BirthWise

Maternity Survey

A survey of self-selected women who gave birth
in Northern Ireland between January 2015-August 2019

BirthWise Survey Report September 2019

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1. Background

Maternity services in Northern Ireland are provided mainly by the five Health & Social Care Trusts. Pregnant women also access information and support through Sure Start, as well as through a range of third sector and private services including antenatal workshops, classes, and therapies, doulas, and some private obstetric services. There are currently no independent midwives in Northern Ireland.

The *Maternity Strategy for Northern Ireland 2012-2018* was published in 2012 by the then Department of Health, Social Services and Public Safety. It made a series of recommendations for maternity care, including the provision of alongside midwife-led units on the same site as obstetric units, reducing inappropriate variation in practice across trusts, and recommending separate pathways for midwife-led and consultant-led care. Since then, significant achievements have been made through the hard work and dedication of service providers, service user representatives, maternity care researchers, commissioners, and policy-makers.

The strategy highlighted the importance of considering prospective parents as *"partners in maternity care"* (DHSSPS 2012, p.12) and recommended that they be *"given all relevant information, in appropriate formats, to make informed choices about what is best for them and their baby"*. (DHSSPS 2012, p.27).

BirthWise is a new, Northern Ireland based charity focusing on pregnancy, birth, and new parenthood. We are a grassroots movement of expectant and new parents and those who support them. We aim to connect, empower, inform and support new parents, and campaign for continuous improvements in maternity care and other relevant services. We are a values-based charity: integrity, transparency, excellence, equality, selflessness and passion drive us in our work.

The BirthWise Maternity Survey 2019 was developed as part of the charity's mission to campaign for continuous improvements to maternity services in Northern Ireland. The survey was designed by BirthWise volunteers, including service user representatives, advocates, midwives and student midwives, who helped identify key questions about current services and women's experiences. The survey team shared the proposed survey with ORECNI (Office for Research Ethics Committees Northern Ireland), and with academic researchers at Ulster University. Both agreed that the survey was not likely to meet the definition of 'research' and therefore did not need ethical approval. The team also completed the Health Research Authority questionnaire which confirmed this.

The survey provides valuable data to inform the charity's campaigning objectives. There are 14 recommendations, which are based on the survey responses from local women. A total of 1977 responses were received during July and August 2019. The

survey was open to women who have had a baby in Northern Ireland between 2015 and 2019, and it was made clear that women could fill in the survey more than once if they had had more than one baby during the timeframe.

There have been almost 100,000 births in Northern Ireland since 2015, and the 1977 responses we received cannot be seen as in any way representative of all women's experiences. However we are extremely grateful to all of the women who took the time to fill in the survey and tell their stories. Their stories matter. Their voices matter.

In 2016, researchers at Queen's University Belfast carried out a comprehensive survey: "Women's Experiences of Maternity Care in Northern Ireland" (Birth NI, 2016). The report highlighted that *"Overall, women are largely positive about their experience of maternity care, but it is also important to consider the experiences of women who were less satisfied with their care and find ways to improve the quality of care for all women and their families" (p7)*

The BirthWise survey aimed to gather crucial information on the state of current practice in maternity care, with a particular focus on women's sense of agency and locus of control, by investigating how well informed they felt and how their wishes were respected throughout their maternity care.

Aims and Objectives

The key aim of the survey was to explore the views and experiences of women accessing maternity care in Northern Ireland, as well as highlighting important issues in terms of current practice in maternity care. The survey covered all aspects of maternity care, including choice of place of birth, type of care received, antenatal education, induction of labour, caesarean births, infant feeding and postnatal care. Specifically, the survey aimed to:

- Explore practice around the provision of antenatal, birth, and postnatal care in Northern Ireland.
- Highlight high quality care and innovative practice in maternity services in Northern Ireland.
- Explore women's involvement in their care in terms of receiving full, evidence based information, and having a sense of control over their experience of maternity care.
- Highlight strengths and gaps in maternity care, and make recommendations based on women's responses.

Methodology

The online survey was chosen as it was an accessible way to engage with relevant women, and considered to be the least intrusive in the lives of busy parents. It was made up of 16 sections with open and closed ended questions.

In addition, the ability to share the survey via social media would enable a large sample size to be obtained. The survey was open to anyone who gave birth between January 2015 and August 2019, inclusive.

The survey was launched on Friday 5th July 2019 via the following social media platforms:

BirthWise Facebook page
NI Maternity Forum Facebook group
BirthWiseTwitter account
BirthWise Instagram account

It was shared widely on social media, and highlighted by both Belfast Live and MumsNI.

The survey closed on 31st August 2019. In total, 1977 responses were received.

2. Survey Results

Throughout the survey, most women continually affirmed that they had positive experiences of maternity care. They praised the support, care, and professionalism of maternity staff and healthcare professionals, and highlighted examples of excellent practice.

Some women had difficult or challenging experiences, and it is important to listen to and learn from their stories. The recommendations made in this report are based on these challenging experiences; they highlight areas where attention is needed, or where innovative work in one Trust needs to be rolled out regionally.

[NB figures used throughout may not add up to exactly 100 due to rounding. Also, for some questions, women had the option to select multiple options, giving totals of much more than 100.]

Section 1: About You

a) Participants

The survey was open to women in NI who had a baby between January 2015 and August 2019. There was a good mix of responses across the different birth years.

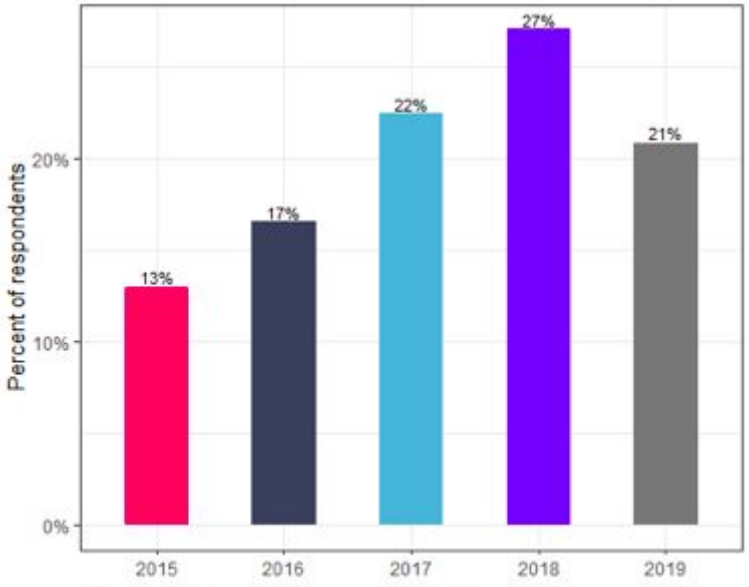


Figure 1. When was your child born?

55% (n=1087) of women focused on their first/only baby, while 28% filled in the survey in respect of their second baby, and 17% reported about their third (or more) baby.

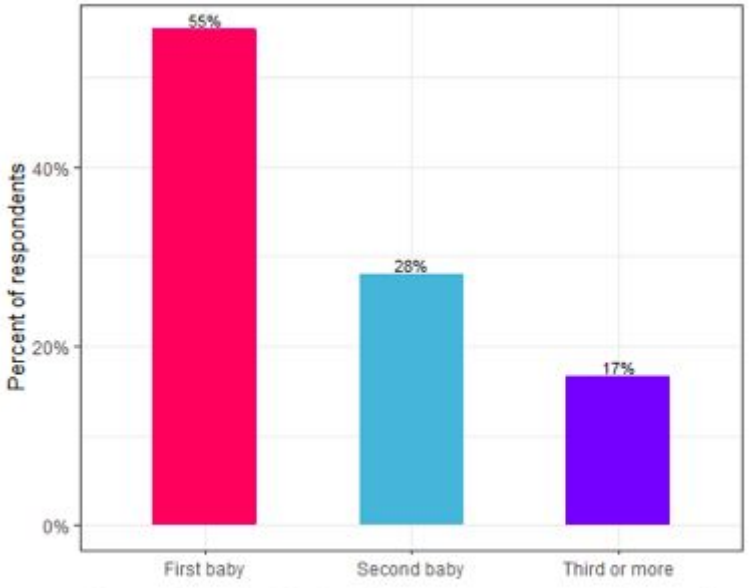


Figure 2. Which baby do your responses relate to?

In terms of maternal age, the majority of women were aged between 25-35 years at the time of this baby's birth (37% aged 25-30, 36% aged 31-35). 10% were aged under 25, while the remaining 17% were aged 36-40 (14%) or over 40 (3%).

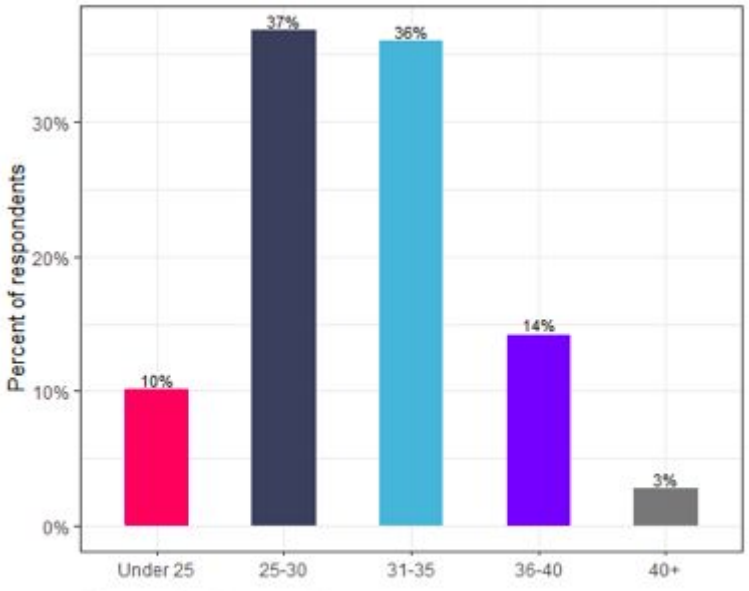


Figure 3. Maternal Age

Women from across Northern Ireland filled in the survey, with more responses from Belfast and the South Eastern area than from the other HSC Trust areas.

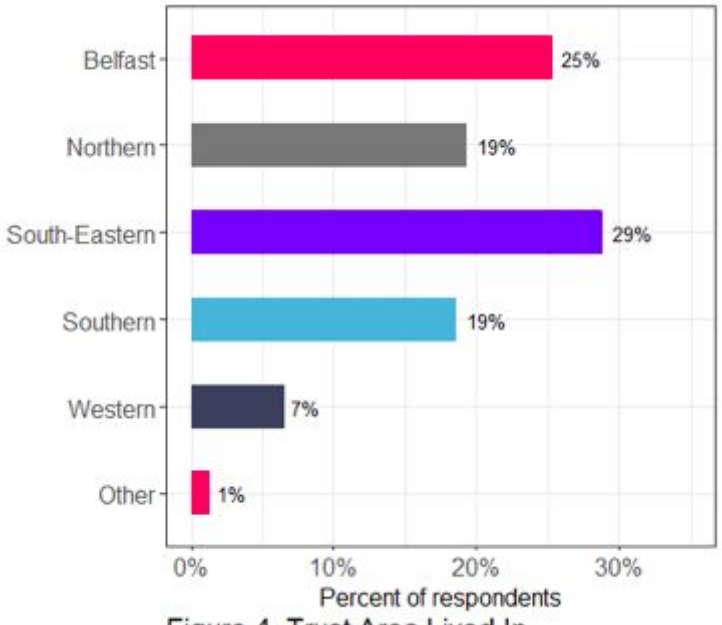


Figure 4. Trust Area Lived In

The majority of women (82%) gave birth in their own local HSC Trust. 18% gave birth in a different Trust.

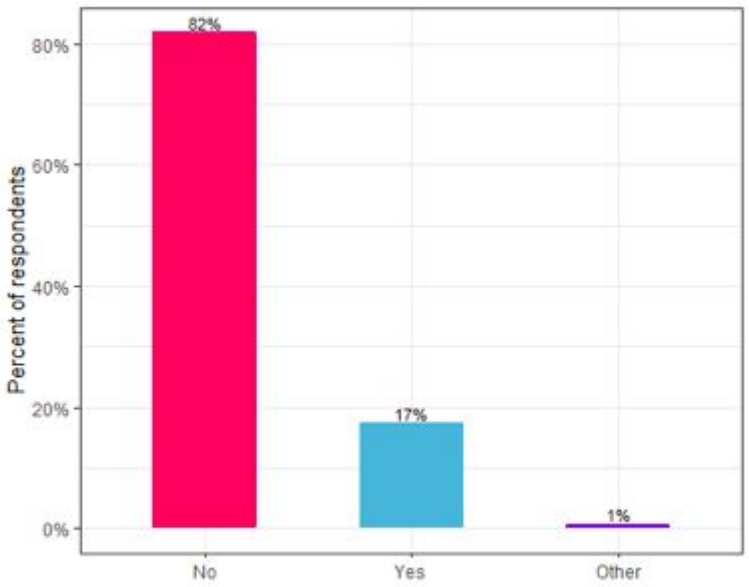


Figure 5. Did you give birth in a different trust?

Of those who gave birth in a different Trust area to where they lived, the most common reasons were as follows:

Geography: For some women, their nearest unit was in a different Trust area to their home address. Other women chose to birth in their home area (when this was different to their current residence) or where they worked. It is helpful that the boundaries between Trust areas are seamless and that women have this choice.

Complications: Some women reported that they were advised to attend the regional specialist unit in the Royal Jubilee Maternity Service, due to complications—either for themselves or their baby.
Some women reported that Neonatal care was required, but this was not available locally at the time.
In addition, some specialist services are not available in every unit—for example women with gestational diabetes in SHSCT are advised to attend Craigavon Area Hospital. Some of these women were very distressed that they could not access care at Daisy Hill Hospital.

> "[I had] no choice as I developed Gestational Diabetes - I had wanted to deliver in MLU at DHH and was devastated at the time to find out I had to deliver at CAH."

Lack of midwife led unit: Some women living in the Northern HSC Trust area chose to go to a different Trust area specifically because they wished to birth in a midwife led unit (MLU) and the Northern Trust does not have one. This is particularly interesting, given a clear statement in the previous maternity strategy (DHSSPS, 2012) "*Where a consultant-led unit is provided, a midwife-led unit will be available on the same site*" (p14).
The Northern HSC Trust has recently developed innovative midwife-led care within the existing obstetric units, including the new birthing room in the Causeway

hospital, complete with birthing pool. The Northern HSC Trust has also developed an integrated community midwifery team who provide midwife-led care antenatally in the community, supporting women to plan their birth in the new birthing room. The Trust also has the highest home birth statistics in NI. This is all to be welcomed, and the development of midwife-led birthing rooms in an obstetric unit will be of great value to women. However it is also vital that women should have access to the full benefits of a self-contained MLU.

RECOMMENDATION 1: The Northern Health and Social Care Trust should prioritise the development of three MLUs - alongside units in both Causeway and Antrim, as well as a freestanding unit elsewhere within the Trust.

Care options: Some women chose to attend a different unit in order to access care options not available locally. This included women who wanted the option of a vaginal birth for a breech baby, a vaginal birth after a previous caesarean section (VBAC), or a vaginal birth after two previous caesarean sections (VBA2C). It is clear from women's responses that there is a great deal of geographical variability in the provision of key maternity services, including support for VBAC and vaginal breech birth. This was reinforced by women's responses to other questions in the survey.

> "Elective section due to breech presentation - this was the only option I was told I had."

> "I was very keen to have a VBAC and while a couple of the midwives I saw during my appointments were supportive of this, it wasn't consistent. At times I felt my choices were being scrutinised. As a result I didn't feel totally supported."

> "Obstetrician questioned why I was attempting a VBAC when, in his opinion, I should have been automatically booked for a caesarean birth."

Women who attended the Birth Choices clinic in the Royal reported high levels of satisfaction:

> "I gave birth in RVH to attend birth choices clinic."

> "I gave birth in Belfast HSC as I wanted a VBAC and referred to a consultant who worked out of the Jubilee Maternity unit"

> "I had my first by caesarean in [different Trust]. I had a vbac in 2016 [with the Birth Choices team] and wanted the same again"

> "My consultant [name] and the midwife [name]were amazing throughout and made the experience fantastic. Having PTSD from a horrible first birth it made so much difference. I felt liberated."

RECOMMENDATION 2: Birth Choices clinics / VBAC clinics / breech clinics should be available in all Trust areas. Individualised care plans should always be developed with women who are deemed to be outside guidelines.

Work connections: Some women chose to birth in another Trust area because they are/were employees of that other HSC Trust.

Personal choice: A number of women reported that they chose a unit outside their local area based on opinion/recommendation, because they had private antenatal obstetric care, because they had previously had a negative experience in their local unit, or based on a positive experience in the unit they attended previously.

b) Sure Start

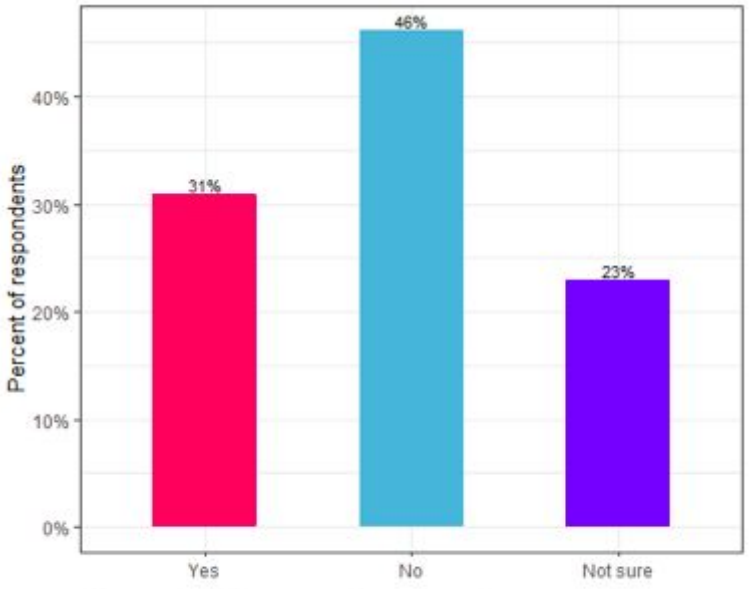


Figure 6. Did you live in a Sure Start area?

31% of women indicated they lived in a Sure Start area, with responses from women attending Sure Start projects across Northern Ireland.

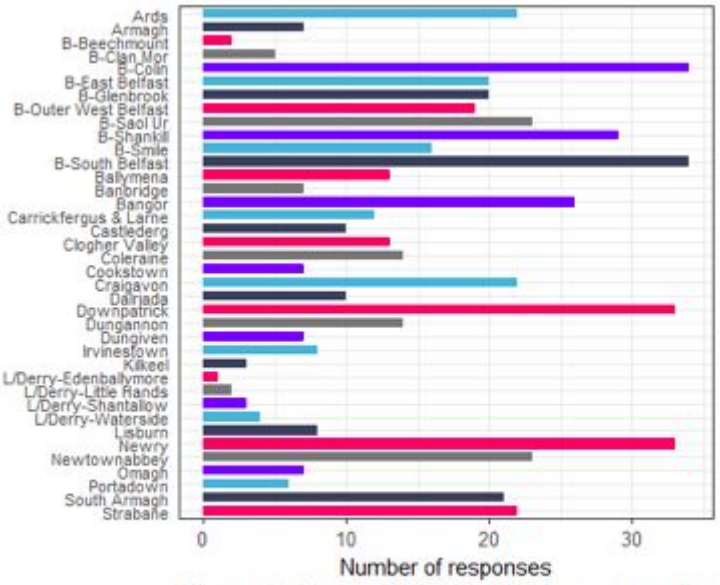


Figure 7. Number of respondents attending a Sure Start Partnership

When asked which Sure Start services women had accessed, baby massage and 'baby classes', along with breastfeeding support, were the top three most frequent Sure Start services mentioned.

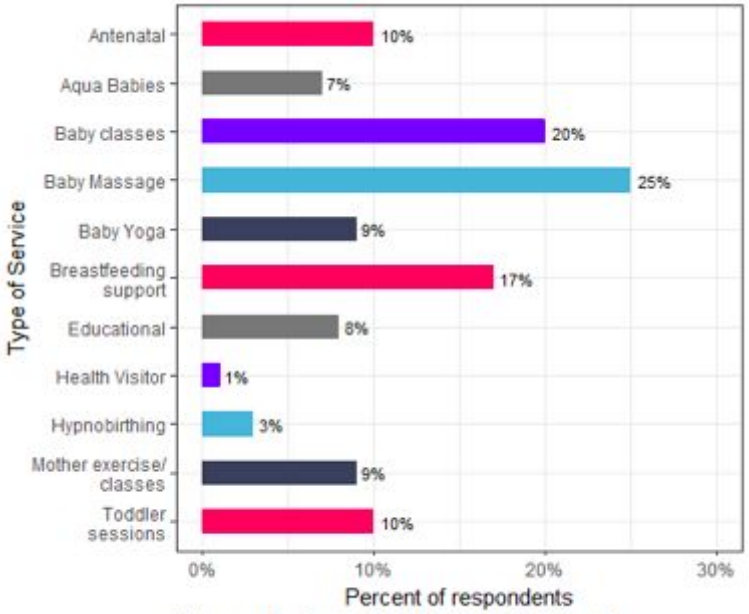


Figure 8. Sure Start services used

c) Previous Births

Women who had had a baby before were asked what type of birth/s they'd had previously, including if they had induction/augmentation of labour. Almost half of women reported they had had a previous labour induced, while 38% had had augmentation of a previous labour via a drip. 27% of women had had at least one

previous caesarean section, and a similar number had previously had a forceps birth. 23% reported having had a previous straightforward birth.

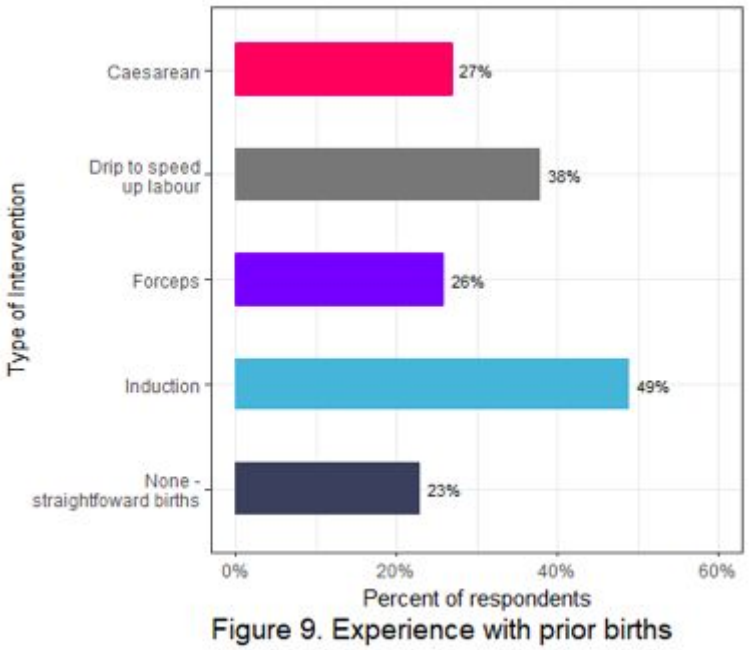


Figure 9. Experience with prior births

In total, of the 925 women who reported having previously had a baby, 709 (76%) reported having some sort of medical intervention during their previous birth.

