# Breech Specialist Midwives in the OptiBreech Trial feasibility study: an implementation process evaluation

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**Abstract**

Objective: Refine the programme theory for OptiBreech Care Design: Concurrent mixed methods implementation process evaluation Setting: 6 NHS hospitals in England participating in the OptiBreech 1 Feasibility Study Sample: 15 women planning a vaginal breech birth at term and 6 breech lead midwives Methods: Outcomes were recorded on case report forms and descriptively analysed. Interviews were recorded, transcribed and analysed using the Theoretical Framework of Acceptability. Iterative analysis informed subsequent interviews and the on-going process of implementation across sites. Main Outcome Measures: Acceptability of service delivery models and their outcomes. Results: Actively recruiting Trusts implemented services through a dedicated clinic and/or a proficient intrapartum support service, organised and provided primarily by a Breech Specialist Midwife. While we identified challenges, this model has achieved 93% fidelity to the intervention's goal of ensuring attendance of OptiBreech-trained professionals at vaginal breech births, and it is highly acceptable to women. Our initial suggested model of a multi-disciplinary team composed of 5 obstetricians and 5 midwives does not appear feasible, due to very low overall current breech experience levels and the context of current pressures on NHS services. Conclusions: Appointment of a Breech Specialist Midwife, whose role is to co-ordinate a dedicated clinic, training and a proficient intrapartum care team, appears to be highly acceptable to women. This model appears to be a feasible implementation strategy, in order to test the safety and effectiveness of OptiBreech Care in a clinical trial, but further work needs to be done to develop sustainability.

## Introduction

'Physiological breech birth' is an approach to facilitating vaginal breech birth (VBB) centred on the optimisation and restoration of normal physiological processes to achieve a safe outcome. This includes upright maternal birth positions, such as kneeling, which promote active maternal movement and efficiency during expulsion. Interventions are performed in response to specific clinical indications, based on evidence of what is considered 'normal' breech birth physiology. These are summarised in the Physiological Breech Birth Algorithm. The use of upright positions for VBBs has been associated with a significantly reduced need for manoeuvres, neonatal and maternal birth injuries, lengths of second stage and intrapartum caesarean sections (CS) when compared with routine supine positioning in observational studies. However, neither upright maternal positioning nor the physiological breech birth approach have been tested in a randomised clinical trial.

Before a trial can be conducted, the ability to reliably deliver the intervention needs to be established. This depends on the capacity to ensure, to a reasonable standard, attendance at breech births by professionals who have, at a minimum, completed an enhanced training package in these methods, and ideally, who have achieved proficiency, as defined by previous research. The OptiBreech 1 study was designed to evaluate

whether teams are able to implement a service in which they reasonably ensure proficient professionals attend VBBs (intervention feasibility) and provide consistent care (fidelity), in a way that is acceptable to woman and staff (acceptability), while maintaining low neonatal admission rates (safety), and whether women are willing to participate in such a study (trial feasibility). We wanted to understand why or why not by speaking with care recipients and providers. A detailed implementation process evaluation alongside a feasibility study will increase the chances of a successful substantive trial and potentially quicken the public health impact of the intervention if it is effective. The purpose of a process evaluation to inform trials of complex interventions is to understand the effects of implementing a new intervention and the mechanisms of these effects in new contexts.

OptiBreech 1 is a qualitative and observational study, following women who request to plan a VBB at term under current Trust guidelines. This report focuses on analysis of data concerning the *models of service delivery* , to refine the programme theory for the trial.

## Methods

We used a concurrent mixed methods design to evaluate implementation of proficient breech team care in these settings. Quantitative data was used to identify what was working and in which contexts. Qualitative data was used to understand how, why and for whom it was working, and to identify challenges to effective implementation. We integrated these insights to refine the programme theory around service delivery in our complex intervention, OptiBreech Care.

