be there, they could say when you get to this stage go on to the website, or whatever, but the fact that that was there I thought was quite, you know, I took comfort from that 320 - I felt confident that we sort of ticked that off the box we'd informed the labour line so kind of as far as we were concerned um the hospital and the appropriate authorities were aware that you know we'd reached that stage and perhaps er you know fairly short period of time we'd be coming in to the hospital so in a way I was sort of er sort of erm erm satisfied that that was done 45 - to obviously to kind of alert the labour line I guess on our behalf alert the hospital that probably at some point in the not too distant future [partners name] and [name] would be coming in to the hospital
Nathan - Virtual support and reassurance	394 - you were going to be speaking to one of those two and they were going to be with you for that process which was quite quite almost like a comfort and reassurance to that 744 - to get that little bit of reassurance from them sort of saying you you as a you as a partner are doing the right things...it was nice to have the reassurance for me to say actually you as a birthing partner are doing the right things by Mabel if that makes sense like you are supporting her the best way that they know how kind of thing 786 - we are with you as as much as you can be at the other end of the phone but it was kind of like yeah it was it felt like a little support team in the background 794 - you kind of get hinted at beforehand by you know midwives and the NCT people saying you know this happens this happens this happens and when that kind of co aligns with the labour line and everything they were saying doing you're like oh ok this is working out well because we are following their little plan of action that everyone said we would and their marrying up with exactly what we think should be happening to that that there's a reassurance in that

Group Experiential Theme: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line	
	909 - I think it was always pretty clear that you know the day that we think that labour started you phone that number and then they're there to help
Charlie - Instilling calm reassurance - Easy access to an efficient system	37 - on both the first and second occasion of phoning the labour line the the lady we spoke to was very calm and collected and gave us complete reassurance that everything was kind of ticketyboo 73 - it was always the excitement and the fear that something's kind of happening and might go wrong so speaking to them because they were so so relaxed and calm about everything it kind of made you feel that bit more secure 83 - their tone of voice their demeaner and what they're saying because it's it's a nice routine there's nothing to worry about sort of manner that they come across with that it makes you feel everything's fine we're in good hands you feel that you're being looked after so therefore you don't need to worry so much 234 - I think knowing that you've always got somewhere you can phone for advice whether it's because you think you're obviously going into labour because I know the the [birth centre name] has office hours as it were erm to call so knowing that that's always there that you can speak to somebody if you've got a concern is beneficial 92 - having this centralised labour line kind of took away from any having to get through to a specific department obviously something very to straightforward to to call up and speak to them and then they just dealt with things you didn't have to worry
Anthony - The reassurance of virtual support at home in labour	59 - that's kind of what our midwife had said was you know when like the waters break that's the first thing you should do just to like make them aware that you know it's gonna to be happening imminently and kind of like they'll then give you some advice about what to do next

Group Experiential Theme: “...it felt like a little support team in the background” – Finding reassurance in the 24-hour labour line

642 - you know always saying like well if anything does change or if you've got any more concerns ring us back there wasn't any 'right we've told you to do that don't call us back for another hour' or anything like that it was very much like 'you know if anything changes if it gets worse or anything like that then give us a call'

648 - cos it gave us a bit more confidence I guess that you know they knew our situation and were kind of like giving us advice on what to do next so we kind of like knew that we weren't alone I guess

497 - they just said they would let them know so that all the details were there ready to go so when we arrived they like know who you are and like they've read your notes and things

Group Experiential Theme: “...it was more like a telling” – Tension and togetherness in early labour

Personal Experiential themes leading to Group Experiential Theme	Line number and key quote
Bernard - Trusting partners lead to address concerns through face-to-face assessment	148 - perhaps when we discovered the bleeding maybe became a bit more concerned certainly [partners name] was and then I was more concerned cos she was concerned 355 - her position was 'I think its time to go in' and as far as I was concerned ok, if she's decided that, we've been here now over two hours erm if she's obviously concerned it's time to go in, I'm now concerned that it's probably time to go in 353 - probably in her um voice, her responses probably she was a little bit more er panicked is not the right word but probably closer to that in terms of anxiety that I could sort of tell in her voice