Section 2: Antenatal Care

Women were asked about six aspects of their antenatal care:

a) Type of antenatal care
b) Discussions regarding place of birth
c) Decisions about place of birth
d) Complications
e) Antenatal education
f) Satisfaction with antenatal services

a) Type of antenatal care

Midwife-led and consultant-led care were the most common types of care with 43% and 40%, respectively. Just 13% of women attended shared care with their GP and 5% experienced other maternity care, such as shared care with consultant and midwife, private care and inpatient care.

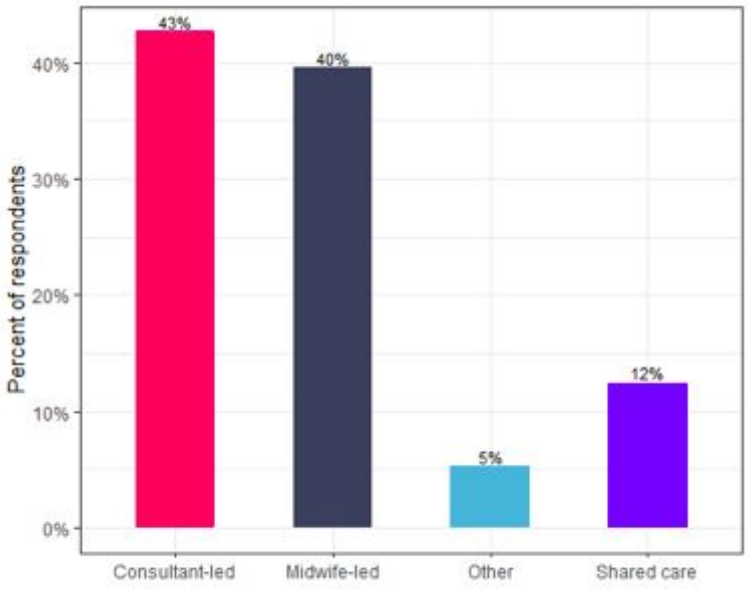


Figure 10. Type of Antenatal Care

a) Discussions around place of birth

Birth in a consultant-led unit was the most commonly discussed option (62%) followed by alongside midwifery-led units at 36%. Free standing midwifery-led units were discussed with 18% of women and the option of home birth was discussed with just 7%. In 17% of cases, women reported that healthcare professionals did not discuss any options with them. 2% reported other options were discussed. While there are examples of good practice, and some women with particular complications were clear about why obstetric units were being recommended, many other women with no complications did not have a discussion with a maternity care provider regarding the full range of options for place of birth.

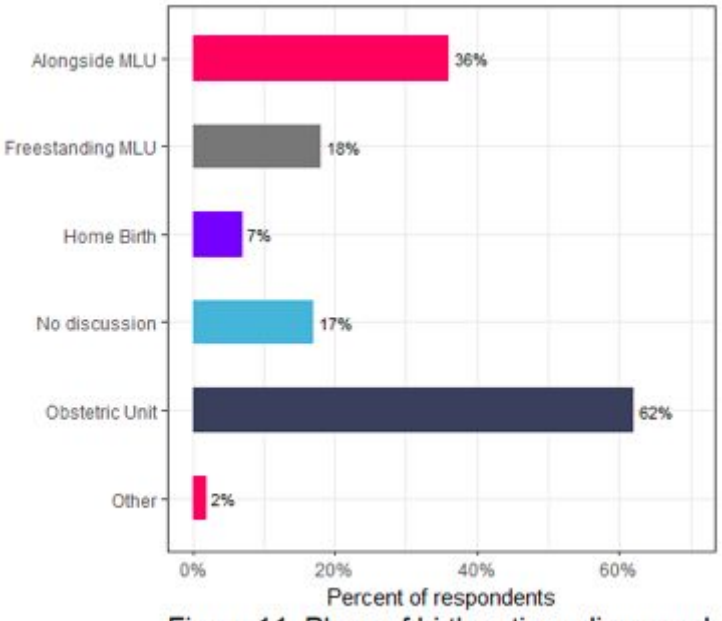


Figure 11. Place of birth options discussed

NICE guidelines specifically recommend that all four options for place of birth (home birth, freestanding midwife-led unit, alongside midwifery led unit, and obstetric unit) are discussed with all healthy women having a straightforward pregnancy. It is clear from women's responses that this is not always happening, and even when women specifically request a certain place of birth, they are often discouraged from their choice:

> "I was just asked what hospital I wanted to go to for birth."
> "I tried to discuss home birth but home from home was recommended."
> "I requested home-birth at booking. I was then told about the MLU options locally."

Other women reported good discussions about place of birth:

> "I was given options of consultant led unit or MLU. My GP advised strongly I considered MLU and I am so glad he did as before that I thought I would definitely choose [obstetric unit] in case anything went wrong."
> "Discussed in depth at Getting Ready For Baby course."
>
> "Advice provided on all 4 options ticked above, alongside unit seemed most favoured by midwife"
>
> "All options were fully explained, I had all the information I needed to make my decision and didn't feel pushed towards a certain route - I was able to keep my options open between the Lagan Valley and the Ulster depending on how my pregnancy progressed"

Some women with complications were not provided with full information to enable them to make an informed choice supported by an individualised care plan.

"Due to my BMI I believe consultant led was my only option."

"Due to gestational diabetes HCPs were not keen to discuss anything other than consultant delivery suite even though I had asked if MLU was possible. I felt they really wanted to deter me even though I was diet controlled and no concerns with baby size."

"Told I could not go to close midwife unit because of risk, but was not discussed in any detail."

Other women reported having full information and support, including from the innovative Birth Choices clinic in the Royal:

"I was offered to have my waters broken but no drugs as I was attempting a VBAC. I was also offered expectant management as an alternative by [consultant]."

"[Name] was my consultant and was happy to explore all options."

"Full information given by [Birth Choices consultant] as had VBAC."

RECOMMENDATION 3: Regional guidance should be developed to standardise approaches to discussing place of birth with women. This should build on the RQIA guidelines for admission to midwife-led unit, and the RQIA guidance for women planning birth at home. An individual evidenced-based care plan for planning place of birth should be developed in partnership with any woman experiencing a complex pregnancy.

b) Decisions about place of birth

After discussions with health care professionals, as well as with partners, friends, and family, most women (61%) decided to give birth in an obstetric unit. Alongside midwifery-led units were chosen by 31% of women and 6% wanted to have their baby in a free standing midwife-led unit. Fewer than 2% of women wanted a home birth. This reflects the responses to the previous question. In addition, some women who had booked for home or MLU ended up birthing in an obstetric unit. Often this was for clear medical reasons, but in some cases women were not clear about why their planned place of birth needed to change.

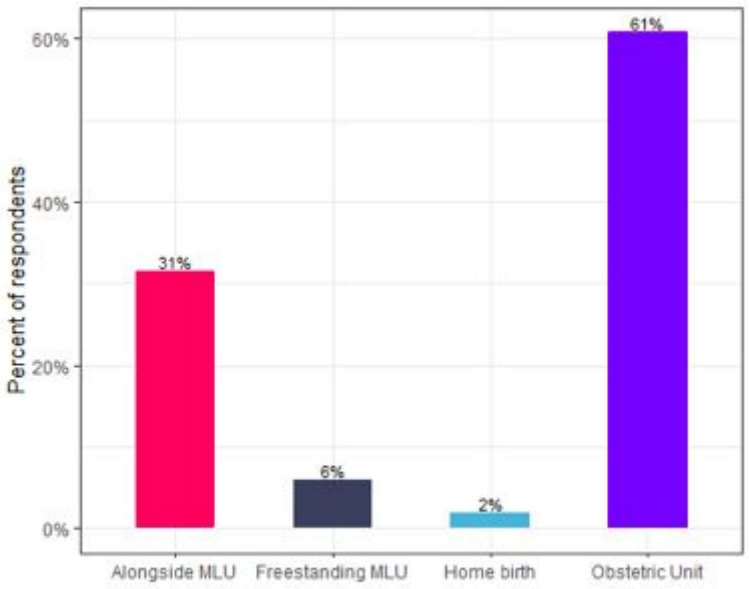


Figure 12. Choice of birth location

	OU	AMLU	FMLU	Home
First baby	57%	35%	7%	<1%
Second baby	65%	28%	5%	3%
Third or more baby	67%	24%	4%	5%

OU – Obstetric Unit
AMLU- Alongside Midwifery Led Unit – beside obstetric unit
FMLU-Freestanding Midwifery Led Unit – no obstetric unit on site
Home – planned home birth

Table 1: Choice of place of birth analysed by parity (number of previous pregnancies)

While some women were content to follow advice from health care professionals [HCPs] and family members, other women made choices that were not in line with others' expectations. Many of these women reported that their decision about where they wanted to birth their baby was not always met with support and acceptance from family and/or health care professionals. Some women also indicated they were unaware that they even had any choices.

> "HCPs actively tried to persuade me against home birth without any reference to evidence. There was a big discussion about risks of home birth at my first community midwife appointment. It was ridiculous, completely unbalanced and one sided and not evidence based at all. I had read the evidence so I pulled the midwives up on what they were saying and pointed out that those choosing a hospital birth weren't subjected to being told about the risks of their choice. I was very angry about this."

> "Mum was concerned re the pain relief should I need this & none available as well as if intervention needed & transfer to [obstetric unit] was needed."

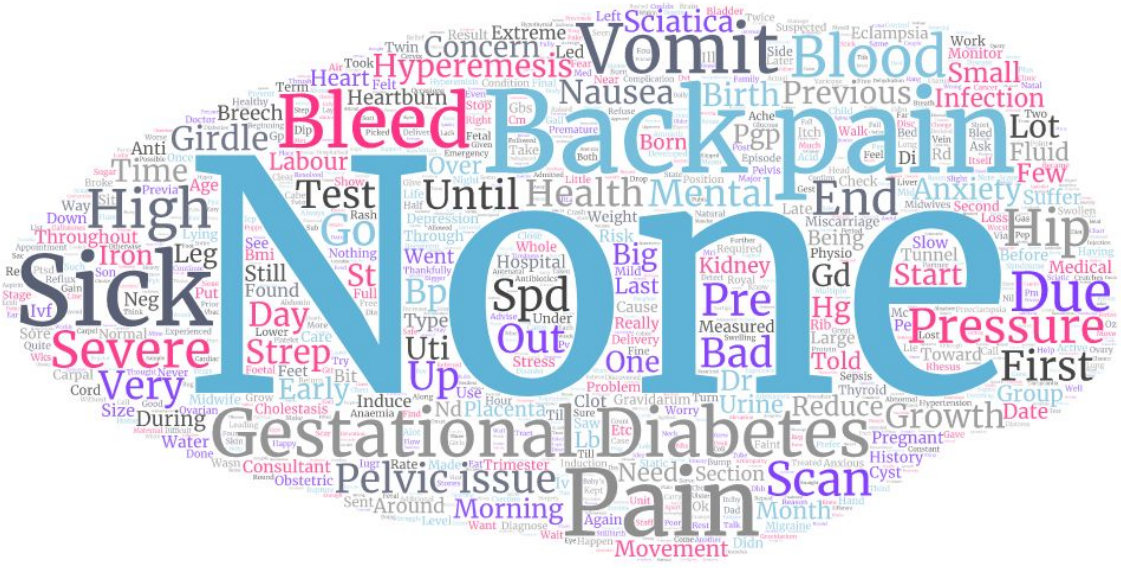
Other women clearly stated that they had themselves decided where to have their baby, with reasons often connected to their previous births, or medical issues in the current pregnancy.

> "I opted for a repeat section."

> "I wanted an elective c section following previous traumatic birth with forceps and 3rd degree tear."

c) Complications

We asked women what complications, concerns, or conditions they had during their pregnancy. These were the most common responses:



Many women had no complications, while back pain, nausea/sickness/vomiting, gestational diabetes, and bleeding were relatively common. [NB the more times a word is used by women, the bigger the word becomes in the cloud]

d) Antenatal education

More than half of the women who responded (59%) had attended some form of antenatal education.

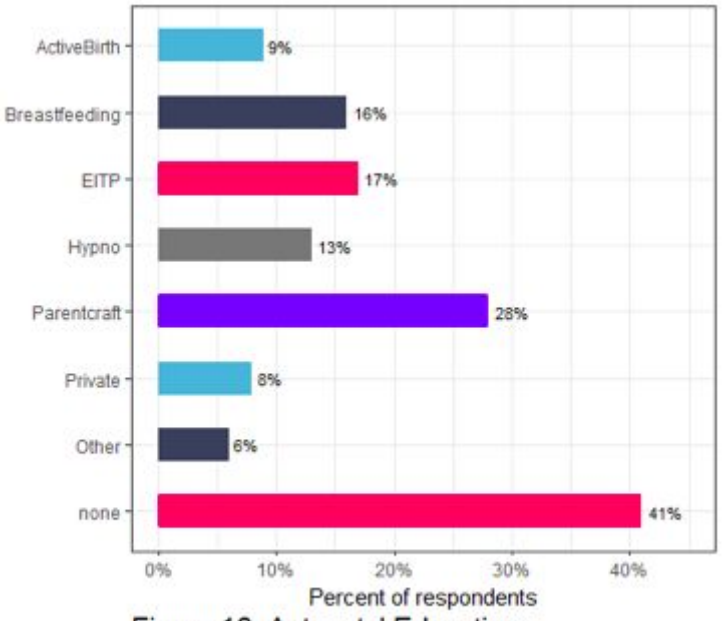


Figure 13. Antenatal Education

Some women accessed more than one form of antenatal education, while others, particularly those who had had a baby before, did not access any antenatal education.

	No antenatal education	Single Antenatal Education	More than one type of antenatal education
First baby	15%	43%	38%
Second baby	67%	19%	10%
Third or more baby	76%	16%	5%

Table 2: Antenatal education by parity (number of previous babies)

Some women attended antenatal courses offered by the various HSC Trusts while others attended private antenatal preparation courses. Parentcraft classes were found to be 'informative, but basic', with some women commenting that they felt 'rushed' and as if it was 'a 'tick-box' exercise'. Satisfaction with HSC Trust-based courses appeared to increase with MLU workshops and the EITP (Early Intervention Transformation Programme)/GRFB (Getting Ready For Baby) programme, with midwives who took the sessions being described as being 'woman and baby centred'.

> "Grfb was excellent I couldn't recommend it enough!"
>
> "The parentcraft classes were a little disappointing."
>
> "Midwives very warm, supportive and caring during sessions."
>
> "Parentcraft was basic and informative."

"The Active birth workshop and breastfeeding workshop were fantastic."

Many women commented that HSC Trust courses spent the majority of the time focussing on the labour and birth, but did not prepare them for the first few weeks postnatally and the reality of breastfeeding. They wished that they had received more information on how the body changes, how they would feel physically after the birth, and what was considered normal. Additional breastfeeding information and support was also highlighted as a gap.

"There could have been more info and better support for breastfeeding."

"Wanted more advice about how would feel physically afterwards. Despite being a nurse I didn't realise how much pain I would be in and this is normal."

Women were positive about the antenatal education and support they received via Sure Start.

"Really helped me prepare for labour and parenthood."

"Hypnobirthing within Sure Start was very good"

"It was a surestart breastfeeding support group, it was amazing. I got to speak with ladies who had started their breastfeeding journey and how to overcome some hurdles without giving up."

Women who had attended paid-for classes, including Daisy, Gentlebirth, NCT, hypnobirthing courses and pregnancy yoga, or who had engaged a doula (professional birth companion), rated these services as 'excellent' and 'amazing'. Many of these women reported feeling prepared, confident and empowered for their birth, enabling them to make informed decisions.

"Hypnobirthing was wonderful."

"GentleBirth was the best money we ever spent and truly prepared us both mentally and physically for the birth I wanted."

"1:1 in my home with a Doula. I had done my own reading and practice as well as these sessions."

"Hospital sessions were very basic so we booked an NCT course. It was expensive but much more informative and calming."

"I did my own reading, in particular the Milli Hill Positive Birth book was great and learned a lot from my doula and home birth support meetings."

"I loved the Daisy Classes - feel confident and prepared, amazing."

In further analysis trends were noted regarding place of birth following various types of antenatal education:

- Parents taking Parentcraft, those with no antenatal education, or 'other' antenatal education not listed were more likely to give birth in an obstetric led unit.
- Parents taking an active birth class on its own or combined with another class were most likely to give birth in an alongside midwife led unit.
- The highest home birth rate in relation to antenatal education was seen in those who completed hypnobirthing (10% home births) or private classes (6%).
- 69% of women who did not attend any antenatal education gave birth in an obstetric led unit.

e) Satisfaction with antenatal care

In terms of satisfaction with antenatal maternity care, 76% of women reported they were happy or very happy with the care they received from maternity services and just 3% reported being very unhappy with the care they received.

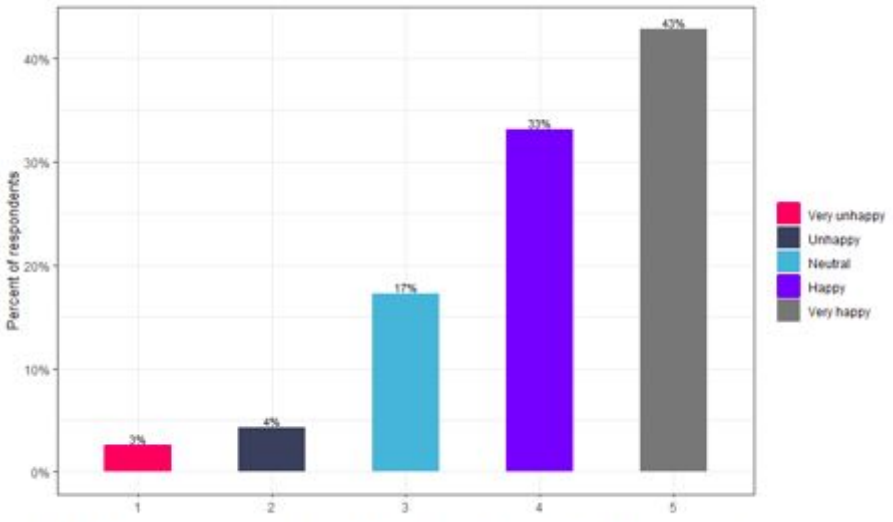


Figure 14. How happy were you with the antenatal maternity care you received?

Those who gave positive ratings commented that they did so because of supportive health care professionals, the benefits of building a relationship with the same midwife/small team of midwives, and that they had generally felt 'well looked after'.

> "The midwives in [unit] were absolutely fantastic."
>
> "Mostly down to the [GRFB] course and midwives. They were so helpful and friendly and patient with my million questions."
>
> "Medically nothing was missed, extremely caring staff, but slightly go through the motions, as a major life experience for me I was just another number for NHS."

"My midwives were always fantastic, helpful and caring."

Having a sense of control throughout their pregnancy and birth, even if the birth does not go to plan, has been shown to positively impact a woman's experience of childbirth. The importance of this can be seen in the quote below, as a woman highlights what was required to get the birth she wanted. It also highlights how empowering birth can be when a woman's wishes are respected and supported. (VBAC=vaginal birth after caesarean).

> "Looking back it took a lot of convincing to get vbac and I felt as though someone else had the power to decide what way my birth experience should be, I have always wanted a water home birth but even suggesting that seemed ridiculous to consultants and midwives, however the midwives' care throughout my labour was fantastic. I just wish women had more freedom and power over birthing choices - after all no one knows our bodies more than we do."

In addition to maintaining a sense of control, women highlighted that continuity of carer was particularly important to them.

> "I liked seeing the same midwives regularly for appointments and EITP course sessions."
> "I saw [Birth Choices consultant] for every appointment and she treated us as a family, not as a piece of meat."
>
> "Very supportive midwives. I loved seeing the same midwives each time."

Those who gave negative responses highlighted poor care, their choices not being respected, breaches of autonomy, privacy, and/or dignity, lack of compassion from some health care professionals, and a lack of continuity.

> "No continuity of care, lack of information, different midwives every time meant I had to explain my situation and medical history every time."
> "I didn't feel supported in my choice of place of birth. I thought the midwives were very defensive and focused on risk."
>
> "I had very mixed care. Some appointments I left in tears yet my consultant midwife [name] was an absolute darling and really supported me."

Maternity Services in England, Scotland, and Wales are all developing maternity care models based on maximising continuity of carer. The evidence is clear that such models deliver improved outcomes for women and babies, and that women value relationship-based care. Women benefit from care provided by a small team of midwives and other HCPs that each woman knows and trusts; this enables the midwife to get to know the woman and her wishes, thereby ensuring individualised care.

The Cochrane review (2016) on midwife-led continuity models versus other models found women who had continuity of carer were less likely to experience interventions and had higher satisfaction with their birth. Additionally, it was found to result in

fewer preterm births, fewer foetal deaths before 24 weeks and fewer neonatal deaths overall. Furthermore, research has found that relationship continuity in particular has been found to have a greater effect on the overall experience of women. This can be seen from the responses of women who felt their experience was positive and that the care they received was personal.

The Chief Nursing Officers from across the UK have highlighted continuity of carer as a key element in the Midwifery 2020 vision, and both the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists have endorsed continuity models as the way forward.

RECOMMENDATION 4: The NI Department of Health should commission a review of maternity services in Northern Ireland, and commission a new maternity strategy. This should explore models that support continuity of carer across antenatal, birth, and postnatal services for women. In advance of this, HSC Trusts should begin to explore, develop, and strengthen continuity/caseload models within existing maternity services.

Section 3: Late pregnancy

Women were asked about three aspects of their care in late pregnancy:

a) Baby's position
b) Membranes sweeps
c) Induction of labour

a) Baby's position

A key issue in late pregnancy is the position of the baby. 82% of women reported their baby was head down at 36+ weeks. 8% of women reported a breech position and 9% reported other positions such as transverse or unstable lie. Some women told us that they had realised their baby was breech but this was only confirmed in late pregnancy.

> "I knew my baby was breech from around 33 weeks but this was dismissed by my community midwife. I had to seek a private scan at 38 weeks to confirm this as I was frightened of going into labour with a baby I knew was breech but kept being told was cephalic."