*Quantitative data and analysis*

Quantitative data included recruitment figures, demographic data, fidelity criteria and neonatal admissions. Fidelity criteria for this portion of the study included: attendance of someone who completed the OptiBreech training package; attendance of someone who met the full proficiency criteria; whether or not maternal movement and effort were used as a first intervention before hands-on assistance; whether or not the birth was complete within five minutes of the birth of the fetal pelvis; and maternal birthing position. To achieve full proficiency, as defined in this trial, the professional needed to have completed the training package; attended at least 10 births including complications; attended 3 births within the past year; and contribute to teaching and reflective reviews of births attended. This is assessed by the breech leads, one of whom was also the Principal Investigator (PI) at each local site. All quantitative data was obtained from individual Case Report Forms completed by local investigators and analysed descriptively.

*Qualitative data and analysis*

Qualitative data included semi-structured interviews, lasting 36 minutes average (range 15-51). Care recipient- and provider-specific interview guides were drafted, based on the Theoretical Framework of Acceptability (TFA). Interviews were conducted via Microsoft Teams by a non-clinical member of the research team experienced in qualitative research (TD) and transcribed. A maximum variation purposeful sampling strategy was used to explore the acceptability of the intervention for different stakeholders across settings. Participants included 15 women across 4 sites (A,B,C,D). Their experience included 7 VBBs, 1 forceps breech birth (FBB), 6 CS in labour (EMCS), 1 CS prior to labour (ELCS). Three cases involved difficulties with communication or births where the attendants did not meet the full proficiency criteria. Two women chose to give birth at home or in a midwife led unit. One woman was the first recruit at a slowly recruiting site. We additionally interviewed 6 breech lead midwives, who were also PIs, across 6 sites (A,B,C,E,F,G).

Anonymised transcripts were initially coded with reference to the TFA component constructs, using NVivo 12 qualitative data analysis software. Recurrent themes and patterns were compared across interviews. Lay members of the team were provided with a sample of anonymised transcripts and supported to provide narrative feedback on the themes they identified with and comment on those identified by other members of the research team. Matrix and cross tabulation features within NVivo were used to compare results across demographic categories and to observe how recurrent themes interacted with the TFA component constructs. Analytic memo-writing, reflective meetings among the research team and open meetings with stakeholders

to discuss emerging results were used to refine these results.

When the centrality of the breech lead midwife's role in each setting became apparent, we also performed a thorough content analysis to identify the roles the midwives described themselves doing. We refined our topic guide to include exploration of the role of the breech lead midwife, as understood by our participants.

*Programme Theory and Logic Model*

Clinical trials of complex interventions should articulate a programme theory for how the complex intervention works, which can be summarised in a logic model (Figure 1: The OptiBreech Care Logic Model). Refining the programme theory is an important component of feasibility work.

Our original logic model included 'funding for team training' as one of the key OptiBreech inputs. As our feasibility testing progressed, it was evident that this was not working as intended. The OptiBreech 1 protocol recommended that an initial team of 10, including 5 obstetricians and 5 midwives, complete the in-person physiological breech birth training programme, and funding was set aside to back-fill staff time to attend. However, the need for social distancing precautions during the COVID-19 pandemic and the effects on staffing levels created a context in which this was impossible for all but two sites to achieve. To adapt to the new contextual constraints, the training package was put online. To supplement this, local hands-on training was organised by at each site through mandatory training and ad hoc activities, primarily led by the breech lead midwives.

Rather than dictate how sites should achieve the proficient team attendance criteria, given the significant uncertainties in the current clinical and research context, we elected instead to observe our participant sites' own strategies, how these varied across sites, and how they related to our key outcomes. We then used these observations to refine our programme theory.

*Stakeholder engagement*

The OptiBreech Trial research team have facilitated involvement of multiple stakeholders from the start of the project (https://optibreech.uk/category/ppi/). The project grew out of a body of evidence indicating that women who wished to plan a VBB do not always feel that services meet their needs. There was a need to identify a more effective model of service delivery, in collaboration with service users. Due to concerns about low recruitment in previous breech trials, it was a priority that our method of testing be acceptable to women currently using maternity services and the staff that provide them. Additionally, while they valued accurate effectiveness and safety data, users favoured the development of a model of care that reliably supports informed decision-making and the autonomy of the birthing person, rather than a model that promoted either CS, VBB or external cephalic version (ECV) as the 'best' option. Stakeholder engagement in analysis and interpretation was facilitated through regular online meetings with the study Patient and Public Involvement group. These were advertised by email to participants, the OptiBreech website and blog, and relevant social media channels.