Group Experiential Theme: “...it was more like a telling” – Tension and togetherness in early labour	
	247 - I think to be honest we always make more or less make decisions collegiately in that respect its er generally goes that way we're both more comfortable doing it that way
Nathan - Negotiating with partner - Advocating for Mabel	101 - [laughs] we spent most of the evening not arguing is too strong a word but discussing heavily like when I was gonna be allowed to phone them and when I wasn't allowed to phone them 109 - I guess so you were like no no no it's fine it's fine I really think you should phone them so it became a negotiation 267 - so that was always that was always [laughs] the little bit of a sticking point between the two of us 543 - we'd sort of discussed between the two of us so we phoned at midnight and then it was we're gonna phone again I wanted to phone again at half twelve you wanted to phone again at half one we settled on one o'clock 547 - yeah more more my decision but definitely not solely if you'd said to me I'm not going to hospital I I wouldn't have done anything other than 755 - I likened it to when you phone the bank you know or you phone your mobile phone contract once you've agreed you've gone through the security for me it was kind of the same like they wanted to talk to you every time because quite rightly so they needed to check you're ok but once she said no no can you talk to Nathan for me? they were kind of happy to
Charlie	
Anthony - Negotiating with partner	583 - yeah it was more like a telling [laughs]

Group Experiential Theme: “...it was more like a telling” – Tension and togetherness in early labour	
	174 one of the courses we’d done they said something about I think it was three contractions within 10 minutes or something like that so we said OK when I was looking at the times I was like well actually it pretty much is that now and [partners name] by this time was pretty like ‘yeah no we’re going in we’re going in whatever’ 369 - erm it was relaying it to [partners name] actually cos [partners name] was like ‘no just ring them like we’ve gotta go in’ so kind of like come off the phone and saying ‘well we’re not gonna go in yet’ [laughs] ‘we’re gonna try this first’ 156 - I said look if their telling us like not to come in then we probably stay at home for a little bit longer so the labour line were really helpful

Group Experiential Theme: “...it’s in everybody’s best interest to stay at home for as long as possible” – timing the admission right by relying on signs of labour	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Bernard - Monitoring contractions to reach the criteria to call - Staying in the comfort of home to achieve birthing goals	71 - to a certain extent at that stage we were already at the three within the ten minutes so we sort of knew it was kind of sort of a trigger point 163 - we knew that you know sort of three sort of frequency of sort of at least three every ten minutes for a duration of I think maybe one minute is kind of the point where um that's where you sort of alert them as such 304 - they were sort of four every they were sort of every every sort of every four minutes that's now come down to um three every ten minutes erm which as far as we are concerned is the trigger point

Group Experiential Theme: “...it’s in everybody’s best interest to stay at home for as long as possible” – timing the admission right by relying on signs of labour	
	95 - we were aware that you know it is advisable to stay at home erm because er its generally a calmer environment and generally labour, early stages of labour, progress better, more quickly er less painfully if you’re in a calm friendly sort of environment and theres nothing that can be done in the hospital in the early stages 217 - as I say we were happy, I keep using the word happy, erm we were er quite willing to stick it out at home as long as necessary erm in order to facilitate erm an easy and smooth and straightforward birth as possible 414 - we were aware that the earlier you go in that you are tying up resources you are getting in people’s way...it’s best in everybody’s best interest to stay at home for as long as possible
Nathan - Aiming to meet non-existing criteria	571 - I’m like but you need to keep telling me when the contractions are coming cos we need we need to be able to tell them because that's the deciding factor 147 - I was like you you need to keep telling me when these are because we need to track them because they’re not convinced that they’re like in in coming at the right intervals and I was saying to you I think they are I think 608 - I was kind of like well if you miss one one was a bit late that would skew the figures 330 - I think they latched on a little bit to your the fact that sometimes the contractions would would slightly be further apart and I think that might of been our mistake cos we'd mentioned it to them in a bit of naivety going this is the situation and I think they sort of went oh that means you’re still in latent phase
Charlie - Focussing on frequency and duration of contractions	21 - after a good few hours we were timing the contractions and as we getting towards the the kind of the length and frequency we were advised to be calling the labour line