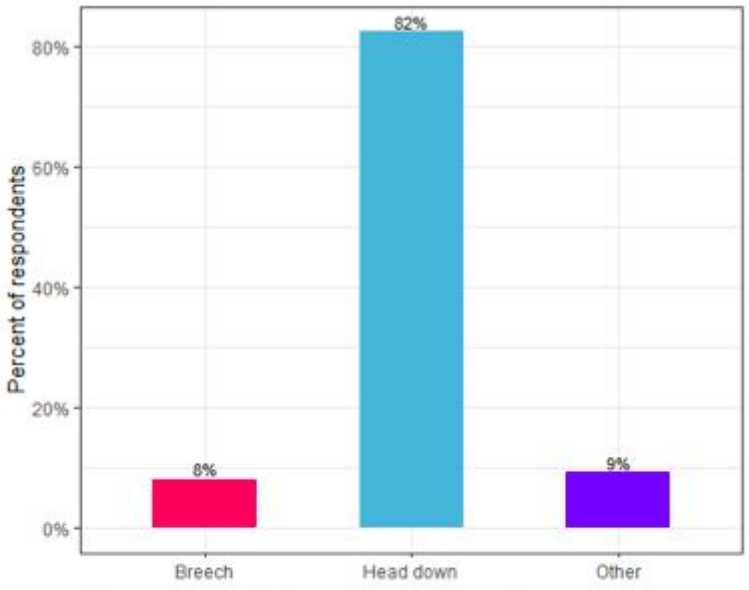


Figure 15. Baby's position 36 weeks +

Of the 161 women who reported their baby was breech, over half (58%) didn't avail of any methods to try and turn their baby. 19% decided on ECV (external cephalic version, when a doctor physically turns the baby), 7% opted for moxibustion, 27% used optimal positions to encourage their baby to turn, and 7% reported using other strategies. Some of the 'other' responses included chiropractor sessions, acupuncture, homeopathy, swimming, pregnancy yoga, and old wives tales such as sitting in the bath with frozen peas on top of their bump! Other women reported that the baby turned spontaneously.

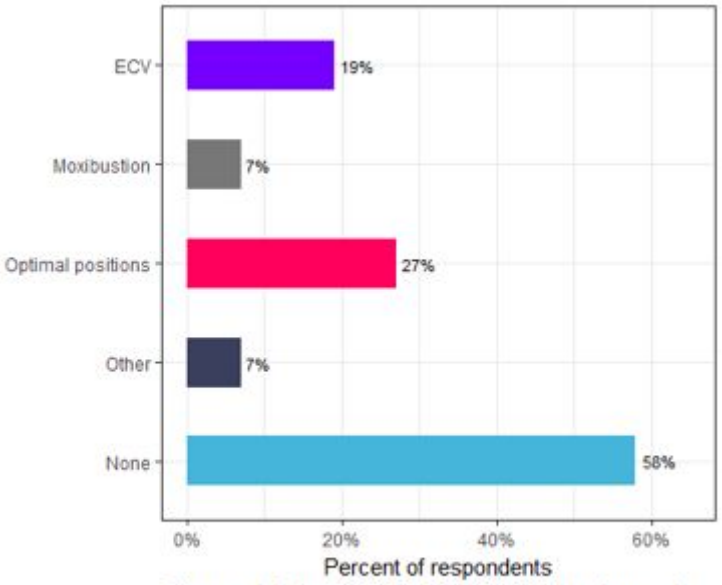


Figure 16. Interventions to resolve breech position

A number of women reported trying a range of methods to turn their baby as they had wanted to have the baby vaginally. However, very few women in our survey mentioned vaginal breech birth.

Some women had specifically requested a vaginal breech birth but were informed this was not possible.

> "At 39 weeks I was booked for a caesarean due to baby being breech. I did not want a caesarean and asked for a different option but was refused any other kind of delivery."

> "I was happy up until a point where I realised my baby was breech and wasn't listened to. After that point I felt all control was taken away from me and decisions were made which I didn't agree with."

> "Wanted to try a vaginal birth, midwife said I could but the skills have been lost, consultant said would be up to the consultant on call to decide if I would be able to, and they'd most likely make me have a c section."

It is interesting that this woman uses the words 'make me' in this context. Throughout the survey, women regularly used words suggesting health care professionals had control of what happened. Sometimes this seemed to be based on women's own beliefs; at other times it was clear that each woman's right to make autonomous, informed decisions about her body was not being respected by some maternity care workers.

The Royal College of Obstetricians and Gynaecologists, in its leaflet for women whose babies are in breech position, makes it clear that vaginal breech birth is an option, but

is not recommended if the baby is footling, deflexed, or there are concerns about the baby's size. None of this seems to be routinely discussed with the women who responded to this survey.

RECOMMENDATION 5: Regional guidelines should be developed for breech birth, including vaginal breech. Trusts should ensure that women are informed of vaginal breech birth as an option, and training should be provided to 'reteach the breech' where needed.

b) Membranes sweep

A 'sweep' is a procedure often offered in late pregnancy. It involves a midwife or obstetrician during an internal examination sweeping their fingers around the woman's cervix in order to separate the membranes from the cervix, which should encourage the release of prostaglandins that may start labour. 59% of women in our survey were offered a sweep in late pregnancy.

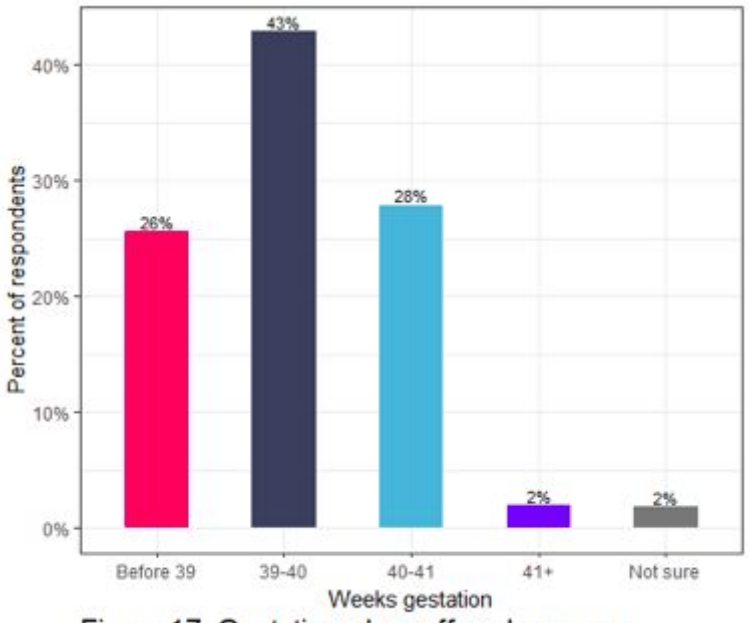


Figure 17. Gestation when offered a sweep

NICE guidelines recommend that women are offered a vaginal examination for a sweep prior to formal induction at 40 and 41 weeks for first time mothers, and 41 weeks for women who have had a baby before. However, responses showed that a quarter (26%) of women who were offered membrane sweeps were less than 39 weeks pregnant when this happened, with a further 43% offered sweeps between 39-40 weeks. This means that in total, over two thirds of women (69%) in our survey were offered a membrane sweep prior to the recommended 40 weeks.

Many women who were offered a membrane sweep prior to 40 weeks had additional health conditions, such as high blood pressure or gestational diabetes. However, a

number of women reported that there had been no health concerns. One example was a woman who had a 'low-risk' pregnancy, with no other health complications. She reported she was offered a sweep as well as induction at 39-40 weeks, with no reason or information given. She declined this and went on to have a spontaneous onset of labour and birthed in an alongside midwifery-led unit.

Further analysis of the data shows that 61% of the 299 women who were offered sweeps before 39 weeks had consultant led care, while 23% were on a midwife led pathway.

Of the 1170 women offered a sweep, 77% went on to have the procedure. Some women reported that this was for clear reasons such as pre-eclampsia or concerns about their baby's pattern of movements. Others highlighted that it seemed to be routine, or were given reasons that do not match NICE guidelines, such as maternal age or a possible big baby.

> "I was told it was due to my age. I was 40 at the time."
>
> "Very little information other than baby was large and it was advised since it may get labour started naturally, therefore avoiding induction."

There was wide variation in how well-informed the women felt, with some getting little to no information, while others had a full explanation of the process and the pros and cons.

> "Description of what would occur, asked for consent and a person was asked to come and supervise."
>
> "The process was explained to me along with pros and cons."

Some women felt as if they had no choice on whether to have a sweep, while concerningly, some women reported having a sweep that they had not consented to.

> "Wasn't given any information. Was given a sweep at 39 weeks without being asked or told during examination."
>
> "It was more so that I was told I was getting it. Thought it was essential."
>
> "No information, it was just "I'll do a sweep today"."
>
> "Given by a male doctor who I hadn't met, just walked into the room to do the sweep."
>
> "Admitted with meconium in my urine. Doctor did a sweep without telling me or asking my permission."

The quote below is particularly worrying:

> "The consultant said he would examine me which I thought meant my bump but he asked me to remove my underwear and in the presence of a trainee

obstetrician gave me an internal exam and a surprise sweep which he only explained was a sweep afterwards. It was painful and I felt absolutely violated. I would have liked to have been prepared mentally for it and to have been given the option of whether to have it or not. I also felt I had no dignity with a trainee sitting there watching everything."

In terms of the experience, some women found it distressing, invasive, uncomfortable, or painful. Others commented they were keen to have it in order to avoid induction.

"I discussed the matter with my consultant who suggested it be an option for me as I wanted to avoid induction."

"I had had a sweep with my first pregnancy which seemed to bring on labour so was happy to have one again. I wanted to avoid induction so was happy to try this alternative."

"Was booked in for induction which I had said all along I didn't want but had to go be booked in anyway. They were fine about me not wanting it thankfully, exam and sweep offered (overdue, 40+10) and accepted, sweep was fine, mild contractions started after sweep Friday morning, baby born Sunday morning at 42 weeks."

The percentage of early sweeps (before 39 weeks) was similar across all pregnancies.

	Number of women	Percentage of women offered early sweeps
First Baby	160	15%
Second	89	16%
Third or more	50	15%

Table 3: Early sweeps by parity (number of previous babies)

In terms of reported reasons for early sweeps, these were the most common responses:

Common conditions among this group	Number of women reporting
Gestational Diabetes	96
None	54

SPD/PGP/Back pain	49
Big baby	37
Sickness	34
Bleeding	32
Small baby / slow growth	32
BP / Pre-eclampsia	12
Cholestasis	11

Table 4: Common conditions in women offered early sweeps

Gestational diabetes was the most common reason given, followed by 'no reason'. It is concerning that a significant number of women are unclear why they had a sweep before 39 weeks.

Analysis by year of birth shows there has been a year on year increase in early sweeps.

Year	Number of sweeps before 39 weeks
2015	22
2016	43
2017	70
2018	97
2019 **	100.5 **Est. 2019 total based on 67 to July end.

Table 5: Early sweeps by year of birth

RECOMMENDATION 6: Training on consent and human rights in childbirth should be provided to all maternity health care staff.

c) Induction of labour

According to NICE, women should be informed that labour is a natural process - one that usually starts on its own by 42 weeks. Sometimes labour needs to be started artificially; this is called 'induced labour'. Over half (55%) of the women taking part in our survey had been offered induction of labour, despite the fact that this is a significant intervention.

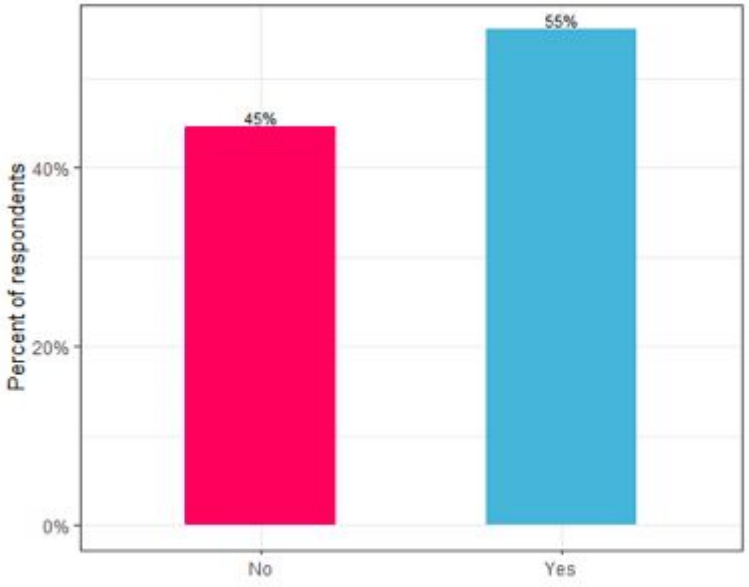


Figure 18. Induction offered

According to NICE guidelines on inducing labour, women with straightforward pregnancies should be offered induction between 41 and 42 weeks, taking into account the woman's preferences and local circumstances. Each woman should be fully informed about the reasons why induction is being offered, as well as offered alternative options, such as expectant management (increased monitoring), should she choose not to have an induction.

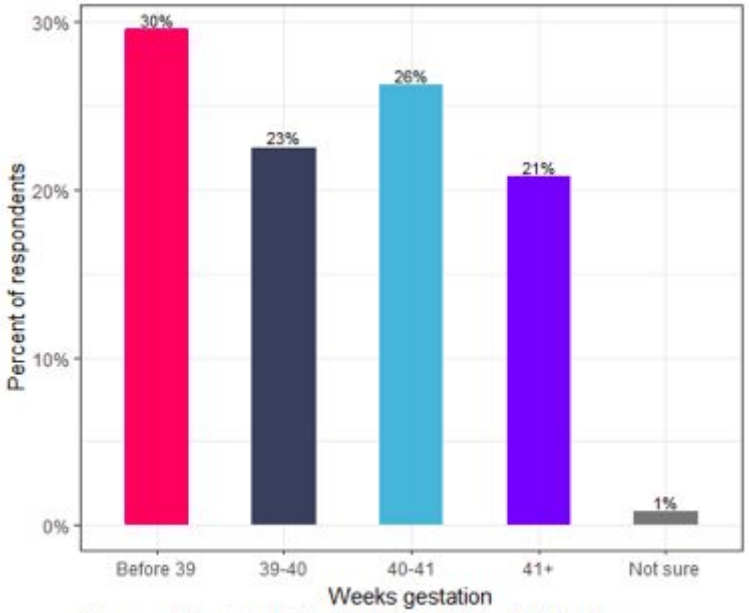


Figure 19. Gestation when offered induction

In our survey, 30% of the women who were offered induction were less than 39 weeks pregnant when this happened, with a further 22% offered induction between 39-40 weeks. This means that in total, more than half of women (52%) were offered induction prior to 40 weeks.

26% of women were offered induction between 40-41 weeks, while 21% were more than 41 weeks pregnant. Some women reported clear medical reasons for being offered induction.

> "I was 3 days over and had preeclampsia"
>
> "Reduced movement, reduced liquor"
>
> "Waters broke without contractions starting. Meconium in my waters."

However, many women reported that the offer of induction was presented as 'routine', while some women commented that they felt pressured into agreeing to an induction.

> "Looking back I felt like I was pressurised into induction of labour"
>
> "I do not feel I was given a choice, it was something that had to happen. I was not offered ongoing monitoring as an alternative."
>
> "Told baby would die if I didn't accept."
>
> "No information was given and I wasn't aware that it was a choice."

In terms of the reasons given for induction, women responded as follows:

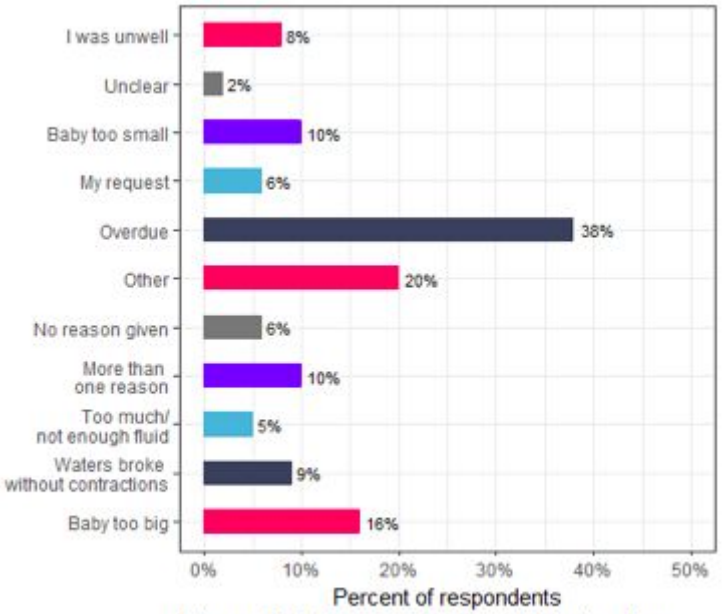


Figure 20. Reasons given for induction

Some women were given clear medical reasons for their induction, such as reduced/too much fluid around the baby or that the woman, baby or both were unwell. However, the most common reason given was that the woman was overdue (38% of women who were induced). NICE guidelines recommend that women with healthy pregnancies should be given every chance to go into labour themselves.

Overdue:
Further analysis was completed on the responses of the 38% of women who reported that the reason for being offered an induction was that they were 'due' or 'overdue'.

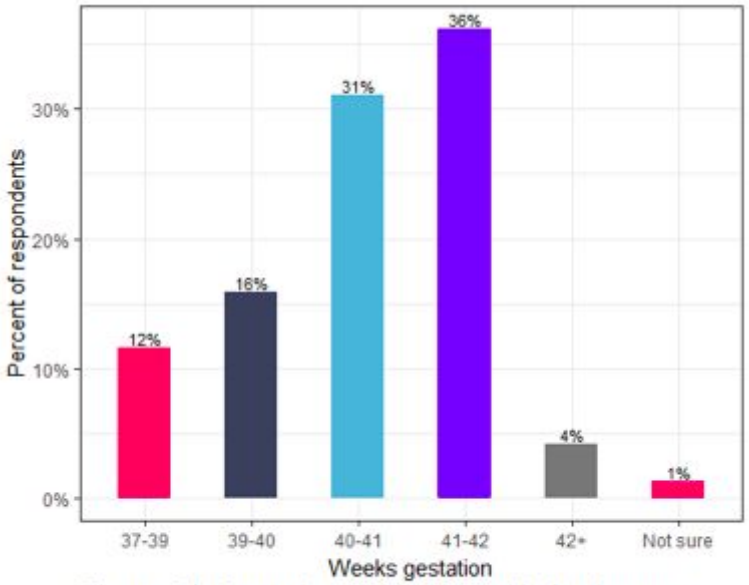


Figure 21. Gestation when offered induction as overdue

NICE guidelines recommend that induction is offered to women between 41 and 42 weeks, yet of the women who offered induction because they were 'overdue', nearly 60% were 40 weeks or less (12% 37-39 weeks plus 16% 39-40 weeks plus 31% 40-41 weeks). Only 40% of these women had reached 41+ weeks. This suggests that induction based on due dates is currently being offered to too many women in Northern Ireland.

Suspected big baby:
16% of those who responded reported the reason for induction was a suspected big baby, with no other factor. This is despite NICE specifically defining induction for a suspected large baby as a DO NOT DO recommendation:


Home > NICE Guidance > Conditions and diseases > Fertility, pregnancy and childbirth > Intrapartum care

Do Not Do Recommendation

In the absence of any other indications, induction of labour should not be carried out simply because a healthcare professional suspects a baby is large for gestational age (macrosomic).

These results suggest that Trusts are offering induction to some women in contravention of NICE guidelines.

Option to decline induction:
Women who choose not to be induced at 42 weeks often come under significant pressure:

> "They told me the placenta looked tired and booked me in for 2 weeks time."

> "I reluctantly agreed to induction at 40+14 because I was told that if I left it any longer I would not be allowed to deliver in MLU. I felt bullied and pressure from hospital and also family members who did not understand why I was "going against advice" like I was just doing it to be awkward or stubborn."

> "They told me they would book me in for a date when I would be 2 weeks overdue which, they said, was the maximum time they could allow me to go over. I wasn't offered ongoing monitoring as an alternative."

Other women were supported to wait for labour to start by itself:

> "Reg wanted to induce me early as baby was 'small'. saw consultant who said baby was perfect and was happy to wait for things to progress naturally"

> "I was offered induction at my 40 + 5 appointment if I hadn't gone by 42 weeks, brief discussion of Foley balloon but when I said I was happy to wait and have the discussion at the time if needed, [consultant's name] was happy with that and confident I would birth before then.

> "Apart from [consultant's name] who was happy to wait for labour to start naturally, there was some pressure for induction after 40 weeks."

Unclear:
An additional 6% of women were unclear about the reasons for induction. With regards to the decision-making process around induction of labour, many women commented that they felt they were pressured into having an induction or that it was a 'given'. This was similar to the responses to the question on sweeps.

> "I was told I had to be induced without scanning me to check on my placenta, which had appeared to start to age at a previous growth scan. The next consultant said it wasn't an issue and the final consultant just said induction and that was it. I had no choice in the matter. No room for discussion either. I felt scared and let down."

> "I was told that I would be booked in for induction for 10 days from 40 weeks. When I said I didn't want that the doctor went off to find out what my options were. She came back to say that was fine but I'd have to go in to [hospital] every day past 40+10 for monitoring."

> "As I would be forty years old when baby was due I was told I would be induced two days before baby due."

"Hospital policy."

Many women reported no other options were discussed with them, with expectant management only being discussed when the offer of induction was declined, or that it was offered but discouraged. They were often told that their baby could die if they didn't have an induction, or given a choice between induction and caesarean. In addition, some women reported that their induction was scheduled before 40 weeks because of an upcoming bank holiday.

"I was never offered monitoring. Induction was scheduled for 39 +5 because the following Monday was a bank holiday."

"Was told it'd be more or less inevitable I'd need it so might as well get it when hospital was quiet."

Induction rates across NI are on the rise, with almost 50% of labours being induced (Birth NI). Our survey found the same trend, with more than half of women who responded being offered induction of labour. As with sweeps, some women were given clear explanations, while others felt uninformed about the reasons induction was being offered.

In terms of outcomes for women who had inductions, 59% went on to have vaginal births, with 18% having assisted births (forceps or ventouse). 21% of women in our survey had an emergency caesarean section following induction.

Type of birth	Number / % of total inductions		Number / % of inductions at this gestational week							
			Before 39		39-40		40-41		41+	
Vaginal	639	58.8%	200	61.7%	144	58.3%	169	58.7%	126	55.3%
Assisted	196	18.0%	44	13.6%	47	19.0%	54	18.8%	51	22.4%
EMCS	227	20.9%	72	22.2%	50	20.2%	57	19.8%	48	21.1%
Elective CS	25	2.3%	8	2.5%	6	2.4%	8	2.8%	3	1.3%

Table 6: Outcomes for women who had induction of labour

It would be helpful to understand better how induction of labour impacts on birth outcomes in Northern Ireland. This would be better analysed by Trusts via clinical audit using the Robson groups tool.

Outcomes for the women in this survey who had induction of labour varied by whether it was the woman's first, second, or subsequent baby.

In first time mothers, induction of labour resulted in 25% assisted delivery (forceps or ventouse), 35% caesarean section and 40% vaginal birth.
In second time mothers induction resulted in 11% assisted delivery, 14% caesarean section and 74% vaginal birth.
In third or more pregnancies induction resulted in 6% assisted delivery, 9% caesarean section and 85% vaginal birth.