## Results

*Implementation strategy, recruitment rates and fidelity*

Between February 2021 and December 2021, 54 women requested to plan a vaginal breech birth across 10 sites. Recruitment rates varied significantly between sites, ranging from 1 – 20 women, and study set-up times were heavily impacted COVID-19 pressures (Table 1: OptiBreech Recruitment 2021). The three highest recruiting sites (A,B,C) each had a breech lead midwife who was formally enabled to lead the service as part of her role and enabled to work flexibly to attend the majority of breech births that occurred in these settings. Two of these had a dedicated specialist clinic (A,C), and the third (B) attracted a high number of externally booked women who self-referred for breech specialist care, including from site F.

Three additional sites had midwives informally functioning as specialists (D,E,G). These midwives were enabled to work flexibly to support breech births and counsel women referred to them, but it was not formally part of their job description. Sites C & G were the only sites to clearly identify a multi-disciplinary

team as originally suggested, but in practice, all of the births were attended by the breech lead midwife or another midwife in the OptiBreech team. Only one of the midwives reported receiving on-call payments for planned breech births, but all were paid bank hours for time spent at breech births, which also provided clinical negligence insurance cover.

In three of the four sites that only recruited 1 participant, none of these features were operational; the breech lead midwife was on-call for the birth at the fourth. At one site, management actively prohibited the breech lead midwife and obstetrician from attending breech births outside of their regularly scheduled hours.

The breech lead midwives described themselves as fulfilling a number of roles that reflect their operation as specialists within the service, including counselling and clinic co-ordination, communicating plans, attending breech births, supporting less experienced team members, providing training, and leading service development. Interviews with the women indicated that these roles were understood by the recipients of the service, who referred to them as 'specialists' or 'consultants.'

Mode of birth, fidelity and basic feasibility safety outcomes are reported in Table 2: OptiBreech 2021 Fidelity and Safety Outcomes. We originally aimed to ensure >90% of births were attended by someone who fulfilled proficiency criteria, but this was an unrealistic short-term goal given low levels of baseline experience in most centres. Following early discussion with sites, this was modified to >90% of births attended by someone who had completed the OptiBreech training, and this was achieved. Due to the unpredictability of spontaneous labour, some births were attended by on-call obstetric staff. Both neonatal admissions occurred following births where someone meeting the full proficiency criteria was present, so were not attributable to failure to provide proficient attendants.

*Interviews with women*

Analysis of our interviews with women revealed three pivotal needs for breech care in late pregnancy. Meeting these needs made care acceptable to women and led to higher recruitment rates. These were: balanced information, access to skilled breech birth care, and shared responsibility. We have included exemplary quotes in a supplementary table, available online (Supplementary Table: Exemplary Quotes).

At the beginning of their breech care, women needed 'balanced information.' Clear, unbiased counselling about their options enabled them to make informed decisions, which in turn gave them a sense of self-efficacy and control over the situation. They valued being fully informed about both potential risks and potential benefits of VBB. Women consistently described the information they received from specialists as balanced, detailed and delivered in ways that met their needs.

This contrasted with the way they described counselling from other professionals, which they often experienced as biased. Having a caesarean section was presented as a completely safe option with no risks, which they knew not to be true. This conflicted with their values, undermined their trust in their care team and sometimes created conflict between women and their partners. They also described attempting to access information about their options online as difficult, time consuming and laborious, with little information available about VBB, even on NHS and Trust websites. This led women to express ethical concerns that counselling and publicly available information did not always reflect the fact that they had a choice about how to give birth to their baby.

In sites with routine referral to a breech specialist clinic and/or midwives, women experienced less conflicting information. Women particularly valued the breech midwives' ability to describe complications and their resolution. They interpreted this as a reflection of the midwives' skill and experience, which they perceived could contribute to their and their baby's safety. Detailed counselling instilled confidence not only in the midwife but also in themselves. However, though women all reported receiving information about potential risks, some reported feeling doubt that the risk could apply to them.

