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

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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.