There are a number of different methods used for induction of labour, and the particular method(s) chosen should be based on the woman's individual situation, preference and health. Non-pharmacological or mechanical methods include Foley's catheter and Cook's Balloon, and artificial rupture of membranes (waters manually broken), while pharmacological methods include prostaglandin pessary/Propess and syntocinon IV drip. Labour can start after only one method has been used, such as the balloon or pessary, or a woman could experience a number of induction methods.

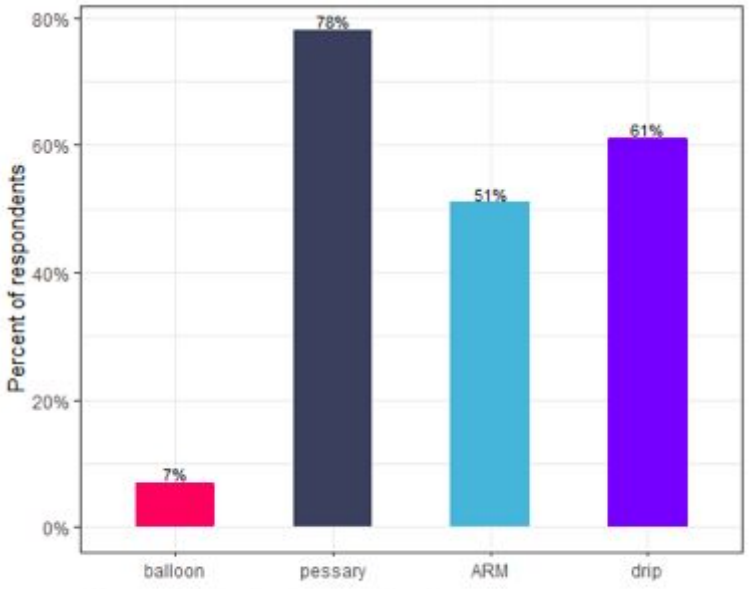


Figure 22. Induction methods

More than three-quarters of women who experienced induction of labour (78%) had induction via propess/pessary, 61% had a drip, 51% had their waters broken (ARM), while a small group (7%) were induced via a Cook's Balloon/Foley catheter. 62% of women experienced more than one induction method, generally starting with propess/pessary and continuing on to have their waters broken, followed by a syntocinon drip if labour failed to start.

Women were also asked about the process of induction, including questions regarding whether they were able to labour at home or able to move about freely, who was with them and did they feel fully informed about what was going on. The experiences of women varied; however, several common themes emerged.

Feeling isolated and alone: this was often because the woman's partner/birth partner was sent home. Women reported feeling alone, afraid and unsupported, anxious and often uninformed.

"My partner was told he had to go home (over 45 minute drive) because he couldn't stay on the ward (even though I was the only patient on the ward). I asked my partner not to go home as I needed support to labour, he had to 'sleep' in the corridor."

"Husband was told to go straight home... very hard on us as he missed birth... staff very cold and could have shown more empathy."

"I felt pretty alone and scared... which is not how a woman going into labour for the first time should feel."

"I was induced with the Foley catheter and was kept in the hospital until baby was born. It took 27 hours in total. From waters were broken it took 6.5 hours."

Going home while awaiting labour to start following induction:
A small number of women were delighted that they had been supported to go home and wait for labour to begin after a catheter/balloon/pessary had been inserted. This innovative approach is to be welcomed:

"I had an outpatient induction at [name] hospital as I was low risk and second pregnancy. My husband was with me. Pessary was inserted and I was allowed to go home."

Lack of privacy:

"Induction ward was busy ... felt it was very open and there was no privacy labouring in front of all them women in an open bay."

"I didn't like the induction bay, had no privacy."

Feeling a loss of control over their birth, coercion or lack of consent:

"Doctor broke waters and did the drip immediately, without full consent."

"The midwives were brilliant and supportive, but I felt like everything was out of my control and each step was reactive rather than a choice."

"Withholding pain relief unless consent was given for an internal examination."

"I felt out of control, railroaded into things I didn't want and unsupported by my midwife throughout."

Feeling ill-informed as the process was not fully explained:

"Midwife didn't explain what was happening during labour - just sat writing notes"

"My midwife for first shift was excellent. But by 8pm handover I was definitely experiencing contractions but my second midwife was totally unhelpful. First midwife looking after me was brilliant - talked me through exactly what was happening etc. After this I felt communication was very poor and I didn't really know what was wrong/what my options were/why doctors were being called. As a healthcare professional myself I wished to be informed."

Women not being listened to/believed:

"The midwives seemed unfamiliar with hypnobirthing and consistently mistook my quiet calm for exhaustion and lack of progress."

"Induction was very quick. The midwives were nice but one refused to examine me when I requested as she didn't believe I would have responded to the propess so quickly. I had the propess at 9am, my waters broke at 3pm and my baby was born at 5pm. I would have liked to have been taken more seriously by the midwives in the induction bay - I was 23 when I had my son so I felt like my age was a factor in this."

"Given pessary at 11am with my husband present then at 10pm he was sent home and contractions started at 11pm lasting a minute and happening every two minutes but nobody believed I was in labour until I crawled into the corridor at 4am to be told when they examined me I was fully dilated and it was mass panic to get me a bed in the delivery suite and to get my husband to the hospital at which point it was too late for any pain relief."

Positive Experiences:
Some women had positive experiences throughout the induction process. This was often down to the care the women received from supportive midwives who treated them with compassion and respect, kept them informed, listened to them, and maintained a calm and relaxing environment.

"Induction was great! I had my partner with me the whole time. Luckily the induction bay was empty when I was there with the pessary so I had a great nights sleep ...the care from the midwife, consultant and sister was top class. We were never left alone and everything was fully explained.

"I was taken to the delivery suite and the nurse explained what would happen. I have a huge dislike towards needles in my hand so the midwife listened to my request and put it in my arm instead. From start of induction to baby being born was 2hrs 50mins. First midwife was wonderful, calm, reassuring, helped me focus and relax and encouraged my hypnobirthing."

"My midwife for the birth, who did the ARM, was wonderful though. She read my birth plan and talked me through what she could do, and that bit of feeling heard and respected made such a difference."

"We loved our induction, my husband stayed with me the whole time and ...we were able to walk around the hospital and use a birthing ball the whole time which really helped things progress...we liked the fact that everything was very controlled and that the baby was getting checked regularly."

"All staff members were respectful of my choices, took time to go options with me clearly and answer any questions that I had."

"My midwife was amazing, she hardly left my side. She listened to me and helped me. She delivered my son with such care. She made it all so bearable. Unlike my first induction. My partner and friend was there with me."

"The midwives were amazing and keeping me calm and focused. The care I had throughout this period from midwifery staff was excellent. They were attentive, caring, professional and efficient. I was given updates and information about my situation at every opportunity to enable me to make informed decisions."

RECOMMENDATION 7: Training and or/guidance should be provided for all maternity care staff to ensure adherence to NICE guidance on sweeps.
Trusts should review practice on induction of labour and ensure that women are not offered induction before 40-41 weeks unless there are clear, documented clinical reasons.
Trusts should review practice regarding women's experiences of induction of labour to ensure that women can give fully informed consent, and are respected and supported to feel safe throughout.

Section 4: Birth

In terms of birth, women were asked about:

a) Where they had their baby
b) The birth environment
c) Pain relief
d) Type of birth
e) Caesarean birth
f) Position during vaginal birth
g) Second stage pushing
h) Reducing the chance of a severe tear

a) Place of Birth

Of the women taking part in the survey, 57% had their baby in an obstetric (consultant-led) unit, while 31% birthed in an alongside midwife led unit. A further 5% had their babies in one of the three freestanding midwife led units, and only 1.2% had planned home births, despite these being safe for many low-risk women. A small number of women had babies who were unexpectedly born out of hospital, while many of the women who chose 'other' had their babies in theatre via caesarean section. These women would also have had care from obstetricians.

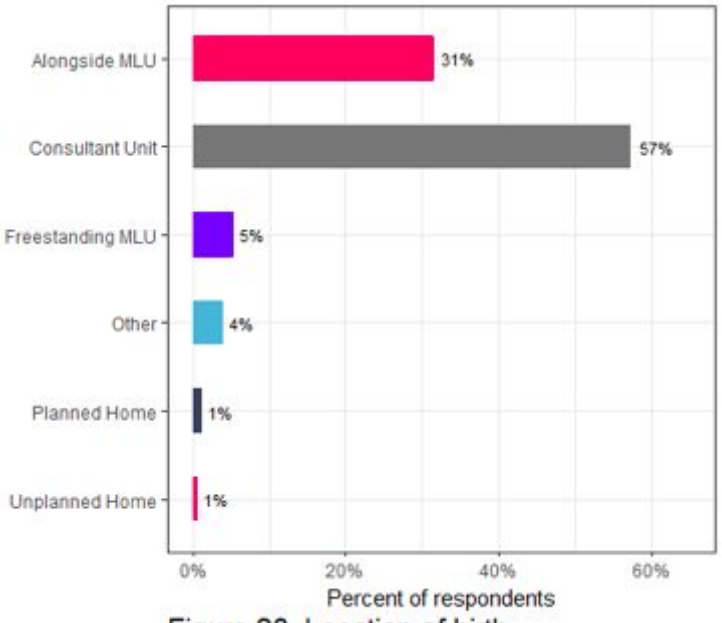


Figure 23. Location of birth

It is estimated (NICE 2014) that around 45% of women would be automatically suitable to birth in midwife-led birth settings (MLUs and home birth) if they wish, with others supported to do so via an individualised care plan. While local trusts have been working to increase the numbers of women birthing in MLUs, this work needs to continue.

In addition, women who choose home birth often meet resistance to their plans, despite the evidence and NICE guidelines. This reinforces the need for evidence-based

information to be shared with women, and caseload midwifery/continuity models, which may assist in triaging women to the most appropriate care.

b) Birth Environment

Women were asked about their birth environment - who was with them, and about positive factors they experienced.

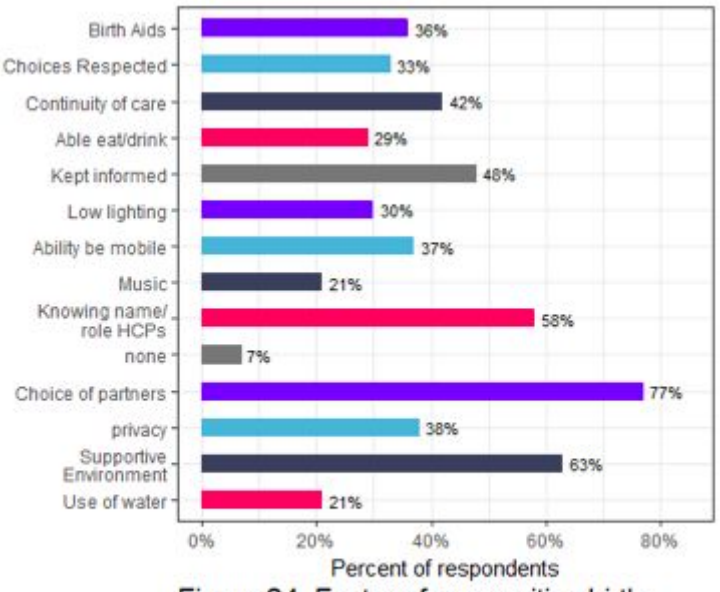


Figure 24. Factors for a positive birth environment

Despite clear evidence that these low-cost elements can significantly improve birth experiences, and can lead to better outcomes, many women are not accessing factors likely to make the birth environment more conducive to positive birth experiences.

Birth partners:
Most women (77%) had the birth partners they wanted present.

> "My husband who had also attended the hypnobirthing classes with me and I'll be forever grateful because it felt like a true team effort."
>
> "People who made me feel supported and safe."
>
> "Just my partner, which was my choice"
>
> " My husband, a friend who was a student midwife, her mum also my friend, my Doula and my two older kids were upstairs in bed."

However some women did not.

> "I really needed my mum and partner, however they were made to switch out and only one was allowed at a time."

Students:

Despite some women experiencing resistance towards them having their chosen birth companions present, women sometimes report significant numbers of students are present, particularly in theatre:

> "Unfortunately my theatre was full of people I didn't know - they all wanted to witness a breech section. I was asked if the students could stay but at that stage I was so petrified & panicked about the section that I agreed without thinking about it. In hindsight I had a complete lack of privacy during a traumatic & personal experience."

The majority of women reported that their partner was with them when they gave birth. 11% had a female friend/relative, while less than 1% of women had the support of a birth doula.

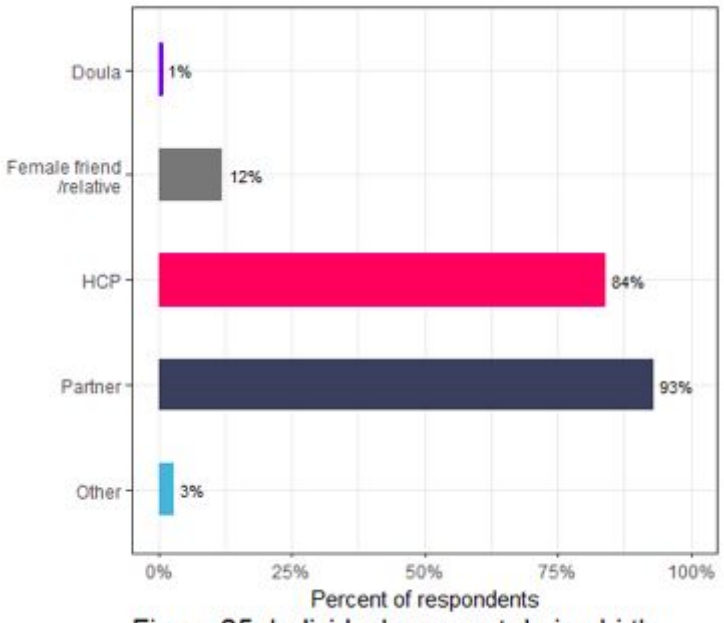


Figure 25. Individuals present during birth

Feeling informed:
For women who were kept well informed, this had a significant positive impact:

> "My second midwife was excellent ... and listened to everything I wanted and explained everything as it happened."

> "My midwife explained everything clearly and calmly the entire way through the birth. I felt very confident in her at all times. She was the strength that made it a very positive experience."

However, fewer than half (48%) women reported feeling adequately informed about what was happening:

> "Was in the delivery suite approx 8 hrs. No idea what the midwife was called. She didn't explain anything to me, just kept writing and had minimal interaction with me."

"The midwives were very supportive but the two doctors who came and went were very keen for a caesarean and spoke 'about' me instead of to me."

Water for labour and birth:
Only 21% of women used water/a birth pool, despite clear evidence about the benefits: this was also highlighted in women's responses to the question about pain relief below. Women who had water births, or who used water in labour, were positive about it:

"In water over the side of the pool holding hubbys hand. I felt I could relax my pelvis and breath baby out best."

"In the birthing pool , this should be available to everyone"

"Crouching/kneeling in the pool facing my husband with midwife team behind me. It was incredibly calm"

"I was in the water and it felt the most natural position to be in. Nobody was touching me and I birthed and caught my baby. She latched on straight away and fed for the whole of the 1st hour"

Mobility:
Worryingly, only 37% of women reported they were able to be mobile.

"Very clinical, unable to move around due to drip and heart monitor, really uncomfortable experience."

Those who had the ability to be mobile reported it made a difference to them:

"Nice low lit labour room when drip was started, ability to move around the room as much as possible with monitoring, lovely midwife with me for most of the day."

Privacy:
Despite clear evidence about the benefits of privacy for birthing women, only 38% reported that they experienced minimal interruptions and privacy. This can be facilitated even at a caesarean birth, so these figures are disappointing.

Staff preferences:
At times women felt they were expected to adapt to the individual preferences of staff.

"On labour ward I had two midwives, the first was helpful and I had low lights, and a calm environment. The second wouldn't facilitate the low lighting and wanted room lights on."

Women who birthed in an MLU were generally positive about the birth environment:

"All of these in midwife led unit but when labour stalled had to move into ward with very little of these."

"The MLU was brilliant, they allowed me to do all of the above. It was calm and relaxed."

c) Pain relief

In terms of pain relief options, gas & air (Entonox) was the most commonly used form of pain relief, with 75% of women having used it during labour. Many women reported that they used various non-pharmacological forms of pain relief such as breathing and relaxation techniques, water and hypnobirthing (44%, 19% and 14%, respectively). Opioid drugs such as diamorphine were used by 37% of women, and a similar number (38%) had an epidural or spinal. This last figure includes most of the women who had caesarean sections, as only 2.4% report they gave birth while under general anaesthetic. A small group of women (2.9%) reported that they did not use any pain relief.

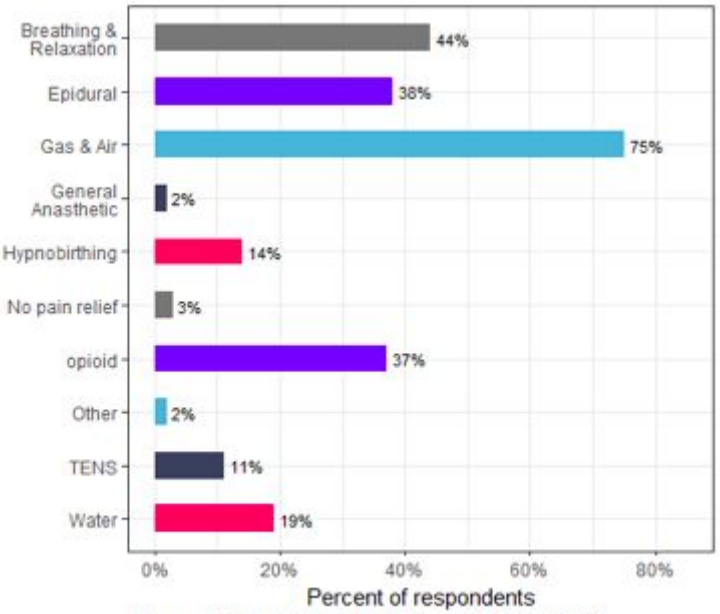


Figure 26. Pain relief used during birth

Some women used different forms of pain relief to what they had anticipated. Women who had their labour induced or augmented, particularly via a drip, often used stronger forms of pain relief than they had expected or wanted.

> "I wanted a natural water birth with gas and air. When the drip was administered the pain got too intense and I was also exhausted by then."

> "I wanted to have just had and air, but being induced was far quicker and more painful than I had expected so I had diamorphine also."

> "I had planned to use gas and air and remi. Pain became too intense with the drip so I requested an epidural."

The use of hypnobirthing is increasing, with sessions now being offered by some maternity units as well as Sure Start projects and private providers. Most women who said they had used hypnobirthing techniques were very positive about the impact.

> "I got through majority of labour at home using Hypnobirthing and arrived at hospital 7 cm."

However some women struggled to use hypnobirthing effectively in delivery suite:

> "I had planned to Hypno birth but when I got to hospital the environment was very stressful and it did not facilitate this."

Telemetry (waterproof wireless monitoring of the baby's heartbeat) was not made available to every woman who needed it, due to a shortage of equipment. This in turn prevented some women from using the pool or bath in labour, or having a water birth:

> "I planned for a water birth but the only pool with remote monitoring on labour ward was being used."

RECOMMENDATION 8: All Obstetric Units should review the birth environment, particularly in delivery suite and theatres, with a view to making this more supportive of women's emotional and physiological needs.
Obstetric units should ensure there are enough telemetry monitors to meet the level of evidence-based need.
Regional guidelines are needed on best practice in facilitating gentle caesarean sections.

d) Type of birth

56% of women in our survey had straightforward vaginal births, while 15% gave birth with the assistance of forceps or ventouse (vacuum). Caesarean births accounted for 29% of births, either planned (12%) or emergency (17%). In Northern Ireland, caesarean rates are generally around 30%, despite a World Health Organisation finding that the rate should be 10-15%.

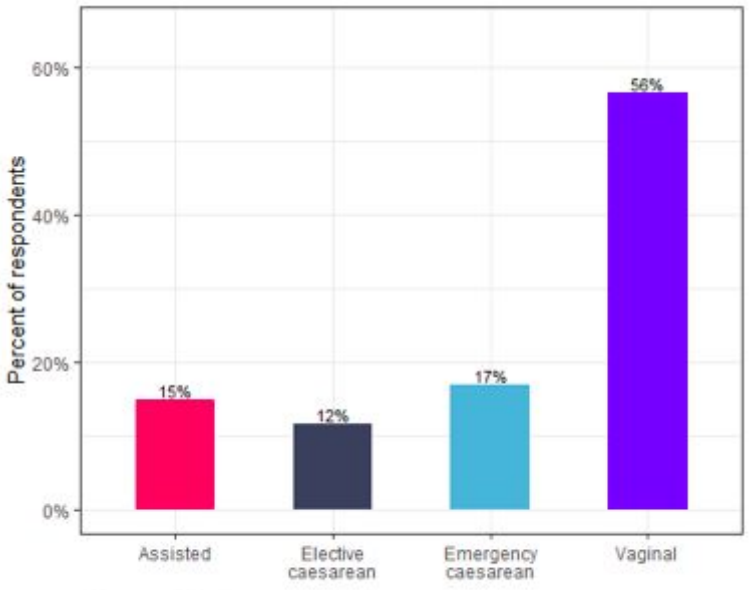


Figure 27. Type of birth

When women's labour/birth left the normal pathway, many women understood what was happening and why, and retained a sense of control over events:

> "I knew every step, even when I was stressed about my baby's crashing heartbeat, I had a soothing midwife trying to make me relaxed."

Other women reported that they were not listened to, that they did not get adequate explanations, or that they were treated disrespectfully.

> "Baby breech, water broke 2 days before planned section, had baby 11 hrs after waters broke, had to wait until all planned sections were completed, left abandoned on a cold empty wing of a ward, in my theatre gown and socks 5 hrs too early, wet from waters breaking was horrible, isolating, uncomfortable experience."

> "My birth was very traumatic to me. I had been pushing for 2 hours and my little boy was not coming. He was back to back. I ended up with a vacuum delivery. It was the most pain I have ever experienced in my life...The whole experience felt out of my control. The doctor who was performing the vacuum failed to make me feel comfortable and inform of what was happening...The experience was rough and I remember shouting over and over you are hurting me!!!!! ...When my son was 18 months old I sought private counselling due to the experience I had."
> "Baby born after nearly 2 hours pushing. Didn't feel overly well supported - again like I was a silly girl who needed to suck it up and get through it."

Occasionally, women reported that the interventions they had may not have been necessary:

> "I had laboured to 5cm when I was told my daughter was in distress and I needed an emergency section, I was prepped for a spinal but was put under GA. I was later told the trace was fine."

e) Caesarean Birth

As mentioned above, for optimal outcomes for both mothers and babies, the World Health Organization recommends that no more than 10 - 15% of births are by caesarean section. In our survey, 29% of women reported having a caesarean birth, more than double the recommended level.

Reasons given for elective caesarean:
For some women, the reason given was medically justified; this includes placenta praevia, baby being in a transverse position, cord prolapse or the baby having congenital abnormalities that could potentially make a vaginal delivery less safe.