'Access to skilled breech birth care' also affected women's ability to plan a VBB when they wanted to. They understood the importance of skill and experience in making VBB as safe as possible and therefore perceived that this was only a reasonable option if skilled professionals were available. Participants found

it convenient to access care when referred during their routine care. They expressed reassurance that there was a good chance the breech specialist midwife would be at the birth, and that a plan would be in place if not. Women who were referred to dedicated clinics valued the input of consultant obstetricians who also appeared knowledgeable and confident about VBB.

On the other hand, for some women, trust and confidence in specialist breech care was centred solely around the breech specialist midwife. In one instance, when the woman was not reassured that the specialist could attend her birth, she chose to change her plan to an ELCS instead. The focus on the breech specialist midwife rather than a team was especially apparent when women felt that not all staff appeared to be both aware of the service and/or supportive of its purpose. There was evidence that even within units with a specialist clinic and formal role in place, the service was not fully embedded.

Some women who had no access to skilled breech care locally transferred their care to an OptiBreech hospital; some even moved their place of residence. Accessing specialist care was sometimes associated with opportunity costs such as time off work, financial costs, travelling long distances to the hospital, additional trips and a lack of antenatal continuity they would have received in local care. However, many were happy to make the increased effort because they had chosen to plan a VBB, and they could not access skilled care in hospitals close to their home. Women expressed concern that the situation raised equity of access issues, and perhaps other women who lacked similar resources would not be able to give birth the way they wanted.

Finally, women who planned a VBB benefitted from 'shared responsibility' with their care team. Prior to accessing supportive care, women often felt a significant emotional burden. They felt alone to bear the responsibility of any potential adverse events. They also reported that other people in their lives, including professionals, family and friends, expressed judgement of their birth choices and suggested that they were perhaps being irresponsible. This led to feelings of guilt and selfishness.

For many, transferring care to the OptiBreech team meant developing a relationship with an experienced breech midwife who supported the women's choices, which lightened this emotional burden. Women perceived the specialist midwives as taking responsibility for cultivating a safe-as-possible service, including accurate counselling about complications, spending time on-call to attend births and training other members of the team. Some women focused on the breech specialist midwife in contrast to other members of the team, in whom they did not have confidence. But others perceived that provision of a specialist service reflected a shared commitment to skill development within the wider team, which they were prepared to trust, while they understood that not all members of the team had the same level of experience.

## Discussion

*Main Findings*

In contexts where women are frequently choosing to plan a vaginal breech birth within the OptiBreech 1 study, breech specialist midwives have been the main mechanism of both service delivery and maternity team skill development. This model of service delivery appears to be highly acceptable to women, especially when obstetric colleagues are involved and supportive. Appointment of a breech specialist midwife appears to be an effective implementation strategy that will enable physiological breech-proficient care to be tested in the OptiBreech Care Trial. However, further work is needed to identify the most effective way of embedding this model of care within current multi-disciplinary team functions.

*Strengths*

Our description of our intervention has changed substantially through our feasibility work. Refining our programme theory and intervention in this way acknowledges the complexity in health services research and the need to adapt to emerging circumstances. Observing and collaborating with stakeholders, rather than dictating a researcher-led strategy, resulted in an adaptive model of service delivery and may result in a more successful trial with more reliable recruitment. The level of involvement of the OptiBreech PPI group and lay members of our research team has been significant and meaningful. Women's descriptions in this study are consistent across multiple services and despite varying outcomes.

*Limitations*

Our finding that a model in which a specialist clinic and team are led by a breech specialist midwife is the only one that appears feasible to test in a trial at this time does not mean other models are ineffective. Our findings are heavily influenced by context, including the continuing impacts of the COVID-19 pandemic on staffing levels within the NHS, and low overall breech experience levels in these settings after decades of erosion. We therefore consider this our transparent record of what is working in these contexts at this time, to explain the way we have defined our intervention. Other models have been reported in other contexts.

We have focused on interviews with women in this analysis. Further work is needed to describe the roles of breech specialist midwives and evaluate acceptability of the role among the wider MDT team.

The Chief Investigator (SW) in this study fulfils multiple roles, including service leadership and delivery in one of the sites. This may introduce bias. To balance this, a non-clinical member of the team conducted and independently analysed all interviews (TD). The findings were subject to member checking with participants and lay research team member feedback (SH, SR).