Group Experiential Theme: “...it’s in everybody’s best interest to stay at home for as long as possible” – timing the admission right by relying on signs of labour	
	28 - but I do recall we were given quite clear guidance on the number we should be expecting per ten minutes and the length of each contraction should be lasting as a cycle
Anthony - Aiming to arrive at the “right” time	312 - I think we’re thinking like if you get sent home it’s almost like well what do we do now then? cos it feels like its imminent but you know you’re back to almost square one again 328 - so it was kind of like a really fine line between like we wanna get there but then we wanna get there when the baby is ready as well 533 - I knew that you know the contractions were the right distance apart

Appendix FF Midwives Group Experiential Themes – Supported by Personal Experiential Themes and key quotes

Group Experiential Theme: “...the end decision is always theirs” – Doing right by women	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Stephanie - Empowering women to have the final say, free from external factors	425 - even if my clinical opinion isn't that someone shouldn't go in or isn't ready to go in I will still I'll listen to what they say cos I always say what do you think? so I always say this is my clinical decision what is what do you think and what do you feel? do you feel like there's any reserves left in you? 452 - well for me I always think the thing is it's not about what I necessarily its what I think but it's not necessarily about what I want so it's not about me I'm not that person who's hasn't slept for three nights who's absolutely knackered who isn't coping so I always think well I'm not in their position so it's about what they what the women want and what they feel they can cope with 315 - other people feel like they know their bodies and they know like actually no I feel like something more is happening and I feel like I need to come in now and they feel really confident in their bodies and their own abilities and that's fine too and I'm like right okay that's how you feel we'll get you in 473 - personally if a woman needs to go into hospital she needs to go in it doesn't matter whether the hospital is full diverted whatever or they haven't got any staff that isn't that isn't the woman's issue and that isn't ours

Group Experiential Theme: “...the end decision is always theirs” – Doing right by women	
Michaela - Supporting women’s choice through prioritising psychological wellbeing - Advocating for women free of the influence of external pressures	94 - all women have the option we will always say to them this is what I suggest is that okay with you? or are you thinking you would like to go in? so the option is always there for them that the end decision is always theirs 75 - if we can get them to those magic numbers then fantastic but if they need to go in because they're not coping they need a face to face 57 - if that woman had a previous stillbirth and she's contracting one in ten but she's really not holding it together then she needs a face to face she doesn't need a phone call to tell her everything's gonna be ok she needs that human element that's gonna help her carry on with her labour as normally as possible 29 - I’m quite assertive in my midwifery nature [laughs] and erm I think people know that...if I said I want someone to come in then they're coming in it's not up for discussion 34 - I will stand up for them and you know it's not a request I’m telling them she's coming erm because that's my own assessment of that woman that she needs to be seen...so for me it's not a problem and I will go higher if I need to and I have done erm but I know for some of my colleagues they do find those conversations quite difficult
Penelope - Promoting women’s choice following professional recommendation	462 - if I feel that the women the right place for the woman is at home I’ll say that but I can know when that's not that's not the right answer for them so I’ll say what would you like to do? 487 - we all know that the home environment is better for them psychologically and the food is nicer it's more comfortable all of those things but actually some women that's just they just want to be in hospital 470 - some women particularly kind of want to go in earlier than others and that's and that's I think that's a reflection of their support they've got at home as well I think some women just don't have any support at home and they would just prefer to go in

Group Experiential Theme: “...the end decision is always theirs” – Doing right by women	
	516 - if the women need to come in they need to come in it doesn't matter what day it is what the acuity is like if they need to be seen they need to be seen we just have to deal with it 523 - their problem is being in pain in labour and needing support so that that's our priority that that that's why they should go in they don't need to get involved with the all the background stuff it's not it's not their fault [laughs] so they need to be seen when they need to be seen that's it
Naomi - Advocating women's choice	116 – at the end I will say so I'm happy maybe for you to continue at home at the moment if you're happy with that however we will never stop you going into hospital if that's what you would like to do 196 - again if they are distressed and adamant to go in for pain relief you just let them go back 395 - we're definitely not not the gatekeepers 593 - once they need to go on in you know they need to go on in 120 - I would never want the responsibility of having upset someone or ruined their birth experience because it appears that we are the gatekeepers and not letting them in
Monica - Shared decision-making - Advocating for women by taking control	315 - I would like to say it is a joint decision cos I can't speak for my colleagues but certainly when I am talking to people after explaining the process and why we need those 3 things to be working in the best way they can be erm making the suggestion and then saying 'how do you feel about that?' quite often you get the impression that its that authoritative thing they don't feel they can go against it so it's trying to put things in such a way that you're giving them permission to say no if they want to 276 - when they've had several babies before I tend to reflect it back to them and say 'OK so you've told me this this and this in most cases we know that you need these things to be happening but you're the only one that knows what