The number of 'maternal request' caesarean births was low; only 4% of the women in our survey who had had caesarean births reported this was because of their own decision.

The most common reason given for caesarean section was **breech**. This had already emerged in our survey as one of the reasons why some women transfer their care.

However it seems most women are not told about the possibility of breech vaginal birth, and they instead proceed directly to caesarean section. Giving women full information about their options may lead to a reduction in breech caesareans, which could impact on the overall c section rates. As previously highlighted, training for healthcare professionals on vaginal breech birth should be offered, along with the development of Birth Choices clinics in every Trust in order to ensure choice for women whose babies are in the breech position.

Some of the other reasons given for c section appear not to be in line with the evidence, guidelines, or best practice, such as women who were told their babies were too big, or that they had a 'short cervical canal'.

As there are no known benefits for women or babies who do not require a caesarean section, our survey shows that some women in Northern Ireland are more than likely having unnecessary caesarean births, along with the risks and postnatal recovery challenges that come with major surgery while caring for a new baby.

According to NICE, women who have had a previous c section should not automatically be booked for a repeat section, yet many women reported this is what happened to them. Women in this situation highlighted that health care professionals focused on the chance of uterine rupture, yet the evidence shows that this is **rare** with up to four previous sections. The relevant guideline specifies that women should be informed that...*'the risk of uterine rupture, though higher for planned vaginal birth, is rare'*. (NICE, 2011)

NICE guideline:

1.8 Pregnancy and childbirth after CS

1.8.1 When advising about the mode of birth after a previous CS consider:

- maternal preferences and priorities
- the risks and benefits of repeat CS
- the risks and benefits of planned vaginal birth after CS, including the risk of unplanned CS. **[new 2011]**

1.8.2 Inform women who have had up to and including four CS that the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and that the risk of uterine rupture, although higher for planned vaginal birth, is rare. **[new 2011]**

In fact, women stated that the opposite was happening; that there was an emphasis on the risk of scar rupture.

> "I was told I had the option of having a VBAC but was then scare mongered about scar ruptures and infant and maternal death. Thankfully I was armed with statistics and the midwife admitted I was correct in my figures...I did not feel at all supported in attempting a VBAC."

Some women reported feeling delighted on achieving a vaginal birth after a previous caesarean section:

> "From start to finish [the previous caesarean section] was awful, I felt like a car with mechanics working in the bonnet. I attended counselling privately to deal with it and had subsequent babies elsewhere. 2 VBACs at [different unit] without pain relief. The difference was night and day."

This reinforces the need for VBAC/Birth Choices clinics to be developed in all Trusts (Recommendation 2).

The birth environment was particularly important for women choosing VBAC:

> "I didn't feel that I had a supportive environment that would have enabled a successful VBAC."

The experiences of women who had elective caesarean sections highlighted a common theme - that many women did not know they could use a birth plan or were not supported in their birth plans. This underlines the need for regional guidelines in facilitating 'gentle' caesarean sections if women request them.

> "I had made a gentle caesarean plan, but was told that many of my wishes would not be possible so I had to take them out of my plan."

> "I had requested a 'gentle caesarean' (low lighting, my music, no talking, immediate breastfeeding etc) but was told that this wasn't possible."

> "I was told a caesarean didn't warrant a birth plan."

> "Yes I did. None of which was followed , absolutely none of it"

> "Yes had a birth plan which was basically laughed at & dismissed."

This did appear to vary, with some women's birth plan wishes being met:

> "Yes I had a plan and yes these wishes were met. Eg. Skin to skin in theatre and pico dressing".

> "Yes all were met very positive experience

We asked women additional questions about their caesarean birth experience, such as who was with them and were they kept well-informed. Some women had a very positive experience:

> "I was awake and kept informed"

> "As smoothly as possible calm professionals who put me at ease and explained all to me"

Others said they did not know what was happening or felt they were coerced into having a caesarean. This was particularly apparent in women having emergency caesarean sections:

> "We had no idea what was going on. Had a spinal anaesthetic. Husband was only allowed into theatre after I'd been coerced into signing consent forms for procedures I didn't want."
>
> "I wasn't kept informed, everything was in a panic"

This woman summed up the feeling of a lot of the responses:

> "For the theatre staff another day, another section. Not for me."

f) Position during vaginal birth

Of the 1117 (56%) of women in our survey who had a vaginal birth (without forceps/ventouse), 63% reported they gave birth lying on their back. This is contrary to good practice, best evidence, and gravity.

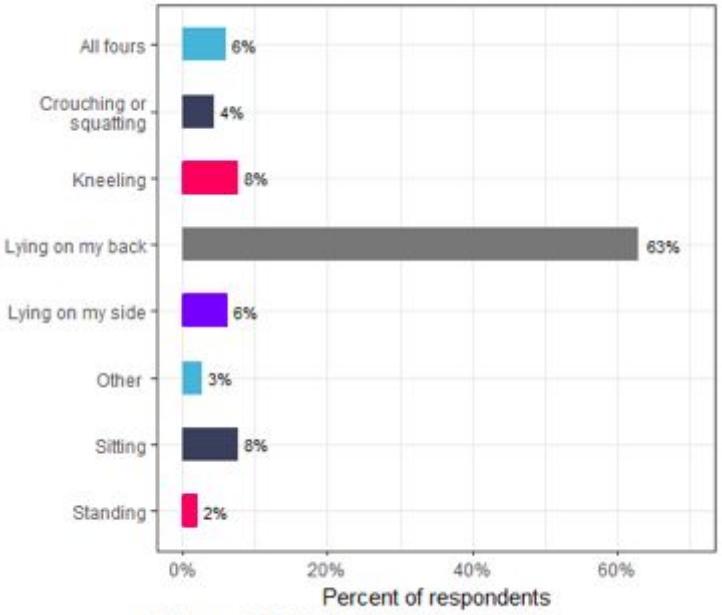


Figure 28. Position during birth

Some women chose their own position or were facilitated to find a position that worked for them:

> "I was kneeling in the birth pool with my arms flopped over the side. Intuitively that was the position I needed to be in."
>
> "Staff in delivery suite were fabulous and allowed me to remain upright and sit out in a chair whilst being monitored and were very supportive of my desire to not deliver my baby while lying on my back."
>
> "In the water reclining back. It's what felt most comfortable at the time."

"I was on a bed on my back with a CTG monitor attached. I had wanted to be on all fours/more active but was in too much pain for this."

"I felt instinctively I needed to be in this position, I was kneeling on a pillow with my elbows on the bed."

However the majority of these women reported they were asked to get onto the bed, and/or onto their back. Women's language in response to this question was telling. Many women replied in passive voice:

"This is where they put me. I would have preferred being upright."

"I was on my back on the bed with legs in stirrups. I didn't want to be in this position... My husband felt forced into making me go on to my back."

"On a bed on my back - because doctors told me to so they could see/examine me. I wanted to stay on my knees over the head of the bed as I had been in for my whole labour."

"Unable to move due to monitoring."

"I was told they couldn't monitor baby's heart beat in any other position."

"The back pain and being made lie on my back was truly an awful experience."

RECOMMENDATION 9: Trusts should monitor, review, and reduce the number of women birthing on their backs. Intermittent monitoring and telemetry rather than CTG should be used whenever possible.

g) Second stage pushing

Of those women who had unassisted vaginal births, 63% were instructed to push.

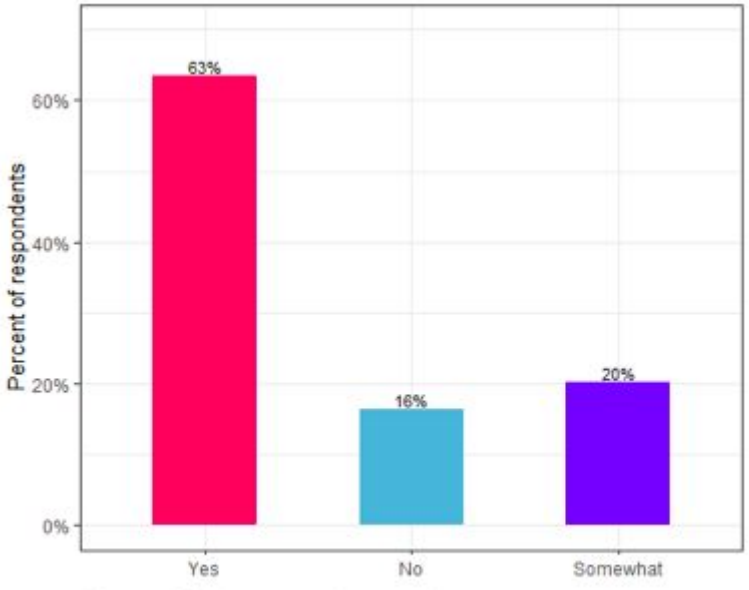


Figure 29. Instructed to push

Some of these women had an epidural in place, and therefore may have needed guidance as to when to push, since they may not have been able to feel the contractions.

> "I wanted the midwives to tell me when to push as I couldn't feel the contractions."
>
> "Because of epidural I had to be told when to push."

Evidence suggests that a slow crowning of the head may help women avoid tears. Despite this, women's comments in our survey show that some health care practitioners are still encouraging 'purple pushing'. For some women this was a distressing experience:

> "I was shouted at that these little pushes weren't going to cut it, I needed to push hard, chin on my chest and was repeatedly told to be quiet."
>
> "I was told to push in ways that I am unhappy about: 'push for your baby' 'stop making noise'."
>
> "[Coached pushing]: Yes, too much. And was told to hold my breath. I wish I hadn't listened. I had burst blood vessels from forehead to breasts because of this."

Other women report being encouraged to 'breathe their baby out':

> "Midwife told me to listen to my body and push if I felt the urge which I did."
>
> "They let my body decide what to do."
>
> "The midwife knew I was using hypnobirthing and I was asked to breathe baby out."
>
> "Midwife told me to trust my body and push when I felt the urge."
>
> "Told not to push. Just breathe out."

h) Reducing the chance of a severe tear

Of the 1117 women in our survey who experienced straightforward vaginal birth (i.e. without forceps or ventouse), almost half (43%; n=484) were encouraged to 'breathe the baby out', allowing the baby's head to crown slowly. Only 7% (n=81) received warm perineal compresses, despite good-quality evidence showing they reduce the incidence of tearing. Almost 10% of women received a hands-on grip from a midwife or doctor, which is a higher than expected figure. 19% of these women had an episiotomy (a surgical cut to the vagina).

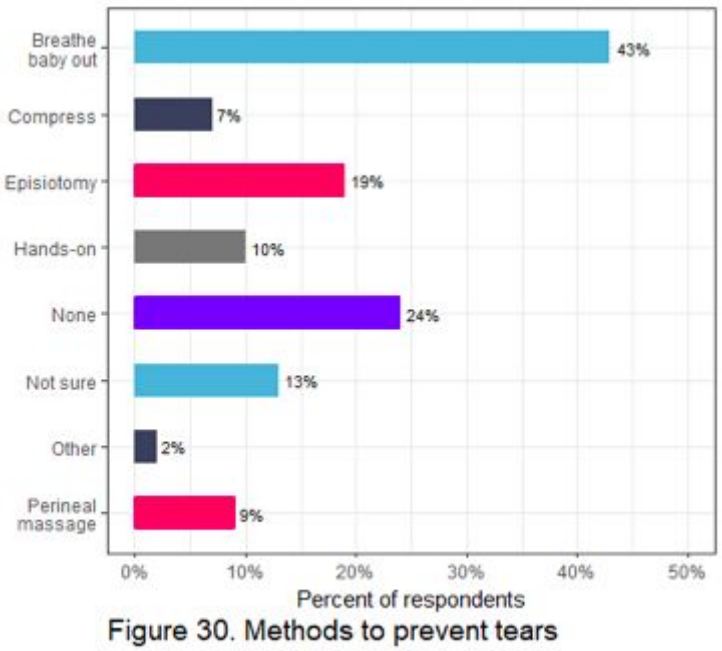


Figure 30. Methods to prevent tears

'Breathing the baby out' is now recommended as best practice, rather than coaching women to push. Many women were encouraged to let the head crown slowly:

> "I had a very strong foetal ejection reflex but the midwife encouraged me to breathe and slow down the final moments a little."
> "Baby's head was visible when waters burst. Midwife arrived into room and told me not to push and just breathe and relax. Baby came easily and calmly soon after."
>
> "I didn't have any tears and think it was mostly due to the clear instructions from the midwife about when to push and when to stop and just breathe and her expertise."

However, only 43% (n=484) of women were encouraged to deliver their baby's head slowly and gently. In some cases, this may have been because this stage of labour happened very quickly. For other women, this was associated with coached pushing, as shown in the comments related to second stage pushing.

Some women were unaware of the importance of these measures in reducing the chance of a more severe tear.

> "Not aware of all these preventative measures - perhaps could have been better informed."

> "Was told not to push but I didn't know why, I couldn't control the urge to push so ended with a 2nd degree tear. I have only recently understood why I was told not to push (my son is 9 months old). This could be better signposted so there is better understanding."

RECOMMENDATION 10: Trusts should continue to monitor, evaluate, and review the various elements of the care bundle aimed at preventing tears, in order to ensure that the more invasive elements (hands-on, episiotomy) are only used when absolutely needed, while other elements including warm compresses and good communication with women to ensure slower crowning should be offered to all women unless there are clear, documented reasons not to.

Section 5: Postnatal

With regard to the postnatal period, women were asked about:

a) Clamping the umbilical cord
b) The first hour
c) Reflections on the birth
d) Birth Trauma
e) Bounty visits
f) Postnatal maternity care
g) Feeding

a) Clamping the baby's umbilical cord

Despite the clear benefits of waiting for the umbilical cord to turn white before clamping/cutting, only 6% of women reported their baby's cord was cut after a long time. Most cords were cut either immediately (33%) or after a couple of minutes (37%).

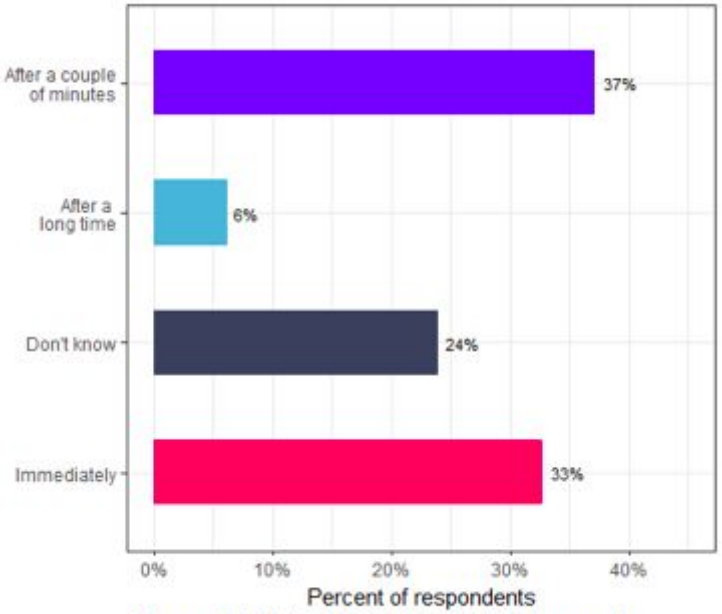


Figure 31. When was the cord clamped

NICE currently recommends that cords are left for at least one minute, but fewer than half of women (37% and 6%) reported that this happened after the birth of their baby.

> "The cord was cut straight away and baby was taken to side of room to be checked over while I was stitched up."

A quarter of women (24%) were unclear when the cord was clamped:

> "I would have wanted a delayed clamping and had this in my birth plan however there was no discussion about it and I am not sure what was done."

Some women reported that their baby's cord was left for a long time:

"I asked for cord not be to clamped for at least 20 mins until we had skin to skin and a breastfeed." **(woman who reported the cord was left for a long time).**

"Skin to skin straight away until placenta was delivered - possibly an hour, then cord cut."

RECOMMENDATION 11: There should be regional guidance on optimal cord clamping, with the majority of cords being left to turn white before being clamped and cut, and as a minimum, NICE recommendations being followed.

b) The first hour

The key words from women about the first hour after the birth of their baby:

Skin to skin contact:
Research has demonstrated that skin to skin contact immediately after birth and for the first hour with breastfeeding being initiated within this time, supports instinctive positive behaviours in both baby and mother. It has a calming and relaxing effect, regulates baby's temperature and heart rate, as well as stimulating digestion and an interest in feeding.
Many of the women in our survey describe having skin to skin soon, if not immediately after birth, including women who had caesarean births:

> "Breastfed and skin to skin in recovery after csection."
>
> "Very nice experience after baby born, lots of time for skin to skin and to allow first feed, baby latched on immediately, midwife very supportive."
>
> "Baby was placed straight onto my chest, he was only taken off so I could get out of the water to deliver the placenta after the cord had stopped pulsating. This is when he was wrapped and checked by the midwife."
>
> "Skin to skin and allowed to breastfeed. No rush to clean or weigh baby."

For those women who opted for a home birth, skin to skin was an integral part of the postnatal experience:

> "I held baby in the pool for 20/30 minutes until 3rd stage was complete. Midwife held baby while I got out of the pool, at which point I requested baby to get weighed and a nappy on, so that we could continue skin to skin uninterrupted after that. Moved to living room, stayed skin to skin and bf on the sofa for the next 4 hours or so."
>
> "Skin to skin straight away in the pool and we remained this way for about 12 hours. Interrupted for only 3 seconds for the midwife to weigh him. First feed within the first few hours."

Unwell baby:
Women whose babies were unwell reported particular challenges, particularly when communication was poor:

> "Nicu team worked on him. Stabilised him (remarkably and so delighted. Thank you Dr [name]). Had to wait 4.5 hours though before we heard what was going on and didn't get to see him for 5 hrs at least. That was tough. Traumatic. Emotional. Scary. Hopeful. All of the emotions."
>
> "Baby's apgar score was only 7 due to difficulty breathing. He was resuscitated and then brought straight to NICU. We didn't have skin to skin until 3 days after he was born. His first feed was a bottle feed."

When women were unwell, often their partners/birth partners did skin to skin:

"Had to go to theatre to have placenta removed, husband had skin to skin with baby."

"I had lost a lot of blood so my husband took the baby and then I made sure there was lots of skin to skin, during my course we were told how important it was."

"I'm not sure how long for but I did have baby skin to skin while in theatre. Then my husband had skin to skin in recovery while I was still in theatre."

"Skin to skin with myself straight away and then when I was getting out of the pool my husband had skin to skin."

Research conducted on neonates who had *paternal* skin to skin after caesarean section found that these babies had a more stable heart rate and temperature, as well as shorter duration of crying. These babies also started feeding behaviour earlier. Additionally the research found longer duration of breastfeeding, lower anxiety scores and a lower incidence of depression in fathers.

Some women reported having little or no skin to skin, including women who had had caesarean births and women whose babies had been born prematurely and subsequently taken to neonatal units:

"No, the baby was premature and was in the NICU."

"My baby received no skin to skin until I woke from the anaesthetic."

"My baby was really lethargic and had 1ml of colostrum via syringe to help."

There were also some women who were not given the opportunity for skin to skin and who didn't report any medical reason to account for this:

"No [skin to skin] which was sad. I felt happy my baby was born but was sort of rushed into the shower and up to the ward."

"She was put on my chest but not skin to skin which I would have liked but wasn't asked if I wanted that."

c) Reflections on the birth

More than half of women (60%, n=1179) described their birth as a positive (24%) or very positive (36%) experience, with 22% indicating their birth was a negative (11%) or a very negative (11%) experience.

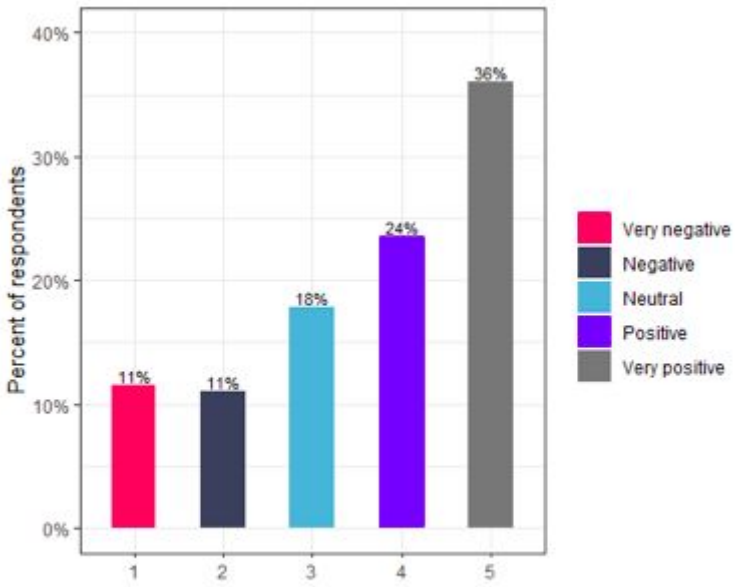


Figure 32. Overall how was this birth experience?

Most women (60%) reported having an extremely positive experience of birth. They used words like 'safe', 'calm', 'empowering', and many praised the health care professionals who had been with them for labour and birth:

> "All staff involved were amazing. I had complete faith and trust in them all they couldn't have done any more for me. Surgical team were admirably professional and caring. I felt loved and so did my baby."
>
> "It was what I wanted and very different from my oldest son's. I felt safe, in control and listened to."
>
> "Miraculous people, amazing."
>
> "MLU is great and the midwives were fantastic."
>
> "Midwife was amazing, and I felt safe."
>
> "Everyone was fantastic, especially my midwives. I'm so grateful my little girl was ok after so much worry."
>
> "The midwife was just out of this world - a true angel in disguise."

Women frequently mentioned feeling 'in control' as a key aspect of their positive birth experience:

> "I received support, information and encouragement throughout the birth. My choices were respected and promoted. Because of the support provided by [name] I had a very positive birth experience and think of it fondly."
>
> "I felt completely in control the whole time. I was calm and although labour was intense I wasn't in any pain. It was an empowering and awesome experience on my own terms."

"Very calm experience, left to my own devices by two experienced midwives. Contractions very manageable and birth completely controlled. A very empowering experience."

"Was so peaceful and I felt as if I had some control for the first time in my deliveries."

Building a trusting relationship with a midwife (continuity of carer) was key to many positive birth experiences. This reinforces the need for continuity models of service to be developed right across Northern Ireland.

"That one midwife really turned my experience around, after being quite poorly for a while and then to suddenly be in hospital to be induced was quite a shock both physically and mentally and she really made the birth a positive experience when it could have so easily not been."

"Wonderful midwife advocating for our wishes throughout and fantastic company in labour; she made the time fly."

Some women had challenging birth experiences, but wanted to make it clear that this was not because of anything done by HSC staff:

"It was due to the type of birth and not the medical team who delivered her as they were fantastic."

"Was pretty horrific but only because of induction & baby facing wrong way. No fault of hospital staff."

"Due to having an emergency CS. I feel the hospital handled my care really well but in general it was a negative experience."