*Interpretation*

Although the operationalisation of a breech specialist midwife in these settings led to increased numbers of vaginal breech births, this does not appear to be a result of 'normality-centred care' or encouraging vaginal birth 'at all costs.' Our findings suggest that where women are given clear and balanced information about risks and benefits, more women feel able to express their preference to plan a vaginal breech birth. This is consistent with previous research and the ethical principles of informed choice about medical interventions.

While the care model delivered by breech specialist midwives in these services is highly acceptable and successfully achieving fidelity targets, more time will be required for the service to embed and for all members of the MDT to be exposed to the fundamental principles of the intervention. Meanwhile, the burdens of time and responsibility on these midwives is significant, and the service may be vulnerable when they are not available. The model depends on the ability of the specialists to protect their time and work flexibly to cover the service, which will require funding to be sustainable and may explain its lack of prevalence throughout other settings. On-going implementation evaluation work should focus on determining how to manage women's expectations with a new service, the best way to develop additional team members to the level of proficiency, how long it takes for the entire MDT to be exposed to the training, and what level of funding would be required if it were to become standard practice. Safety should be evaluated in a clinical trial.

## Conclusion

Implementation of physiological breech birth-proficient care within these settings so far has been achieved through the enablement of a breech specialist midwife, who leads on service and skill development. A model of care in which breech services are delivered in dedicated clinics and flexible intrapartum care teams by specialist midwives, working in collaboration with obstetric colleagues, is the only model of service delivery that appears feasible to test in a trial at this time. Testing OptiBreech Care in a substantive trial will require additional sites to achieve a similarly adequate level of implementation and recruitment in a relatively short period of time. Therefore, we have refined our intervention in the OptiBreech Care pilot trial to reflect this, to maximise the chances of an efficient and successful trial.

*Disclosure of Interests*

SW is a co-Director of Breech Birth Network, a Community Interest Company, that provides breech training and donated the on-line training package used in the study. SW receives speaking fees and expenses for her activities.

*Contribution to Authorship*

SW, JS and AS designed the study and supervised the data analysis. TD collected and analysed the data

and drafted the first summary of results. SH and SD contributed to analysis and interpretation. SD reviewed qualitative and quantitative analyses. SW finalised the manuscript and all authors approved it.

*Details of Ethics Approvals*

This study was reviewed and approved by the East of England – Cambridgeshire and Hertfordshire Research Ethics Committee (20/EE/0287, IRAS 268668).

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**Previous presentation**

These results have previously been shared in the GOLD Midwifery 2022 online conference.

**Figures 1: OptiBreech Care Logic Model**

**Hosted file**

`image1.emf` available at https://authorea.com/users/740693/articles/713435-breech-specialist-midwives-in-the-optibreech-trial-feasibility-study-an-implementation-process-evaluation

**Table 1:** OptiBreech 1 Recruitment, 2021

| Site | Opening month | Total re-cruits | Antenatal care | Antenatal care | Intrapartum care | Intrapartum care | Notes | Notes |
|---|---|---|---|---|---|---|---|---|
| A | April | 20 | dedicated special-ist clinic | dedicated special-ist clinic | specialist midwife (formal) | specialist midwife (formal) | two hospitals | two hospital |
| B | January | 14 | | | specialist midwife (formal) | specialist midwife (formal) | external referrals | externa referrals |
| C | April | 5 | dedicated special-ist clinic / MDT team training | dedicated special-ist clinic / MDT team training | specialist midwife (formal) | specialist midwife (formal) | | |
| D | March | 3 | | | specialist midwife (informal) | specialist midwife (informal) | | |
| E | June | 4 | | | specialist midwife (informal) | specialist midwife (informal) | | |
| F | August | 1 | None of the above features. | None of the above features. | None of the above features. | None of the above features. | multiple trans-fers to Site B | multipl trans-fers to Site B |

| Site | Opening month | Total re-cruits | Antenatal care | Antenatal care | Intrapartum care | Intrapartum care | Notes | Notes |
|---|---|---|---|---|---|---|---|---|
| G | July | 4 | MDT team training | MDT team training | specialist midwife (informal) | specialist midwife (informal) | | |
| 3 more sites | April – July | 1 each | None of the above features. | None of the above features. | None of the above features. | None of the above features. | None of the above features. | None of the above features |
| **Referred by:** | **Referred by:** | **Referred by:** | **Referred by:** | Midwife 28 (52%) | Midwife 28 (52%) | Obstetrician 15 (28%) | Obstetrician 15 (28%) | Self 11 (20%)* *original booked elsewhe* |