Group Experiential Theme: “...the end decision is always theirs” – Doing right by women

you're feeling at the moment what does your gut tell you is happening? Do you feel like you're almost there? Or do you feel like you've got some time? And then they say 'err I think I'm probably alright at the moment but it might not be long' so I said OK well you sit tight then and as soon as that changes you ring me straight back and we work it that way and make it a team decision rather than [laughs] me just advising them

482 - We are not gatekeepers [laughs] we are advisors [laughs]

372 - I think the conversations have changed from the early days of 'is it OK if I send this lady in?' to 'this lady is coming in' [laughs] to if I feel particularly strongly 'this lady is coming in and we have made the plan that we are going to do this this and this – do you have a room free?' [laughs] erm so your advocating for the woman before she's even got there [laughs]

393 - well I guess [pause] mmmm it's us standing up for the women no matter what and perhaps they have more of a voice now

396 - we are now the intermediary between them and wherever it is that they are going to end up so rather than them having to make that call and they're just being told to come in

Group Experiential Theme: “...it's all the little bits around the words themselves” – Undertaking assessment with the absence of senses
**Personal Experiential Themes
leading to Group Experiential Theme**
Line number and key quote

Group Experiential Theme: “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses

Stephanie - The strengths and restrictions of midwifery practice using only the ears	318 - listening to them get helps me to get to know them listening to them what's happening in the background what they're saying what they're not saying whether they are confident whether they are expressive I definitely can get a grasp of them roughly I think 192 - it can be tricky but then you just use all of your other senses and your gut intuition and your experiences from before and just go with it 182 - I mean they've started this um I've forgotten what it's called show the midwife thing now so like if somebody says oh I think that there's blood and it's a tiny bit they can send a picture so they can email us a picture and we can see and actually that's fine that's a show so that is quite good so it gives you a bit more like more puz more pieces for the jigsaw to put together 267 - on the ward you've got the vaginal examination you can feel the palpation and things like that so erm you can palpate sorry the contraction 236 - you can hear like grunting or you can hear exasperation or you can hear ohhhh like you kinda think right okay or if you hear nothing apart from laughter you think hmmm
Michaela - Utilising visual tools to support assessment	326 - I've tuned in over the years and I've learned to block out everything else 450 - it's really helpful for all those I'm bleeding that's a show that's completely normal and that's fine and they tell you it's loads and they send you a picture of a pantyliner with a five piece smudge on it so that's been very helpful 465 - it doesn't bother me that I can't see what's happening I very much work in I can only work with what I know so they I do rely on them to have to tell me what's happening

Group Experiential Theme: “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses

Penelope - Confidence in and restriction of midwifery using listening	579 - I think you can tell a lot from a conversation you can tell a lot you can tell a lot you can hear pain you know you can you can you can hear fear you know you can you can listen to crying you know there's lots of things there's lots of erm what do I mean not but not body language because I can't see them but you can pick up on the cues can't you from women erm and I feel quite confident in my triage 584 - what women say and what they what I hear are two different things erm that's quite interesting but apart from saying I don't believe you I can't do anything else so I have to go with what they say 603 - I feel like I'm quite confident in in my listening skills and my understanding of you know women in in labour I think I am I mean obviously nothing beats face to face and in intuition when you actually meet somebody you know but we haven't got that 725 - there might be lots of what do you mean by lots of blood is that the waters with mixed in with blood? is she having a PPH? 107 - with this I think it's consistent you know we're we're out of the hospital which makes a big difference erm we've got brilliant communication lines into the hospital but it means that we can focus erm and it's kind of a different role it's a different hat erm and I think that's really important because we're kind of focused on our triage skills really
Naomi - The constraints and signals of telephone assessments	243 - you also um get an idea of how the contractions are as to whether they can actually hold the conversation with you or not so even just doing that helps you 331 - sometimes you can just [pause] feel it 602 - sometimes you'll have the lady will ring twice and then the third time the partner rings because the lady can't speak anymore which is also quite a good sign