"Despite the scary situation, had great support and care."

"I had excellent care from the midwifery team involved. I would have preferred a less medicalised birth, but given the situation this was unavoidable. Overall I had a positive experience."

"The staff were all amazing and kept me up to date with everything going on however my labour was quite tough."

"The birth was stressful towards the end due to complications so I couldn't say it was a totally positive experience but the care I received was nothing short of excellent."

"It was traumatic on my body and a very scary experience but I cannot praise the staff at the emergency obstetric unit enough. They were so professional and fast!"

Others reported a mixed experience, with both positive and challenging elements:

"I have mixed feelings... One one hand I am very proud of how I birthed my first baby with only my own learning and knowledge of natural, undisturbed birth

but I feel resentful of some of practices and advice that was given to me as I feel it was unnecessary and at times against my better instincts."

"Difficult start very painful and frustrating as thought the staff on ward were terrible the true care came when I was in delivery suite. Then I felt cared for and looked after."

"So I feel I had a good birth, but only because I had educated myself well and was confident to stand up for my choices."

"Horrible induction experience was full of pain and confusion nothing was explained properly and I just felt like a number. The two midwives who delivered my baby were lovely though."

"While I would not choose to ever repeat my birth experience in the same way, the arrival of our much loved and longed for daughter was worth every single moment. I felt a little like I was on quite an automated induction conveyor belt where the amazing result was the product at the end and it felt like I was just supposed to accept the way it happened. It felt that my body was forced into doing something it definitely was not ready for."

"Because I rocked it, my partner was an amazing advocate and I felt empowered because of Dr [name] and Gentlebirth. I had a wonderful birth in spite of the midwives who were there who absolutely could not /would not listen."

"I didn't appreciate the attitude of one of the midwives during the birth - she made me feel I was a silly first time mum. The midwife in recovery was amazing - helping me breastfeed and also she gave me a bed bath before my parents and in-laws came to see the baby (I was kept in recovery longer than usual due to blood loss). She was fantastic and made a huge difference to how I felt. I hugged her and thanked her before I was taken to the ward, my husband thought she was amazing too."

A significant number of women had negative or challenging experiences, and many of these described the birth as traumatic. These stories are highlighted in the next section.

d) Birth Trauma

These were the most common words in response to our question about whether women would describe their birth as traumatic:

Worryingly, a third of women (n=662) described their birth as being traumatic, with 60% saying it was not traumatic and the majority of the remaining 7% saying that while their birth was distressing, they did not feel they could describe it as traumatic.

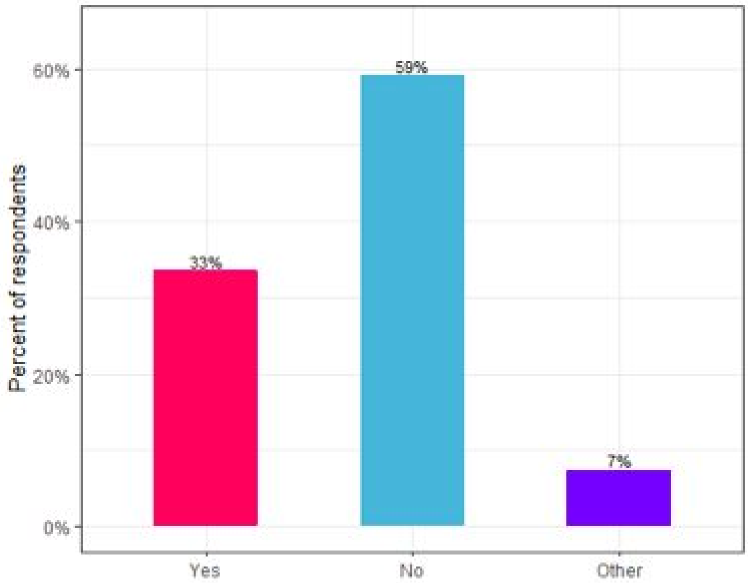


Figure 33. Was your birth traumatic?

The stories women shared in response to this question were distressing and worrying:

> "I read my notes afterwards for weeks and just cried and cried."

"I suffered from Post Traumatic Stress. I had no memory of my son's birth for around 9 months until I received Rewind therapy. I also had depression and anxiety and did not bond with my son during this time."

"Both myself and my birth partner were very distressed. The experience has put me off having any more children. Have had to seek counselling since birth."

"It was a very traumatic experience and I felt like we didn't matter."

"I feel sick when I think about my experience. It was not what I wanted in any way. I can't stop thinking about it and I feel upset and very negative about the whole situation."

"I suffered post traumatic stress from this birth and sought help from [service]. I had repeated flashbacks, nightmares, and anxiety for months. [My partner] still refuses to talk about it."

For some women, this was because of the experience itself, including pain, exhaustion, and fear. Others reported that they felt that their life or their baby's life was at risk during the birth, and this fear has stayed with them:

"With baby's heart rate dropping, needing an emergency transfer and c section it didn't go to plan. My husband was very traumatised by it."

"Rushed emergency section."

"Because for a time I believed my baby wasn't going to make it. My partner thought he might lose us both."

"Baby was not breathing when born and everything seemed rushed and panicked."

For others, the trauma related either to a lack of compassion or poor communication from maternity care workers, particularly in emergency situations:

"The ward sister was too abrupt and antisocial to be near anyone giving birth."

"I found the period when my remi ran out traumatic as I was in intense pain due to back labour and the intensity from the drip. My midwife was on her tea break and the midwife/sister providing cover did not listen to me or help me to regain control. I felt disrespected by the sister. I'm a healthcare professional employed by the Trust I gave birth in and I found her attitude appalling. Certainly not in keeping with with 'CORE values' of the Trust... She also performed an examination without my consent."

"The midwives...scared us a few times with their worried faces and not telling us what was going on."

"Largely due to my son being taken away and the lack of communication regarding his treatment and progress."

"The midwife during the first 8-10 hours was horrible. I didn't know I could have asked for someone else. I wish I would have."

"I didn't feel in control of my experience at all. I felt the midwife was threatening in the way she spoke to me, eg telling me that if they didn't break my waters then I would have to get prepped for a c - section and that if I didn't push more/harder that the baby would be in distress (he wasn't and never was the whole labour and birth)."

A common theme underlying birth trauma was women's feelings of not being in control of what was happening:

"From the moment I entered the induction suite I felt I was not allowed to make any decisions."

"I felt a complete lack of knowledge & control & this affected me for quite a while after the birth. I felt all of my independence was lost which was further compounded by my need to recover from the surgery. This affected my mental health & my relationships with my husband & his family. As a result I'm choosing to have my 2nd child by elective caesarean because at least this way I'll know what to expect & I will insist on standing up for my rights."

"Yes traumatic for both - very fast, frantic, lots of medical people doing things to me not with me and I felt like a vessel for a baby not a person."

"All my wishes were ignored and I was touched without consent."

"Felt like a science experiment - couldn't get my husband near me."

Many women reported that their partner also found the experience traumatic:

"My partner did but I only realised that when we attended a gentle birth weekend to prepare for the birth of our second child. He felt he couldn't protect me. He saw me try to have a bath after birth at home, my body and mind was broken and I cried for weeks. We didn't name our first child for 3 weeks. It was awful for him too."

"Husband found it very traumatic as he was not informed of what was happening. He could hear I was in a lot of pain. He collapsed in delivery room."

"My husband was a broken man watching me go through everything especially the forceps force. Emotionally we try to support each other. Nearly 8 months on its difficult. I don't believe I will ever get over the trauma we experienced."

"He was left in the dark and told he could lose us both and never heard another thing for over an hour."

"Yes my husband tormented himself for days after the birth, thinking he should have done more, why did he not speak up, why did he not stand up for me more. I had explained to him that it was for the same reason I didn't scream or fight

harder - we were trusting the professionals in the room to know what they were doing was right, by protocol, necessary."

RECOMMENDATION 12: HSC Trusts should offer training for staff on the importance of minimising birth trauma, including highlighting communication, locus of control, and compassion.
Midwives should ask women postnatally how they are feeling about their birth, and signpost them to appropriate services if there is the possibility of birth trauma.
All HSC Trusts should provide appropriate services for women and partners/birth partners who have experienced birth trauma.
In emergency situations, a designated person should lead on communication and support for the woman and her partner/birth partners.

e) Bounty visits

Bounty UK is a promotions company. Their staff visit maternity units across Northern Ireland, offering free product samples and a photography service, as well as a range of leaflets. They also harvest women's data for commercial use. Nearly three quarters of women in our survey had a visit from a Bounty representative after their birth.

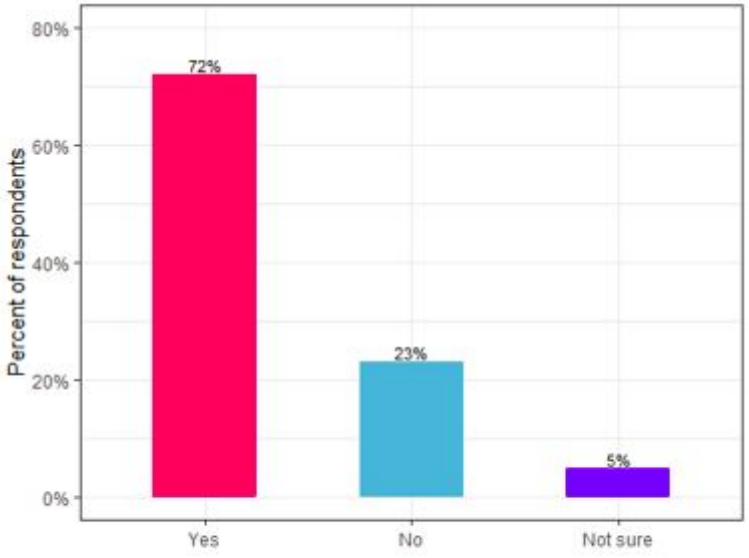


Figure 34. Were you visited by a bounty representative

We asked women how they felt about the Bounty visit. Of those who expressed an opinion, 54% found the visits unwelcome, while 46% welcomed them.

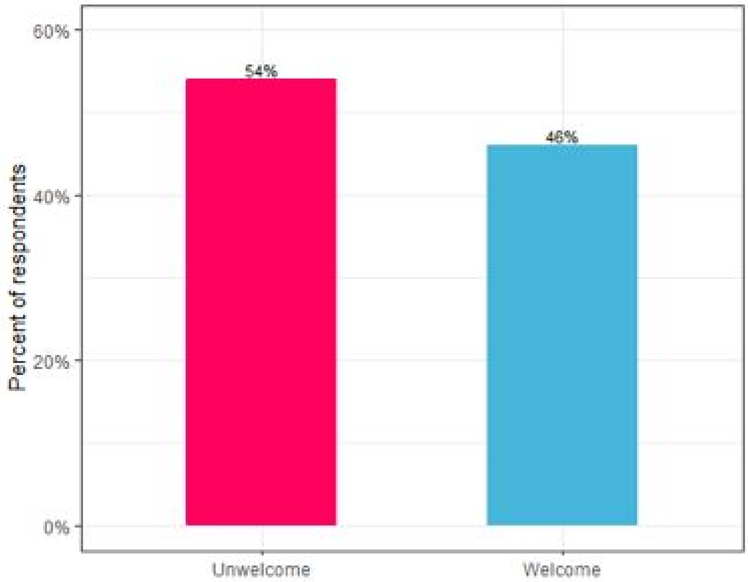


Figure 35. How did you feel about the bounty visit

Here is the word cloud of women's responses to the Bounty question:

In terms of reasons given for their answer, most women who were positive mentioned the opportunity to have photographs taken.

> "I wanted the pictures."
>
> "I got photos and I think it is important to capture those moments, babies change so quickly."
>
> "I wanted the photo and didn't feel my privacy was invaded at all."
>
> "Did not care about free pack but did really value the photos taken."
>
> "I wanted pictures of my gorgeous baby and the bounty woman was lovely."

However women who did *not* want to see the Bounty rep had a range of concerns including loss of privacy, intrusiveness, commercial pressure, and inappropriate behaviour.

> "I didn't want pictures taken of my child by her. She basically came into my cubicle and went straight to the baby. It made me very uncomfortable. She announced she was going to take pictures for me. Having had this with my first child I knew I could say no! However her approach was very full on as if I didn't have a choice. I sent her away much to her horror!!"
>
> "Visitors aren't allowed to just land into the wards when women are vulnerable but pushy sales reps are!! I don't agree that they should be there."
>
> "Trying to exploit new mothers."
>
> "Pulled back curtain when I was trying to feed."
>
> "I felt they can be quite pushy. My baby had just had a seizure and was taken off by a Dr and she was there trying to sell photos despite me sitting crying and telling her it wasn't a good time."
>
> "She was extremely pushy and wouldn't give us time to open my bounty app for free pictures. Didn't explain things properly and i felt pressured into buying the pictures."
>
> "The post natal ward is not a place to be promoting and selling products and services to new mothers who are vulnerable, emotional and in pain following birth. I witnessed a bounty rep sitting with a mother this entire duration of the wards 'protected meal time' her lunch was served, went cold and was taken away all the time the rep was there. She should have said 'eat up mum, you need your strength, I will leave you to eat in peace and come back later'. But she didn't seem to care. Shocking that the Trust allows this."
>
> "I just see it as a money making machine. I never looked at the pack when I brought it home... Too many leaflets etc."
>
> "I told the bounty worker that I did not want photos. She came back later when my husband there with promises of free pictures which he was keen on so I accepted getting photos done. This involved my getting out of bed - I had to ask to get back in it and get photo shoot cut short as I was dizzy and felt sick. The bounty worker then spent ages showing us all the pictures when all I wanted

was peace and sleep. We eventually settled on the cheapest package which turned out to be twice the amount she first quoted - by which point I asked her to leave as I was about to pass out. Awful, awful experience and completely uncalled for. Not the time and place to make a mother shell out £80 for photos of newborn baby or feel like an awful mother for choosing not to. Bounty should be banned from wards in my opinion."

RECOMMENDATION 13: We recommend that all Trusts consider ending Bounty contracts. If appropriate, alternative arrangements should be made to facilitate professional photography without commercial pressure and away from the women's bedside.

f) Postnatal maternity care

Most women were happy (24%) or very happy (55%) with the support they received from community midwives and health visitors after their baby was born.

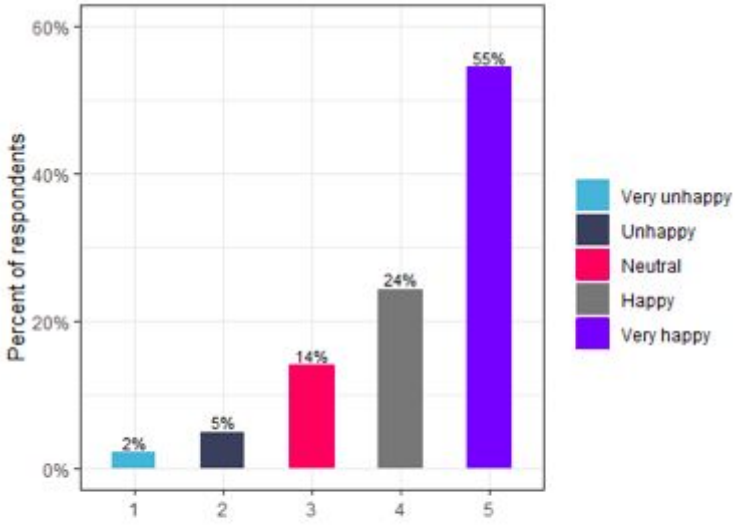


Figure 36. How happy were you with the care you received from community maternity services during the postnatal period?

Many women reported having very positive experiences with their community midwives in terms of support with physical care, breastfeeding support, and awareness around mental health.

"There was a midwife [name] who was second to none. She spent several hours with me both within my home and at [unit] showing me how to breastfeed/getting breastfeeding established."

"I felt she was particularly careful to look after mine and my partner's mental health. She was also amazing support for breastfeeding."

"A fab team of community midwives"

"Excellent. Supported me through a first few difficult days after finding my birth difficult."

"Brilliant community midwives".

"Lovely experienced and patient midwives and student midwife attended me."

"The first 10 days my post-natal care was great. I had lovely midwives and the health visitor was amazing also."

"Exceptional staff visiting me at home. So friendly, caring and supportive. Always answered all my questions and weren't in a hurry."

"The midwife came out and was very attentive to my needs. She changed the dressing on my scar and gave me support when I needed it."

Word cloud: postnatal maternity services

14% of women had a mixed or neutral experience, while 7% rated their experience as negative (5%) or very negative (2%).

"I gave 3 because while I had a good midwife and HV, breastfeeding knowledge was a bit lacking. I was having difficulty with my baby latching; he lost 10% of birth weight and they weren't able to point me in the direction of good support. It was the Surestart midwife who diagnosed a tongue tie and only then did I get a referral for [dentist/orosurgeon]. It took 17 days for my baby to regain his birth weight after the tongue tie snip and topping up with expressed breastmilk."

One of the prominent themes was a lack of continuity of carer.

"Only thing is I'd have liked more consistency on the midwife visiting me."

"Mostly it was great but I don't think I saw the same midwife more than twice."

"Don't believe I saw the same midwife twice."

Some women described feeling as though the midwives were not interested in them if their babies were still in hospital:

"They only seen me once at home. Didn't seem interested as I didn't have babies home even though I was worried about infection in section wound. Told me to get swabbed up in hospital while I'm up visiting twins."

"The first midwife was very caring and helped me to use my breast pump etc. The next midwife who visited was blunt and rushed and didn't offer much support whilst my baby was still in NICU."

Some women felt that health issues were missed by the postnatal team:

"Midwives were always different and dismissed my postnatal heavy bleeding but it turned out I had retained some placenta."

"Baby was ill with severe reflux & CMPA, very little support was given. No continuity of care. My wound was never checked. I wasn't asked how I was feeling."

This included mental health concerns:

"I did feel at the time that I was well looked after, but looking back now I feel that they missed what I was dealing with mentally, however I probably did my best to conceal that I was struggling."

Some women highlighted the challenges in the timing of postnatal home visits:

"I was very happy overall with the midwives that called with me. The only downside was that I was never told a time when they would call so I had to stay in or cancel visitors until they arrived (anytime between 9 and 1)."

Others would have liked some notice before the maternal hand-held record was removed:

"Good care was provided. Towards the end of midwife involvement they took file back during an appointment but I didn't know this was going to happen. I

would have liked some notice so I could have made a note of some info before the file went."

In terms of breastfeeding, some women reported they got good support from community midwives:

"All very supportive to establish feeding."

"I had great care from the community midwives especially with help for breastfeeding. Only thing is I'd have liked more consistency on the midwife visiting me."

"Very helpful and very reassuring when I was struggling with breastfeeding."

"The midwives in [area] are brilliant and very supportive of breastfeeding in my experience. My son had a tongue tie and needed lots of extra help with feeding. One midwife sat with me for 30mins trying to help get expressed milk into him and gave me the use of a pump for supply so I could feed him while waiting for it to be snipped."

Other women reported being unsupported while trying to establish breastfeeding:

"The midwives were lovely but not the foggiest notion about breastfeeding. Genuinely no idea beyond "the latch looks good" while my nipples were bleeding. I was so lucky that [name: breastfeeding lead] is in [hospital] or I would have stopped."

"I struggled with breast feeding when I came home after very little support or advice when in hospital. When my midwife came to the house the next day after a very bad night she really didn't offer any great advice except to start pumping (I now know that wasn't a great suggestion) ... Her attitude (and an unnecessary visit to a and e because of her) really were the beginning of the end of my breastfeeding journey."

"I felt the baby was being weighed too much and I was under a lot of stress to get her weight up and prove I had a milk supply. I was lent a breast pump which was very helpful but I was given terrible advice about how to pump and encouraged to top up with formula from around day 3. I declined and ultimately the community team referred me to the right people to help me continue to breastfeed."

"I was made to feel stupid and going against the rules in how I fed my baby due to slow weight gain and I was not listened to. This made my pn course hard and led to much anxiety."

Women elaborated further on feeding support issues in their responses to the next question.

g) Feeding

46% of women in our survey breastfed, while an additional 24% mixed fed (breastmilk and formula). 27% of women used only formula, while the 2% 'other' responses included orogastric tube feeding, donor milk, and specialist formula.

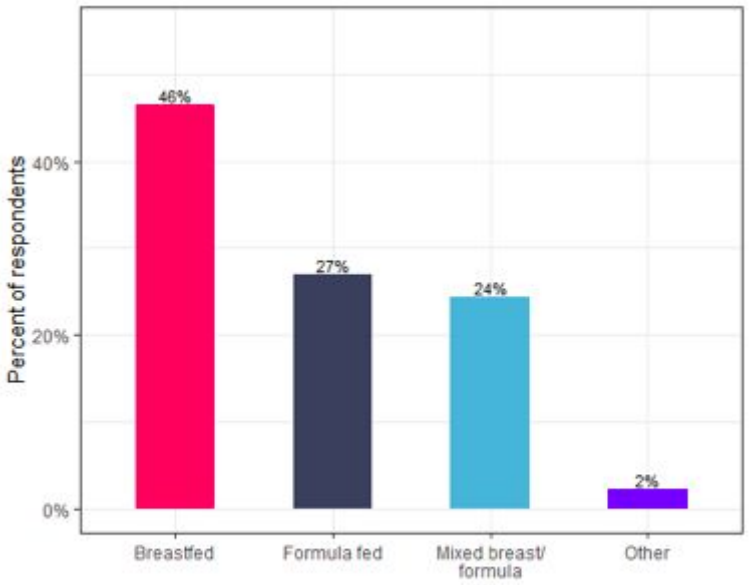


Figure 37. Approaches to feeding

61% of women reported they got the support and information they needed to feed their baby.

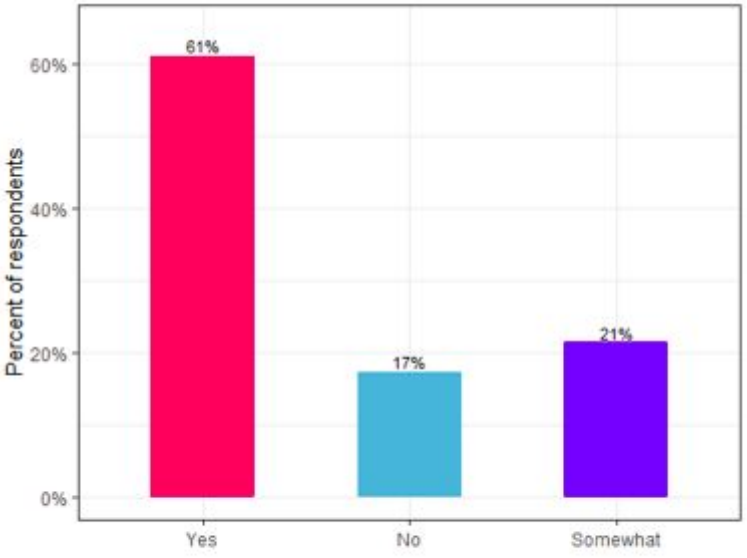


Figure 38. Did you get adequate information and support with feeding?