**Table 2: OptiBreech Fidelity and Safety Outcomes, 2021 recruitment**

| All planned vaginal breech births | **n = 54** |
|---|---|
| **Parity** | |
| nulliparous | 29 (54%) |
| multiparous | 25 (46%) |
| **Diagnosed prior to labour?** | |
| yes | 47 (87%) |
| no | 7 (13%) |
| **Mode of birth** | |
| vaginal breech birth | 28 (52%) |
| forceps breech birth | 2 (4%) |
| cephalic birth | 1 (2%) |
| any vaginal birth | 31 (57%) |
| CS in labour | 13 (24%) |
| CS prior to labour | 10 (19%) |
| **Safety** – *basic measures at feasibility stage, intention to treat* | |
| admission to neonatal unit (at birth) | 2 (4%) |
| neonatal death (within 28 days) | 0 |
| Actual vaginal breech births | n = 30 |
| **Fidelity** | |
| someone present throughout 2$^{nd}$ stage who completed OptiBreech training | 28 (93%) |
| someone present throughout 2$^{nd}$ stage who met all proficiency criteria | 23 (77%) |
| use of maternal movement and effort ('wiggle and push') prior to hands-on intervention | not necessary 4 (13%) yes 22 (74%) no 4 (13%) |
| < 5 minutes between birth of pelvis and birth complete (head) | yes 27 (90%) |
| **Maternal birth position** | |
| upright | 23 (77%) |
| supine | 7 (23%) |
| **Safety** – *basic measures at feasibility stage* | |

| All planned vaginal breech births | **n = 54** |
|---|---|
| admission to neonatal unit (at birth) | 2 (7%) |
| neonatal death (within 28 days) | 0 |



## References

### Supplementary Table: Exemplary Quotes

Below, we identify quotes using each woman's unique identifier, a code for her site and her ultimate mode of birth, to provide a sense of how these views were distributed.

### Balanced Information

1. *[The breech specialist midwife] supported me to make an informed choice. Nothing was sort of pushed on me. She gave me all the information and I was then able to make that decision knowing what I knew. And I was really clear with her that I wanted to know the potential risk . . . and she didn't sugar coat anything. She told me exactly what those potential risks could have been, but then also what the benefits could have been as well. (W100-B-VBB)*
2. *Like from the beginning of meeting [the breech specialist midwife], she knew her stuff, it just felt like, Ok, I actually trust this person even more so than I did the consultants who were going OK, maybe we should give you this. Maybe you should just go for a C-section. And I remember talking with my partner and I remember saying to him like, this woman Niamh, she's gonna, she's telling me everything straight as it is. She's not going, You should go this way or this way. (W101-B-VBB)*
3. *And then after the ECV, [the breech specialist midwife] then also, like, answered all my husband's questions and like gave him all the information. So I think we were, like, really, really supported in the information that we that we needed to kind of make an informed decision about what we were doing, as opposed to just being kind of like scared into a scheduled Caesarean. (W103-A-VBB)*
4. *You know, [booking hospital] were pushing so hard for me to do the ECV and to have the baby in the labour ward. And it just didn't flow, so my doula, she passed me the details of [the breech specialist midwife]. And we had a chat and she was the best thing that happened. Oh my gosh. I was like finally a person that talks my language and understands exactly what I want to do. And she really supported me so I transferred. (W104-B-EMCS)*
5. *So [the breech specialist midwife] actually was very supportive. And she wasn't like, oh pro natural birth. No, she would just literally provided me all options to choose from and gave me a wide information like where, which is available online, that I can look at myself. She answered all my questions. What can be the problems. These statistics for nationwide, the statistics towards like how they appeal to me. So, to be honest, it was a very, very nice, and I felt very informed. (W105-A-EMCS)*
6. *[In the breech clinic,] I never felt like I was being pushed to do anything. I think it was – their aim was to support me to make the decision that's best for me and my baby. And to be informed in that. And I think they did that really well . . . Knowledgeable practitioners. Definitely. Them taking into account your views and your opinions, as well as keeping kind of safety as the priority. And just time. I never felt rushed. I never, ever felt rushed to make a decision, to get out of the appointment, to – none of those things. I was always given enough time to ask my seven million questions and to fully understand what was being, you know, what was being said before we then made any decisions. So time's massively important. (W106, C, EMCS)*
7. *So the midwife said to me, You just let me know what you want to do, if you want to go for vaginal, we'll support you, if you want to have a C section, then we'll support that as well. So we decided to go for a vaginal delivery and – but if I ever got to 41 weeks, because of the risks associated with that, I wanted to have a C-section if I got to 41 weeks. So, I think I must have called [the breech specialist midwife] the next day or emailed her and said that's what we want to do. So she said, OK, that's great, we'll get you booked-in for your pre-op care in preparation for the C-section if it comes to that. (W107-D-EMCS)*