Group Experiential Theme: “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses	
	302 - when people are very vague you do end up having to send people in to be assessed cos you're not sure
Monica - The art of midwifery through the ears	138 - I have found that my listening has heightened since the only thing I can liken it to is if you were deaf or blind and your other senses heightened to compensate because you're so focused on what's going in here [points at ears] and there's nothing else 338 - I mean it's not just about questions and answers it's about hearing what's not said and that again comes from nearly [x] years of doing my midwifery through my ears [laughs]...it's the tone it's the breathing pattern it's the way things are the senses are constructed its all the little bits around the words themselves 147 - it's almost because I guess I've been in that situation where in a labour room with a woman I can visualise what's going on in that lounge at home and I I put myself there so then when I speak to her on the phone again I talk to her as if I'm sat on the sofa with you erm hopefully that comes across to them [laughs] 27 - you hear the tone in their voices just calms erm you know they perhaps they can just about talk through a contraction and then on the next phone they say 'oh I'm sorry can you wait a minute I'm about to have another one' er and the next time it's the partner [laughs] its it's nice seeing it all the way through [laughs] 347 - it's not just about the time constraints it's about everything that is going on around you you know if you stood with your eyes closed on the phone on labour ward people would think you're a bit nutty [laughs] but otherwise you know you've got people running round you've got noises beeps and allsorts going on and you can't shut it down you're tuned in to all of it you know you can be chatting to someone on the phone you can hear a bradycardia in the room next to you [laughs] erm you haven't got those distractions and the way that we are kind of sat in our desks with the

Group Experiential Theme: “...it’s all the little bits around the words themselves” – Undertaking assessment with the absence of senses	
	screens round you’re almost cocooned as well and quite a few of us I’ve noticed if you watch them as well they kind of move in to the desk so they are even more cocooned so its just you and that caller and that’s it nothing else

Group Experiential Theme: “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Stephanie - Unprofessional attitudes of hospital-based staff	536 - you know sometimes you get people questioning your your judgement your clinical judgement or basically insinuating that you’re stupid erm and ringing you back to tell you that actually by the way you're wrong [laughs] erm which I think is really quite rude but anyway 522 - it just depends so sometimes there's conflict sometimes there’s aggression sometimes there’s anger sometimes there’s just everyone like exhaustion sometimes there’s burnout sometimes you are literally just the you just get the flack because it feels as though you are that person sometimes 500 - sometimes you get people who will say well have you asked the woman this and [sternly] I’ll ring the woman myself and ask and ask her the questions which I think is a total waste of time and money 515 - I said there's a woman a multip on her way to you and she said to me errrrr what the hell do you think you’re doing and I said look this was a decision made by the band seven in [place name] and erm literally I think I got about ten minutes of abuse from her

Group Experiential Theme: “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	
Michaela - Questioning professional recommendations	32 - we will say we've got a lady to come in and they'll question actually whether they need to be seen and I think some professional courtesy would be nice in those situations when we've made that decision 47 - I think sometimes it it does get forgotten that actually we're all qualified to the same level and so actually a little little bit of respect for each other goes a long way 48 - and I think they're so tired they're so worn out they're so pressured that that [respect] goes by the wayside a lot lately
Penelope - Managing the tension of removing control - Advocating for women	508 - we're not adding to their workload we're actually streamlining it a bit actually that's what we're actually doing without us they would have far more admissions I don't I sometimes think they forget that we're not phoning women up from the yellow pages encouraging them just to come in erm we're actually erm staggering them in order to make their workload probably more bearable but that's sometimes not how it feels to them 802 - we of course have taken away some of the triage from them and I think that that was always tricky when it first happened 500 - I think I've got quite broad shoulders I know what they're thinking erm it is what it is my job is to do that I'm the advocate for the woman I've triaged her I've risk assessed her that in my opinion or in the woman's choice she wants to come in so they have to see her [laughs] that's it that's their job you know it's our job isn't it? 282 - we've got experienced midwives there we could do with them on the floor so I think it's that kind of mentality really that needs to change or the culture or the understanding of it all 504 - sometimes we have some battles sometimes we have some negativity erm but I'm pretty broad shouldered and I understand where it's coming from but it doesn't deter me from liaising them in anyway