21% reported "somewhat" and 17% reported that they received inadequate information and support with feeding.

The World Health Organisation recommends "exclusive breastfeeding for the first 6 months of life, followed by continued breastfeeding with appropriate complementary foods for up to 2 years or beyond" (p6). There are clear benefits in terms of improved outcomes for babies, for women, and for society as a whole.

According to research carried out by Queen's University Belfast, because of increased economic activity among people who were breastfed as babies:*"Even an additional 10% of babies breastfed in NI next year would result in … £21.6 million in additional tax revenue."* This research report also highlights the relatively small cost of increasing breastfeeding support: *"Costs at £200 per additional breastfed child: less than £500,000."*

Research has also found that women's experiences in the healthcare system, along with HCP's attitudes towards breastfeeding and a lack of breastfeeding education within the healthcare sector has an impact on breastfeeding initiation and duration.

In terms of healthcare professionals, the women in our survey had support from midwives, health visitors, and breastfeeding specialists.

Breastfeeding support teams: Women were generally positive about hospital-based breastfeeding specialists:

> "I had great support from lactation consultant in hospital."
>
> "Excellent support from breastfeeding coordinator, she was brilliant"
>
> "Breastfeeding peer support team were fantastic. We had a poor latch."
>
> "They did put me in contact with the feeding support worker in the hospital which was vital."

Women also reported they were supported by other women who had breastfed – either via trust peer support schemes, Sure Start, or online groups. The Breastfeeding in Northern Ireland facebook group was highlighted by a number of women:

> "There were a few of the nurses and midwives in hospital and once I got out who were very supportive of Breastfeeding and made a real difference. The Breastfeeding NI Facebook group was also an invaluable resource for me."
>
> "Surestart were valuable as their feeding support worker came to see me and encouraged me to continue breastfeeding postnatally and did not see formula as an obstacle to the breastfeeding. It was more every breast feed is a bonus despite what else you do."
>
> "My baby was very sleepy post-birth and difficult to latch. I felt like I was bothering the postnatal midwives when asking for help/advice and left hospital not 100% happy with how feeding was going. At home, community midwives simply suggested nipple shields but didn't offer any real help with latch/positioning. My family were very supportive and the Breastfeeding in NI facebook group is invaluable."
>
> "Baby didn't take great feeds to begin with, I was allowed to stay an extra night to establish feeding and helped to express and feed colostrum! I have been involved in advocating for more breastfeeding support from my first birth so got a lot of support on the bfni group and drugs in breastmilk team! I also knew a

lactation consultant led a sure start breastfeeding group so availed of that! Again without knowing these things it might have been a different story!"

Challenges

A number of themes came through in the survey about challenges relating to feeding support: general lack of support; a lack of consistency in the advice provided by HPCs; feeding options not discussed for those who were facing difficulties; midwives not having enough time to be able to provide adequate support; mums who had fed before feeling unsupported; HPCs' lack of breastfeeding knowledge, and issues around consent. These are detailed below.

Lack of breastfeeding support: For women who wanted to breastfeed, some commented on the general lack of support in the early days and weeks postpartum.

> "I would have loved some one to one support for breastfeeding in those first weeks."
>
> "I felt I got very little support while in hospital."
>
> "I feel I didn't get enough support to continue breastfeeding"
>
> "No one showed me how to do it correctly. Very sore. Gave up after 3 days."
>
> "After a very long traumatic birth I found the labour ward to be a particularly stressful experience. It was impossible to get any rest I didn't have any sleep for 4 days due to noise from babies, snoring mothers and the midwives were very overstretched. It was very difficult to look after a baby after a caesarean without your partner there. I believe this led to me developing postnatal depression."

Inconsistent advice: Women described a lack of continuity in care and advice in maternity services.

> "HCPs all very supportive and enthusiastic but info/advice was often inconsistent."
>
> "Mw and hv gave conflicting advice. I had to reach out and look for bf specific people and help."
>
> "Midwives that visited me at home all had different advice, each time a different midwife called and only one seemed to really listen to me and give helpful support and advice."

Time constraints: A strong theme in women's comments was that the midwives were often too busy to provide breastfeeding support. There are acknowledged workforce issues in the system at present, and this was clear in women's experiences.

"Got more help & support through attending local breastfeeding group. Some hospital staff seemed too busy & just offered formula top ups & so did one community midwife."

"Found the midwives in hospital very quick to latch baby on but didn't show me 'how' or explain, midwives at home were very quick."

"The midwives did try to help but they are under pressure and don't have a lot of time."

"They were so busy I had to beg to be shown different breastfeeding techniques. I felt overwhelmed and alone with how to breastfeed."

"Got more help & support through attending local breastfeeding group. Some hospital staff seemed too busy & just offered formula top ups & so did one community midwife."

"Found the midwives in hospital very quick to latch baby on but didn't show me 'how' or explain, midwives at home were very quick."

"The midwives did try to help but they are under pressure and don't have a lot of time."

Mixed feeding: Some women reported inadequate information about mixed feeding. These women described feeling disappointed as they were not provided information on the option of combi-feeding (breastmilk and formula). They describe how this knowledge may have increased the duration of time they fed breastmilk but instead ended up solely formula feeding:

"Felt I was left just to bottle feed once I'd introduced formula as I wished to combination feed when the babies were jaundiced and as they were small. Breastfeeding was then never mentioned again by ward staff so I just got on with it myself. Surestart were valuable as their feeding support worker came to see me and encouraged me to continue breastfeeding postnatally and did not see formula as an obstacle to the breastfeeding. It was more every breast feed is a bonus."

"I had no info about combi feeding - had I been given this I feel I would have continued longer."

Not first time feeding: Each breastfeeding journey is different and some of the women who had had a baby before reported feeling neglected and unsupported:

"In hospital I was very much left to it - previous experience so they felt I would be fine but different baby, different experience. Difficult to latch, difficulties with supply, felt quite unsupported."

"I wasn't given much info as a 3rd time mum."

"A breastfeeding support peer peeked her head around the door of my room and saw I was feeding her myself, asked me how I was getting on and I said I'd fed

my previous child to 2.5 years, so she said you're a dab hand then and off she went."

"There isn't much support especially for 2nd time mums."

Pressure to Formula Feed: Women's responses indicate that breastfeeding support from health professionals varies widely, with some women saying they felt supported by knowledgeable midwives/health visitors and others reporting they felt really let down. Some women even reported they felt pressured into formula feeding by some midwives:

"Lack of support in hospital and was encouraged to give baby formula on night two. I feel that this was the wrong advice"

"No idea about new born behaviour, position or attachment. Poor weight gain etc. The solution offered was a bottle."

"Breastfeeding coordinator was not available and midwives were encouraging me to formula feed."

"The woman in the bed next to me on [date] was offered free formula to take home and told "but don't tell anyone or the UNICEF ones will be on to us".

This raises many queries about the support women receive in the early days of establishing breastfeeding, and also illustrates the powerful position of trust which healthcare professionals occupy.

Women who did not meet their own breastfeeding goals were often very distressed about this:

"Was really heartbroken for a few weeks when we first had to give her formula."

Consent was an issue for some women:

"At one point the hospital team gave formula without my consent. This made me mad as I wanted him to be completely breastfed... there was one local midwife who came to my home for the follow up who was rude and practically accused me of starving my baby and wanting him to be put back in hospital, all because I stood up to her when she was talking down to me and I told her I didn't want to give formula. At one point I began to think she would have my baby taken away if I didn't obey and I felt quite intimidated into giving formula top ups."

Women whose babies were in **neonatal units** faced particular challenges, as did mothers whose babies were admitted to **children's wards:**

"My baby was in an incubator and I did not get him onto the breast for several days. The hospital supplied a pump and equipment for use in the hospital and to take home when I was discharged 2days post delivery. I also had on hand help from the breastfeeding support team (name) and nurses in HDU and special care."

"My milk was delayed and baby lost too much weight... I felt that we should have been re-admitted to maternity but instead we were on a children's ward, so there was absolutely no support for me as a recovering or breastfeeding mum. I was asked to pump, but no-one on the ward knew how to work the pump they provided and I was told to 'just play around with it'..."

Compassion: Infant feeding is an emotive and delicate topic and an area where compassionate care is particularly important, due to the anxiety many women describe when trying to establish breastfeeding:

"As my son failed to attach to my breast, I was getting very upset and kept trying for the first few days of in the hospital and all the midwives were so helpful in offering tips and advice on expressing. My partner was so supportive when I felt like a terrible mum as I had my heart set on feeding him myself and then couldn't."

Some of the care women described was lacking in warmth, empathy, and compassion:

"Some of the midwives were very supportive but one of them wasn't. I went to them very late one night as I was worried about if the baby had taken enough and she snapped at me and said I would just have to make my mind up! My son had a tongue tie and I was also struggling after the c section so was feeling very vulnerable at this stage and she really didn't help."

"Tried to breastfeed this baby but because I had formula fed first baby nobody wanted to spend any time showing me how to get the latch. One midwife at the hospital told me she didn't want to waste time showing me."

"I was told I should have curtain pulled when breastfeeding in hospital as men were on the ward."

"In hospital the midwives did not seem very supportive of my decision to breastfeed as I struggled. They gave my baby formula milk and did not tell me until after the fact... One of the care assistants who worked alongside the midwives was an excellent help and supportive and encouraging. Because of her I continued to breastfeed for six months. At home I felt more relaxed and did not encounter any problems."

HPCs lack of breastfeeding knowledge: As highlighted in research, the impact of HCP's inadequate knowledge of breastfeeding on women's breastfeeding journeys is substantial. To ensure women are given the best chance at meeting their goals it is imperative that women are provided with accurate evidence based information and hands on support if required.

"Midwives need serious serious training"

"Midwives in the hospital refused to provide assistance with latch issues."

> "Seemed to think it was ok for baby to sleep 5 hours without feed. I had to argue to get baby back."

The early days of breastfeeding can be challenging for any woman who may be wondering if baby is latching correctly, questioning why she is in pain or if her baby is getting enough milk. All of these are common reasons for early breastfeeding cessation. It is therefore important that the midwives who are looking after them are well equipped to provide the most accurate advice and support.

Trusts in Northern Ireland have implemented the Unicef Baby Friendly standards, as have many Sure Start projects. While this has led to an improvement in standards, it is clear that more work is needed to provide effective support for women.

Despite having the highest coverage of the Baby Friendly Initiative in the UK, Northern Ireland still has the lowest rates of breastfeeding. This indicates that much more needs to be done, in addition to the Baby Friendly award, in order to ensure that health care professionals are able to support and inform women about the best evidence.

Feedback from formula feeding women: a number of women who chose to formula feed reported they were not supported enough:

> "Because I chose to ff from birth, feeding wasn't discussed, I was told that they couldn't give advice because I wasn't breastfeeding."

RECOMMENDATION 14: **Beyond BFI:** In line with Unicef requirements each Trust should monitor adherence to BFI standards through an ongoing rolling audit programme. Maternity units should also seek to implement the BFI Achieving Sustainability Standards. In addition PHA and the Breastfeeding Strategy Implementation Steering Group should consider what further actions are needed to ensure health care professionals provide compassionate, appropriate, evidence-based breastfeeding support.
Trusts should review breastfeeding support provision and seek to increase access to support from maternity support workers or equivalent to help women establish breastfeeding and provide practical support with positioning and attachment in the postnatal wards.
Women who need further support should be referred to a breastfeeding specialist.
All parents who formula feed should be provided with information and support on how to safely make up feeds and encouraged to formula feed in a responsive way in line with BFI standards and as detailed in *First Steps Nutrition Trust* guidance.

3.Recommendations

Throughout the survey, we have made recommendations for maternity services in Northern Ireland, based on what women told us in their response to the survey. While recognising that there are finite resources including particular workforce challenges, it is vital that maternity care provision reflects the evidence base as a means through which the health and wellbeing of future generations can be enhanced.

The full list is reproduced here for convenience.

RECOMMENDATION 1: The Northern Health and Social Care Trust should prioritise the development of three MLUs - alongside units in both Causeway and Antrim, as well as a freestanding unit elsewhere within the Trust.

RECOMMENDATION 2: Birth Choices clinics / VBAC clinics / breech clinics should be available in all Trust areas. Individualised care plans should always be developed with women who are deemed to be outside guidelines.

RECOMMENDATION 3: Regional guidance should be developed to standardise approaches to discussing place of birth with women. This should build on the RQIA guidelines for admission to midwife-led unit, and the RQIA guidance for women planning birth at home. An individual evidenced-based care plan for planning place of birth should be developed in partnership with any woman experiencing a complex pregnancy.

RECOMMENDATION 4: The NI Department of Health should commission a review of maternity services in Northern Ireland, and commission a new maternity strategy. This should explore models that support continuity of carer across antenatal, birth, and postnatal services for women. In advance of this, HSC Trusts should begin to explore, develop, and strengthen continuity/caseload models within existing maternity services.

RECOMMENDATION 5: Regional guidelines should be developed for breech birth, including vaginal breech. Trusts should ensure that women are informed of vaginal breech birth as an option, and training should be provided to 'reteach the breech' where needed.

RECOMMENDATION 6: Training on consent and human rights in childbirth should be provided to all maternity health care staff.

RECOMMENDATION 7: Training and or/guidance should be provided for all maternity care staff to ensure adherence to NICE guidance on sweeps.
Trusts should review practice on induction of labour and ensure that women are not offered induction before 40-41 weeks unless there are clear, documented clinical reasons.

Trusts should review practice regarding women's experiences of induction of labour to ensure that women can give fully informed consent, and are respected and supported to feel safe throughout.

RECOMMENDATION 8: All Obstetric Units should review the birth environment, particularly in delivery suite and theatres, with a view to making this more supportive of women's emotional and physiological needs.
Obstetric units should ensure there are enough telemetry monitors to meet the level of evidence-based need.
Regional guidelines are needed on best practice in facilitating gentle caesarean sections.

RECOMMENDATION 9: Trusts should monitor, review, and reduce the number of women birthing on their backs. Intermittent monitoring and telemetry rather than CTG should be used whenever possible.

RECOMMENDATION 10: Trusts should continue to monitor, evaluate, and review the various elements of the care bundle aimed at preventing tears, in order to ensure that the more invasive elements (hands-on, episiotomy) are only used when absolutely needed, while other elements including warm compresses and good communication with women to ensure slower crowning should be offered to all women unless there are clear, documented reasons not to.

RECOMMENDATION 11: There should be regional guidance on optimal cord clamping, with the majority of cords being left to turn white before being clamped and cut, and as a minimum, NICE recommendations being followed.

RECOMMENDATION 12: HSC Trusts should offer training for staff on the importance of minimising birth trauma, including highlighting communication, locus of control, and compassion.
Midwives should ask women postnatally how they are feeling about their birth, and signpost them to appropriate services if there is the possibility of birth trauma.
All HSC Trusts should provide appropriate services for women and partners/birth partners who have experienced birth trauma.
In emergency situations, a designated person should lead on communication and support for the woman and her partner/birth partners.

RECOMMENDATION 13: We recommend that all Trusts consider ending Bounty contracts. If appropriate, alternative arrangements should be made to facilitate professional photography without commercial pressure and away from the women's bedside.

RECOMMENDATION 14: **Beyond BFI:** In line with Unicef requirements each Trust should monitor adherence to BFI standards through an ongoing rolling audit programme. Maternity units should also seek to implement the BFI Achieving Sustainability Standards. In addition PHA and the Breastfeeding Strategy Implementation Steering Group should consider what further actions are needed to

ensure health care professionals provide compassionate, appropriate, evidence-based breastfeeding support.
Trusts should review breastfeeding support provision and seek to increase access to support from maternity support workers or equivalent to help women establish breastfeeding and provide practical support with positioning and attachment in the postnatal wards.
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All parents who formula feed should be provided with information and support on how to safely make up feeds and encouraged to formula feed in a responsive way in line with BFI standards and as detailed in *First Steps Nutrition Trust* guidance.

Appendix 1 – Key Documents

A Strategy for Maternity Care in Northern Ireland 2012-2018, DHSSPS, 2012

Birth NI: A survey of women's experience of maternity care in Northern Ireland, Queen's University Belfast & National Perinatal Epidemiology Unit, Oxford University, 2015

Planning to give birth in a midwife-led unit in Northern Ireland, GAIN (now RQIA), 2016. http://bit.ly/MLUwomen

Planning Birth at Home, RQIA, to be published 2019

NICE Guideline CG190 Intrapartum Care for healthy women and babies, NICE 2014, 2017
https://www.nice.org.uk/guidance/cg190

NICE quality statement on delayed cord clamping, NICE 2017
https://www.nice.org.uk/guidance/qs105/chapter/Quality-statement-6-Delayed-cord-clamping

Appendix 2 - BirthWise Survey working group members

Name	Designation
Leslie Altic	BirthWise Treasurer
Aine Black	BirthWise Volunteer
Rachel Black	BirthWise Vice-Chair
Claire Doran	BirthWise Volunteer
Emma Fraser	BirthWise Secretary
Claire Hackett	BirthWise Volunteer
Catherine Muldoon	BirthWise Volunteer
Seána Talbot	BirthWise Chair
Gail Whiteside	BirthWise Volunteer

Appendix 3 - Abbreviations

Page 3.

DHSSPS – Department of Health, Social Services and Public Safety

ORECNI – Office for Research Ethics Northern Ireland

Page 8

HSC Trust Areas – Health and Social Care Trust Areas

Page 9

SHCST – Southern Health and Social Care Trust

MLU – Midwife Led Unit

Page 10

VBAC – Vaginal Birth After previous Caesarean section

VBA2C– Vaginal Birth After 2 previous Caesarean sections

Page 17

HCP – Health Care Professional

OU – Obstetric Unit

AMLU – Alongside Midwifery Led Unit – beside obstetric unit

FMLU – Freestanding Midwifery Led Unit – no obstetric unit on site

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EITP – Early Intervention Transformation Programme

GRFB – Getting Ready for Baby

BF – Breastfeeding

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RQIA – the Regulation and Quality Improvement Authority

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CTG – Cardiotocography

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HDU – High Dependency Unit

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BFI – Baby Friendly Initiative

PHA - Public Health Agency

Acknowledgements

The working group would like to thank all of the women who so generously told their stories as part of this survey. Rest assured your stories will be used by the BirthWise team to challenge for continued improvements in maternity services.

We would also like to thank all of the senior midwives and the obstetrician who reviewed the draft document, as well as the academics and researchers from PHA, Ulster University and Queen's University Belfast who provided informal feedback, guidance and support.

BirthWise

Maternity Survey

A survey of self-selected women who gave birth
in Northern Ireland between January 2015-August 2019

Executive Summary

BirthWise Survey Report September 2019

Executive Summary

Background

Maternity services in Northern Ireland are provided mainly by the five Health & Social Care Trusts. Pregnant women also access information and support through Sure Start, as well as through a range of third sector and private services including antenatal workshops, classes, and therapies, doulas, and some private obstetric services. There are currently no independent midwives in Northern Ireland.

The *Maternity Strategy for Northern Ireland 2012-2018* was published in 2012 by the then Department of Health, Social Services and Public Safety. It made a series of recommendations for maternity care, including the provision of alongside midwife-led units on the same site as obstetric units, reducing inappropriate variation in practice across trusts, and recommending separate pathways for midwife-led and consultant-led care. Since then, significant achievements have been made through the hard work and dedication of service providers, commissioners, and policy-makers.

The strategy highlighted the importance of considering prospective parents as *"partners in maternity care"* (DHSSPS 2012, p.12) and recommended that they be *"given all relevant information, in appropriate formats, to make informed choices about what is best for them and their baby"*. (DHSSPS 2012, p.27).

BirthWise is a new, Northern Ireland based charity focusing on pregnancy, birth, and new parenthood. We are a grassroots movement of expectant and new parents and those who support them. We aim to connect, empower, inform and support new parents, and campaign for continuous improvements in maternity care and other relevant services. We are a values-based charity: integrity, transparency, excellence, equality, selflessness and passion drive us in our work.

The BirthWise Maternity Survey 2019 was developed as part of the charity's mission to campaign for continuous improvements to maternity services in Northern Ireland. The survey was designed by BirthWise volunteers, including service user representatives, advocates, midwives and student midwives, who helped identify key questions about current services and women's experiences. The survey team shared the proposed survey with ORECNI (Office for Research Ethics Committees Northern Ireland), and with academic researchers at Ulster University. Both agreed that the survey was not likely to meet the definition of 'research' and therefore did not need ethical approval. The team also completed the Health Research Authority questionnaire which confirmed this.

The survey provides valuable data to inform the charity's campaigning objectives. There are 14 recommendations, which are based on the survey responses from local women. A total of 1977 responses were received during July and August 2019. The survey was open to women who have had a baby in Northern Ireland between 2015

and 2019, and it was made clear that women could fill in the survey more than once if they had had more than one baby during the timeframe.

There have been almost 100,000 births in Northern Ireland since 2015, and the 1977 responses we received cannot be seen as in any way representative of all women's experiences. However we are extremely grateful to all of the women who took the time to fill in the survey and tell their stories. Their stories matter. Their voices matter.

In 2016, researchers at Queen's University Belfast carried out a comprehensive survey: "Women's Experiences of Maternity Care in Northern Ireland" (Birth NI, 2016). The report highlighted that *"Overall, women are largely positive about their experience of maternity care, but it is also important to consider the experiences of women who were less satisfied with their care and find ways to improve the quality of care for all women and their families" (p7)*

The BirthWise survey aimed to gather crucial information on the state of current practice in maternity care, with a particular focus on women's sense of agency and locus of control, by investigating how well informed they felt and how their wishes were respected throughout their maternity care.
The key aim of the survey was to explore the views and experiences of women accessing maternity care in Northern Ireland, as well as highlighting important issues in terms of current practice in maternity care. The survey covered all aspects of maternity care, including choice of place of birth, type of care received, antenatal education, induction of labour, caesarean births, infant feeding and postnatal care. Specifically, the survey aimed to:

- Explore current practice around the provision of antenatal, birth, and postnatal care in Northern Ireland.
- Investigate women's individual experiences and explore their key areas of concern.
- Highlight high quality care and innovative practice in maternity services in Northern Ireland.
- Explore women's involvement in their care in terms of receiving full, evidence based information, and having a sense of control over their experience of maternity care.
- Highlight current strengths and gaps in maternity care, and make recommendations based on women's responses.

Participants

The survey was open to women in NI who had a baby between January 2015 and August 2019. There was a good mix of responses across the different birth years.

1. **Location:** The majority of women (82%) gave birth in their own local HSC Trust. 18% gave birth in a different Trust. Of those who gave birth in a different Trust area to where they lived, the most common reasons included geographical

convenience, the need to attend the regional specialist unit in Belfast because of complications, the lack of availability of neonatal cots locally, specialist clinics such as diabetes clinics, the lack of a midwife-led unit locally, wider care options such as support for vaginal breech birth or vaginal birth after caesarean in another unit, because they worked in that other Trust, or personal choice.