Group Experiential Theme: “...some professional courtesy would be nice” – Advocating for women amid resistance from colleagues	
Naomi - Coping with criticism from colleagues	321 - the midwife in charge was [sternly] very assertive why on earth are you sending this lady in? she's only contracting every five minutes what kind of assessment tool are you using out there? 341 - I'd say we got a rather frosty [laughs] reception from many of what I'd call the old school some of the remaining old school sisters 545 - if I'm liaising someone to one of the other Trusts that I don't originally come from even if I had one of those frosty people speak to me because I don't know who they are and it doesn't I don't take it personally 571 - it doesn't change my decision making or anything it just makes me think I hope she doesn't answer the phone [laughs]
Monica - Advocating for women by taking control	379 - You're sending someone who is not in labour into the hospital and you know that is not going to go down very well [laughs] 364 - sometimes you feel you need to convince the person at the other end that this person needs to be seen erm again I have found a lot of those conversations alter according to how you start that conversation

Group Experiential Theme: “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote
Stephanie	39 - I think that sometimes like my colleagues think oh yeah you're just having a jolly there

Group Experiential Theme: “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	
- A lack of appreciation for a complex role - Bearing the brunt of broken expectations	561 - I feel like sometimes some of those midwives do need to come...to labour line and just erm listen to a couple of hours of calls just so they can understand what we're dealing with 697 - the expectation thing is hard and it's hard when people aren't kind or they're rude or do you know what I mean or they start swearing at you or they start threatening you that's really really really hard 42 - if you have a call from the matron saying all homebirths are suspended or all the women are diverting from [place name] to [place name] that has a massive impact on people's birth choices people get really angry with you we are definitely definitely notice that people have become more abusive and rude on the labour line because we're telling them bad news 110 - nobody would accept this woman or accept to come out to her so I was like frantically making all these calls and I said look I don't actually care who goes out but somebody needs to come out to her...but it was this problem between [Trust name] and [Trust name] it's something that was beyond my control
Michaela - The unseen value of labour line - Managing divert	400 - I'm still sure that people think we're just sat out there with the desk reading take a break feet on the desk and answering you know an old style phone maybe once every half hour and saying yeah take some paracetamol and have a bath and that's all we do 232 - so I'm thinking child protection possible erm immigration issues possible erm trafficking erm some control issues happening there 359 - when there's a divert on I think people forget that we're then having to have that difficult conversation with them and saying I'm I'm really sorry and I know you live ten minutes from the hospital but actually I need you to drive half an hour to a different unit that you don't know that you've not prepared yourself for that you're gonna feel really

Group Experiential Theme: “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	
	uncomfortable about going to that you've not allowed enough time for because you thought you only had ten minutes [laughs] and those conversations are hard and I think people forget that we're the ones stuck having to do that 389 - I sold it the other day by saying...I'm afraid you are going to have to go into one of the main units because we don't have home birth midwives to send out to you what's your preference [one hospital site] or [other hospital site] so I worded it in a way that they had to give me an answer as to which unit rather than I'm not going [laughs]...and then I said think of it this way what would you like on baby's birth certificate? [laughs]
Penelope - The challenges of working across multiple Trusts - Managing the disappointment of diversion	276 - I think it's quite erm frustrating when you when you're you know because every every system is a little bit different but the the people that we're working with aren't particularly helpful we don't really feel like we feel like we could help them more if they if they join the club 197 - we work across [geographical areas] so every hospitals got a slightly different take on it 221 - the knock on effect has had a massive impact on women because their expectations or their birth plans have kind of gone out of the window erm and of course they've got to adapt to that and it's not a great time to adapt to that when you're you know anticipating a home birth and then you phone the labour line and we say I'm so so sorry we we're gonna have to ask you to come in and of course that's hard for the midwives on the labour line because it's giving news like that it's a really wrong time 227 - you know the erm I you know I had a woman the other day that just put the phone down on me erm an and it and I can understand why she was so upset

Group Experiential Theme: “...just having a jolly” – A lack of appreciation for the multiple challenges faced by midwives	
Naomi - The weight of responsibility	737 - still I'd say I think about that case and several times every week and I didn't actually do anything that wasn't right but because of what was said about you whatever it just stays with you forever 693 - even when the baby is born obviously they all think it's exciting but I'm still thinking I've got a placenta to come yet or bleeding 715 - maybe you'd be tired at three in the morning and you miss something or say something it is all there if you've made a mistake it is there to be see
Monica - Managing the challenges of labour-line	298 - you're just running through different scenarios in your head while still talking to her and trying to keep her calm thinking have I got a midwife nearby? 519 - sometimes that goes down ok and sometimes it doesn't and we'll get people shouting 306 - of course working [x] Trusts as well some of the guidelines and things are very slightly different so just having to bear that in mind when you get one lady from one area another lady from another area same story but you treat them differently

Group Experiential Theme: “...all round everybody gains from it” - A symbiotic relationship with the ambulance service	
Personal Experiential Themes leading to Group Experiential Theme	Line number and key quote

Group Experiential Theme: “...all round everybody gains from it” - A symbiotic relationship with the ambulance service	
Stephanie - Working collaboratively	653 - we can just call an ambulance erm with the click of a button and we can get I think it's an eight or an eighteen minute response they're normally pretty quick if we if it's a time critical and the team are really really good they're really responsive they're really communicative with us 683 - it's nice to work with different midwives outside of the hospital environment from different Trusts and get to bond with different midwives to broaden your midwifery colleague network
Michaela - Mutual benefits of collaboration - Adopting dual identity	301 - I know that the paramedics like having us there as a resource to go to they'll quite often call in if it's a job that we've missed cos we were busy and they'll say oh I'm with so and so and she's this that and the other we were going to do this do you think that's ok? so it's quite nice to be a bit of a backup for them 11 - you've always got a buddy next to you that you can bounce ideas off of if you're not sure about anything and there's the the wider team in [ambulance trust names] should any emergency occur that you need extra help with 284 - that's a really kind of big thing I think from the collaboration of [Ambulance Trust name] working with labour line because potentially I think that baby could have died 304 - I do kind of see myself as 50/50 so I'm there helping emergency services but I'm also doing my bit for the Trust as well so I don't really see it as an assistance thing for me personally I am I always joke that if you cut me in half I'm partially green [laughs] 199 - we're one big happy family we're seen as part of the team they will come to us to ask us for help in the same way that you know we will naturally assist them if we see any maternity jobs coming up

Group Experiential Theme: “...all round everybody gains from it” - A symbiotic relationship with the ambulance service	
Penelope - The benefits of collaborative working to the care of families and professional development	74 - obviously the paramedics you know have a huge you know huge education but obviously maternity's probably a smaller part of it so it's us it's kind of like filling in the gaps just adding a bit more to their jigsaw [laughs] erm so it's just just a general support for them really whether they use us or not but we're there for them to use as as they see fit and if we can help we will and if we don't know the answers we are really good at signposting 82 - they have it's a hotline to the midwives 48 - they've been really supportive [Ambulance Trust] have really welcomed the midwives in the room and I feel that we are quite a valued member actually and we're we're treated really really well 25 - you get quite sort of streamlined into just thinking maternity is the be all and end all of life but actually it's quite interesting to hear listen observe people talking to other people 55 - been useful for both it's given us some understanding of what they have to deal with and their fears and anxieties and it's helped us well it's helped them and our relationships
Naomi	
Monica - Collaborating with the ambulance service for the good of all	535 - I just think all round everybody gains from it the women get better care because its more specialised the crews are advised better so they can do a bit more for the women so they can do a bit more for the women erm those that don't get ambulances get seen quicker generally it's good all round [laughs]

Group Experiential Theme: “...all round everybody gains from it” - A symbiotic relationship with the ambulance service

226 - quite often its things that stop people going into hospital stop people going to A&E and takes the pressure off the service in other areas just for a three minute phone call so I think its good

502 - we will take over those calls and we triage in a non- saying non-structured sounds bad in an individualised way erm get a bit more history which they don't do and find out if they have any other ways of getting in to be seen as well and it could be that they don't need to go to A&E yes they need to see a midwife and we can make that happen but without lights and sirens so we can save the ambulance service some money and save somebody else's life by letting that crew go off to a cardiac arrest

531 - We give detailed handovers to the crews each time as well so they know exactly what they're doing we'll give them instructions

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