2. **Sure Start:** 31% of women indicated they lived in a Sure Start area, with responses from women attending Sure Start projects right across Northern Ireland. Women accessed a range of Sure Start services, including baby massage, baby classes, and breastfeeding support.

3. **Previous births:** Almost half of women reported they had had a previous labour induced, while 38% had had augmentation of a previous labour via a drip. 27% of women had had at least one previous c section, and a similar number had previously had a forceps birth. Only 23% reported having had a previous straightforward birth.

Antenatal Care

1. **Type of antenatal care:** Midwife-led and consultant-led care were the most common types of care with 43% and 40%, respectively.

2. **Discussions around place of birth:** Birth in a consultant-led unit was the most commonly discussed option (62%) followed by alongside midwifery-led units at 36%. Free standing midwifery-led units were discussed with 18% of women and the option of home birth was discussed with just 7%. In 17% of cases, women reported that healthcare professionals did not discuss *any* options with them. NICE guidelines specifically recommend that all four options for place of birth (home birth, freestanding midwife-led unit, alongside midwifery led unit, and obstetric unit) are discussed with all healthy women having a straightforward pregnancy. It is clear from women's responses that this is not happening, and even when women specifically request a certain place of birth, they are often discouraged from their choice.

3. **Decisions on place of birth:** After discussions with health care professionals, as well as with partners, friends, and family, most women (61%) decided to give birth in an obstetric unit. Alongside midwifery-led units were chosen by 31% of women and 6% wanted to have their baby in a free standing midwife-led unit. Fewer than 2% of women wanted a home birth.

4. **Complications:** Many women had no complications, while back pain, nausea/sickness/vomiting, gestational diabetes, and bleeding were relatively common.

5. **Antenatal education:** 59% of women had attended some form of antenatal education. Some women attended antenatal courses offered by the various HSC Trusts while others attended private antenatal preparation courses. Parentcraft classes were found to be 'informative, but basic', with some women commenting that they felt 'rushed' and as if it was 'a 'tick-box' exercise'. Satisfaction with HSC Trust-based courses appeared to increase with MLU workshops and the EITP (Early Intervention Transformation Programme)/GRFB (Getting Ready For Baby) programme, with midwives who took the sessions being described as being 'woman and baby centred'. Women were positive about the antenatal education and support they received via Sure Start. Women who had attended paid-for classes, including Daisy, Gentlebirth, NCT, hypnobirthing courses and pregnancy yoga, or who had engaged a doula (professional birth companion), rated these services as 'excellent' and 'amazing'. Many of these women reported feeling prepared, confident and empowered for their birth, enabling them to make informed decisions.

6. **Satisfaction with antenatal care:** 76% of women reported they were happy or very happy with the care they received from maternity services and just 3% reported being very unhappy with the care they received. Those who gave positive ratings commented that they did so because of supportive health care professionals, the benefits of building a relationship with the same midwife/small team of midwives, and that they had generally felt 'well looked after'. Women also highlighted that having a sense of control and experiencing continuity of carer was particularly important to them. Those who gave negative responses highlighted poor care, their choices not being respected, breaches of autonomy, privacy, and/or dignity, lack of compassion from some health care professionals, and a lack of continuity.

Late pregnancy

1. **Baby's position:** 82% of women reported their baby was head down at 36+ weeks. 8% of women reported a breech position and 9% reported other positions such as transverse or unstable lie. Of the 161 women who reported their baby was breech, over half (58%) didn't avail of any methods to try and turn their baby. 19% decided on ECV (external cephalic version, when a doctor physically turns the baby), 7% opted for moxibustion, 27% used optimal positions to encourage their baby to turn, and 7% reported using other strategies. A number of women reported trying a range of methods to turn their baby as they had wanted to have the baby vaginally. However, very few women in our survey mentioned vaginal breech birth. Some women had specifically requested a vaginal breech birth but were informed this was not possible.

2. **Membranes sweep:** A 'sweep' is a procedure often offered in late pregnancy. 59% of women in our survey were offered a sweep in late pregnancy. NICE guidelines

recommend that women are offered a vaginal examination for a sweep prior to formal induction at 40 and 41 weeks for first time mothers, and 41 weeks for women who have had a baby before. However, over two thirds of women (69%) in our survey were offered a membrane sweep prior to the recommended 40 weeks. Many women who were offered a membrane sweep prior to 40 weeks had additional health conditions, such as high blood pressure or gestational diabetes. However, a number of women reported that there had been no health concerns. Some women reported that there were clear reasons such as pre-eclampsia or concerns about their baby's pattern of movements. Others highlighted that it seemed to be routine, or were given reasons that do not match NICE guidelines, such as maternal age or a possible big baby.
There was wide variation in how well-informed the women felt, with some getting little to no information, while others had a full explanation of the process and the pros and cons. Some women felt as if they had no choice on whether to have a sweep, while concerningly, some women reported having a sweep that they had not consented to.
In terms of the experience, some women found it distressing, invasive, uncomfortable, or painful. Others commented they were keen to have it in order to avoid induction.

3. **Induction of labour:** Over half (55%) of the women taking part in our survey had been offered induction of labour. More than half of these women (52%) were offered induction prior to 40 weeks, which is not in line with NICE guidelines. Some women reported clear medical reasons for being offered induction. However, many women reported that the offer of induction was presented as 'routine', while some women commented that they felt pressured into agreeing to an induction. The most common reason given was that the woman was overdue (38% of women who were induced). 16% of those who responded reported the reason for induction was a suspected big baby, with no other factor. This is despite NICE specifically defining induction for a suspected large baby as a DO NOT DO recommendation. These results suggest that Trusts are offering induction to some women in contravention of NICE guidelines.

4. **Experience of induction of labour:** Women's experiences varied; however, several common themes emerged.
Feeling isolated and alone: this was often because the woman's partner/birth partner was sent home. Women reported feeling alone, afraid and unsupported, anxious and often uninformed.
Going home while awaiting labour to start following induction: a small number of women were delighted that they had been supported to go home and wait for labour to begin after a catheter/balloon/pessary had been inserted. This innovative approach is to be welcomed.
Other common themes: Lack of privacy, feeling a loss of control over their birth, coercion or lack of consent, feeling ill-informed, not being listened to/believed.
Positive experiences: Some women had positive experiences throughout the induction process. This was often down to the care the women received from

supportive midwives who treated them with compassion and respect, kept them informed, listened to them, and maintained a calm and relaxing environment.

Birth

1. **Place of birth:**, 57% had their baby in an obstetric (consultant-led) unit, while 31% birthed in an alongside midwife led unit. A further 5% had their babies in one of the three freestanding midwife led units, and only 1.2% had planned home births, despite these being safe for many low-risk women. While local trusts have been working to increase the numbers of women birthing in MLUs, this work needs to continue. In addition, women who choose home birth often meet resistance to their plans, despite the evidence and NICE guidelines. This reinforces the need for evidence-based information to be shared with women, and caseload midwifery/continuity models, which may assist in triaging women to the most appropriate care.

2. **Birth Environment:** Many women are not accessing factors likely to make the birth environment more conducive to positive birth experiences:
   Birth partners: While most women (77%) had the birth partners they wanted present, this means that 23% did not. The majority of women reported that their partner was with them when they gave birth. 11% had a female friend/relative, while less than 1% of women had the support of a birth doula.
   Students: Despite some resistance towards women having their chosen birth companions with them, women sometimes report significant numbers of students are present, particularly in theatre.
   Feeling informed: Fewer than half (48%) of women reported feeling adequately informed about what was happening.
   Water for labour and birth: Only 21% of women used water/a birth pool, despite clear evidence about the benefits: this was also highlighted in women's responses to the question about pain relief below.
   Mobility: Only 37% of women reported they were able to be mobile during their birth.
   Privacy: Despite clear evidence about the benefits of privacy for birthing women, only 38% reported that they experienced minimal interruptions and privacy. This can be facilitated even at a caesarean birth, so these figures are disappointing.
   Staff preferences: At times women felt they were expected to adapt to the individual preferences of staff.
   MLU: Women who birthed in an MLU were generally positive about the birth environment:

3. **Pain relief***:* Gas & air (Entonox) was the most commonly used form of pain relief, with 75% of women having used it during labour. Many women reported that they used various non-pharmacological forms of pain relief such as breathing and relaxation techniques, water and hypnobirthing (44%, 19% and 14%, respectively). Opioid drugs such as diamorphine were used by 37% of women, and

a similar number (38%) had an epidural or spinal. This last figure includes most of the women who had caesarean sections, as only 2.4% report they gave birth while under general anaesthetic. A small group of women (2.9%) reported that they did not use any pain relief.
Women who had their labour induced or augmented, particularly via a drip, often used stronger forms of pain relief than they had expected or wanted.
The use of hypnobirthing is increasing, with sessions now being offered by some maternity units as well as Sure Start projects and private providers. Most women who said they had used hypnobirthing techniques were very positive about the impact. However some women struggled to use hypnobirthing effectively in delivery suite.
Telemetry (waterproof wireless monitoring of the baby's heartbeat) was not made available to every woman who needed it, due to a shortage of equipment. This in turn prevented some women from using the pool or bath in labour, or having a water birth.

4. **Type of birth:** 56% of women in our survey had straightforward vaginal births, while 15% gave birth with the assistance of forceps or ventouse (vacuum). Caesarean births accounted for 29% of births, either planned (12%) or emergency (17%). In Northern Ireland, caesarean rates are generally around 30%, despite a World Health Organisation finding that the rate should be 10-15%.
When women's labour/birth left the normal pathway, many women understood what was happening and why, and retained a sense of control over events. Other women reported that they were not listened to, that they did not get adequate explanations, or that they were treated disrespectfully. Occasionally, women reported that the interventions they had may not have been necessary.

5. **Caesarean birth:** In our survey, 29% of women reported having a caesarean birth, more than double the WHO recommended level.
Reasons: For some women, the reason given was medically justified; this includes placenta praevia, baby being in a transverse position, cord prolapse or the baby having congenital abnormalities that could potentially make a vaginal delivery less safe.
Maternal request: The number of 'maternal request' caesarean births was low; only 4% of the women in our survey who had had caesarean births reported this was because of their own decision.
Breech: The most common reason given for caesarean section was breech. This had already emerged in our survey as one of the reasons why some women transfer their care. However it seems most women are not told about the possibility of breech vaginal birth, and they instead proceed directly to caesarean section. Giving women full information about their options may lead to a reduction in breech caesareans, which could impact on the overall c section rates. Training for healthcare professionals on vaginal breech birth should be offered, along with the development of Birth Choices clinics in every Trust in order to ensure choice for women whose babies are in the breech position.
Unnecessary c sections: As there are no known benefits for women or babies who do not require a caesarean section, our survey shows that some women in Northern

Ireland are more than likely having unnecessary caesarean births, along with the risks and postnatal recovery challenges that come with major surgery while caring for a new baby.
Previous c section: According to NICE, women who have had a previous c section should not automatically be booked for a repeat section, yet many women reported this is what happened to them. Women in this situation highlighted that health care professionals focused on the chance of uterine rupture, yet the evidence shows that this is **rare** with up to four previous sections. The relevant guideline specifies that women should be informed that…*'the risk of uterine rupture, though higher for planned vaginal birth, is **rare**'*. (NICE, 2011)
VBAC: Some women reported feeling delighted on achieving a vaginal birth after a previous caesarean section (VBAC), yet many others seemed unaware of this option. This reinforces the need for VBAC/Birth Choices clinics to be developed in all Trusts.
Experience of caesarean: Some women had a very positive experience of caesarean birth, while others did not know what was happening or felt they were coerced into having a caesarean.
Birth plans: The experiences of women who had elective caesarean sections highlighted a common theme - that many women did not know they could use a birth plan or were not supported in their birth plans. This underlines the need for regional guidelines in facilitating 'gentle' caesarean sections if women request them.

6. **Position during vaginal birth:** Of the 1117 (56%) of women in our survey who had a vaginal birth (without forceps/ventouse), 63% reported they gave birth lying on their back. This is contrary to good practice, best evidence, and gravity.
   While some women chose their own position or were facilitated to find a position that worked for them, the majority of these women reported they were asked to get onto the bed, and/or onto their back.

7. **Second stage pushing:** Of those women who had unassisted vaginal births, 63% were instructed to push. Some of these women had an epidural in place, and therefore may have needed guidance as to when to push, since they may not have been able to feel the contractions.
   Evidence suggests that a slow crowning of the head may help women avoid tears. Despite this, women's comments in our survey show that some health care practitioners are still encouraging 'purple pushing'. At times this was a distressing experience for women.

8. **Reducing the chance of a severe tear:** Of the 1117 women in our survey who experienced straightforward vaginal birth (i.e. without forceps or ventouse), almost half (43%) were encouraged to 'breathe the baby out', allowing the baby's head to crown slowly. Only 7% received warm perineal compresses, despite good-quality evidence showing they reduce the incidence of tearing. Almost 10% of women received a hands-on grip from a midwife or doctor, which is a higher than expected figure. 19% of these women had an episiotomy (a surgical cut to the vagina).

‘Breathing the baby out’ is now recommended as best practice, rather than coaching women to push. However, our data suggests that only 43% of women were encouraged to deliver their baby’s head slowly and gently. In some cases, this may have been because this stage of labour happened very quickly. For other women, this was associated with coached pushing, as shown in the comments related to second stage pushing.
Some women were unaware of the importance of these measures in reducing the chance of a more severe tear.

Postnatal

1. **Cord clamping**: Despite the clear benefits of waiting for the umbilical cord to turn white before clamping/cutting, only 6% of women reported their baby’s cord was cut after a long time. Most cords were cut either immediately (33%) or after a couple of minutes (37%). NICE currently recommends that cords are left for at least one minute, but fewer than half of women reported that this happened after the birth of their baby.

2. **Skin to skin contact:** Research has demonstrated that skin to skin contact immediately after birth and for the first hour with breastfeeding being initiated within this time, supports instinctive positive behaviours in both baby and mother. It has a calming and relaxing effect, regulates baby’s temperature and heart rate, as well as stimulating digestion and an interest in feeding.
Many of the women in our survey describe having skin to skin soon, if not immediately after birth, including women who had caesarean births.
Women whose babies were unwell reported particular challenges, particularly when communication was poor.
When women were unwell, often their partners/birth partners did skin to skin.
Some women reported having little or no skin to skin, including women who had had caesarean births and women whose babies had been born prematurely and subsequently taken to neonatal units.
There were also some women who were not given the opportunity for skin to skin and who didn’t report any medical reason to account for this.

3. **Reflections on the birth**: More than half of women (60%) described their birth as a positive (24%) or very positive (36%) experience, with 22% indicating their birth was a negative (11%) or a very negative (11%) experience.
Most women (60%) reported having an extremely positive experience of birth. They used words like ‘safe’, ‘calm’, ‘empowering’, and many praised the health care professionals who had been with them for labour and birth.
Women frequently mentioned feeling ‘in control’ as a key aspect of their positive birth experience.

Building a trusting relationship with a midwife (continuity of carer) was key to many positive birth experiences. This reinforces the need for continuity models of service to be developed right across Northern Ireland.
Some women had challenging birth experiences, but wanted to make it clear that this was not because of anything done by HSC staff.
Others reported a mixed experience, with both positive and challenging elements.
A significant number of women had negative or challenging experiences, and many of these described the birth as traumatic.

4. **Birth Trauma:** A third of women (33%) described their birth as being traumatic, with 60% saying it was not traumatic and the majority of the remaining 7% saying that while their birth was distressing, they did not feel they could describe it as traumatic. The stories women shared in response to this question were distressing and worrying.
   Fear: For some women, this was because of the experience itself, including pain, exhaustion, and fear. Others reported that they felt that their life or their baby's life was at risk during the birth, and this fear has stayed with them.
   Lack of compassion/poor communication: For others, the trauma related either to a lack of compassion or poor communication from health care professionals, particularly in emergency situations.
   Sense of control: A common theme underlying birth trauma was women's feelings of not being in control of what was happening.
   Partner trauma: Many women reported that their partner also found the experience traumatic.

5. **Bounty visits:** Bounty UK is a promotions company. Their staff visit maternity units across Northern Ireland, offering free product samples and a photography service, as well as a range of leaflets. They also harvest women's data for commercial use. Nearly three quarters of women in our survey had a visit from a Bounty representative after their birth.
   Of those who expressed an opinion, 54% found the visits unwelcome, while 46% welcomed them. Most women who were positive mentioned the opportunity to have photographs taken. However women who did *not* want to see the Bounty rep had a range of concerns including loss of privacy, intrusiveness, commercial pressure, and inappropriate behaviour.

6. **Postnatal maternity care:** Most women were happy (24%) or very happy (55%) with the support they received from community midwives and health visitors after their baby was born.
   Many women reported having very positive experiences with their community midwives in terms of support with physical care, breastfeeding support, and awareness around mental health.
   14% of women had a mixed or neutral experience, while 7% rated their experience as negative (5%) or very negative (2%).
   One of the prominent themes was a lack of continuity of carer.
   Some women described feeling as though the midwives were not interested in them if their babies were still in hospital. Some women felt that health issues were missed by the postnatal team, including mental health concerns.

7. **Feeding:** 46% of women in our survey breastfed, while an additional 24% mixed fed (breastmilk and formula). 27% of women used only formula, while the 2% 'other' responses included orogastric tube feeding, donor milk, and specialist formula.
   61% of women reported they got the support and information they needed to feed their baby. 21% reported "somewhat" and 17% reported that they received inadequate information and support with feeding.
   In terms of healthcare professionals, the women in our survey had support from midwives, health visitors, and breastfeeding specialists.
   Breastfeeding support: Women were generally positive about hospital-based breastfeeding specialists. Women also reported they were supported by other women who had breastfed – either via trust peer support schemes, Sure Start, or online groups. The Breastfeeding in Northern Ireland facebook group was highlighted by a number of women.
   Challenges: A number of themes came through in the survey about challenges relating to feeding support: general lack of support; a lack of consistency in the advice provided by HPCs; feeding options not discussed for those who were facing difficulties; midwives not having enough time to be able to provide adequate support; mums who had fed before feeling unsupported; HPCs' lack of breastfeeding knowledge, and issues around consent.
   Neonatal units/children's wards: Women whose babies were in neonatal units faced particular challenges, as did mothers whose babies were admitted to children's wards.
   Compassion: Some of the care women described was clearly lacking in warmth, empathy, and compassion
   Lack of knowledge /support among health care professionals: Despite having the highest coverage of the Baby Friendly Initiative in the UK, Northern Ireland still has the lowest rates of breastfeeding. This indicates that much more needs to be done, in addition to the Baby Friendly award, in order to ensure that health care professionals are able to support and inform women about the best evidence.
   Feedback from formula feeding women: a number of women who chose to formula feed reported they were not supported enough.

Recommendations

Throughout the survey, we made recommendations for maternity services in Northern Ireland, based on what women told us. While recognising that there are finite resources including particular workforce challenges, it is vital that maternity care provision reflects the evidence base as a means through which the health and wellbeing of future generations can be enhanced.

RECOMMENDATION 1: The Northern Health and Social Care Trust should prioritise the development of three MLUs - alongside units in both Causeway and Antrim, as well as a freestanding unit elsewhere within the Trust.

RECOMMENDATION 2: Birth Choices clinics / VBAC clinics / breech clinics should be available in all Trust areas. Individualised care plans should always be developed with women who are deemed to be outside guidelines.

RECOMMENDATION 3: Regional guidance should be developed to standardise approaches to discussing place of birth with women. This should build on the RQIA guidelines for admission to midwife-led unit, and the RQIA guidance for women planning birth at home. An individual evidenced-based care plan for planning place of birth should be developed in partnership with any woman experiencing a complex pregnancy.

RECOMMENDATION 4: The NI Department of Health should commission a review of maternity services in Northern Ireland, and commission a new maternity strategy. This should explore models that support continuity of carer across antenatal, birth, and postnatal services for women. In advance of this, HSC Trusts should begin to explore, develop, and strengthen continuity/caseload models within existing maternity services.

RECOMMENDATION 5: Regional guidelines should be developed for breech birth, including vaginal breech. Trusts should ensure that women are informed of vaginal breech birth as an option, and training should be provided to 'reteach the breech' where needed.

RECOMMENDATION 6: Training on consent and human rights in childbirth should be provided to all maternity health care staff.

RECOMMENDATION 7: Training and or/guidance should be provided for all maternity care staff to ensure adherence to NICE guidance on sweeps.
Trusts should review practice on induction of labour and ensure that women are not offered induction before 40-41 weeks unless there are clear, documented clinical reasons.
Trusts should review practice regarding women's experiences of induction of labour to ensure that women can give fully informed consent, and are respected and supported to feel safe throughout.

RECOMMENDATION 8: All Obstetric Units should review the birth environment, particularly in delivery suite and theatres, with a view to making this more supportive of women's emotional and physiological needs.
Obstetric units should ensure there are enough telemetry monitors to meet the level of evidence-based need.
Regional guidelines are needed on best practice in facilitating gentle caesarean sections.

RECOMMENDATION 9: Trusts should monitor, review, and reduce the number of women birthing on their backs. Intermittent monitoring and telemetry rather than CTG should be used whenever possible.

RECOMMENDATION 10: Trusts should continue to monitor, evaluate, and review the various elements of the care bundle aimed at preventing tears, in order to ensure that the more invasive elements (hands-on, episiotomy) are only used when absolutely needed, while other elements including warm compresses and good communication with women to ensure slower crowning should be offered to all women unless there are clear, documented reasons not to.

RECOMMENDATION 11: There should be regional guidance on optimal cord clamping, with the majority of cords being left to turn white before being clamped and cut, and as a minimum, NICE recommendations being followed.

RECOMMENDATION 12: HSC Trusts should offer training for staff on the importance of minimising birth trauma, including highlighting communication, locus of control, and compassion.
Midwives should ask women postnatally how they are feeling about their birth, and signpost them to appropriate services if there is the possibility of birth trauma.
All HSC Trusts should provide appropriate services for women and partners/birth partners who have experienced birth trauma.
In emergency situations, a designated person should lead on communication and support for the woman and her partner/birth partners.

RECOMMENDATION 13: We recommend that all Trusts consider ending Bounty contracts. If appropriate, alternative arrangements should be made to facilitate professional photography without commercial pressure and away from the women's bedside.

RECOMMENDATION 14: **Beyond BFI:** In line with Unicef requirements each Trust should monitor adherence to BFI standards through an ongoing rolling audit programme. Maternity units should also seek to implement the BFI Achieving Sustainability Standards. In addition PHA and the Breastfeeding Strategy Implementation Steering Group should consider what further actions are needed to ensure health care professionals provide compassionate, appropriate, evidence-based breastfeeding support.
Trusts should review breastfeeding support provision and seek to increase access to support from maternity support workers or equivalent to help women establish breastfeeding and provide practical support with positioning and attachment in the postnatal wards.
Women who need further support should be referred to a breastfeeding specialist.
All parents who formula feed should be provided with information and support on how to safely make up feeds and encouraged to formula feed in a responsive way in line with BFI standards and as detailed in *First Steps Nutrition Trust* guidance.