8. *Yeah, they gave me the first the option to do this procedure [ECV], I don't remember the name, too, but I read about it, and I wasn't convinced. I didn't like it was too aggressive for the baby. And I said, no. I want to try other things. I was trying in the hospital I received this thing that you burned [moxibustion], I don't remember the name and I tried with some position, but anything that I tried, the baby is still in breech. So one day I went to the doctor. The doctor told me about the C Section. I said that I didn't want it, and she told me that the breech birth was very risky and she wanted to talk to me again because she tried to convince me that C section was better. (W110-A-FBB)*
9. *So I wanted as natural a birth as possible, I didn't really want many pain killers. Ideally, it would have been in the birthing unit. Maybe in the pool or something, I just wanted to do as much as I could myself. And then when I found out that baby was breech. So there was one scan that we went to . . . It was maybe 35 weeks, and the sonographer said, Oh, the chances are you'll have to have a caesarean, and I don't really, it kind of stuck in my head, but I was a bit like other people have said I might be able to have a natural birth. So, you know, I was told different things. And then I still planned to have a natural birth if I could, but I didn't know if that would be an option. (W111-C-VBB)*
10. *Yeah, they, Janet, the breech specialist midwife, you know, that was always nice, you know. They explain slowly what was going on, you know, they said – no, no, they clearly explain what is what. So we can't complain for that, you know, so we know what's that. We come back home . . . we saw the film [about ECV and breech birth], like a – from A to Z, so we know what's what. (W113-A-ELCS)*
11. *He was very much steering towards having a caesarean, and it almost felt like he just wanted to do it because it would be the easy option, and it will be done straight away. And he said, If you have a caesarean now, you'll be home tomorrow there'll be no problems . . . So I just said I can have a little while to think about it and talk about the risks and the benefits, and he basically said, Well, I'll be taking you down within the hour to have your caesarean and here's the form. Can you sign it when you're ready? And it was as if I was given no option. (W111-C-VBB)*
12. *And after he performed that very painful ECV, he like, it wasn't an opinion, it was like a very strong advice that it will be easier and better for me and for the baby to have C-section which actually caused me and my partner having a bit of confrontation. (W105-A-EMCS)*
13. *I mean, so I always knew it was an option. I'm trained as a midwife and doula as well. So I know people that have had breech births, but I also had never seen a breech birth myself and knew that there weren't many care providers that would kind of be happy to support a breech birth. So it was really only – I mean we were really feeling about 36 or 37 weeks that we didn't really have any options, just because all of – the local hospital was really like, we can offer you an ECV, if it doesn't work, then C-section. Yeah it kind of felt very non-negotiable. (W112-C-VBB)*
14. *There was one thing that made me quite upset, it was in one of these scans. The person was doing this scan actually – In fact, I hadn't had the scan yet, the baby had been breeched previously in the previous scan and I was going to a new one. And I was going through the door and I said hello, and she said, Hello, so we are going to have a C section then? And then made me quite upset in the first place because she was inferring that, supposing that my baby would still be breeched, what could be or not, she didn't know about that. We just would know after the scan. And secondly, I didn't like the tone of obligation that she gave to me that, Okay, if it's breeched to have you need to have a C section. I wanted to have more choices and I wanted to choose, I didn't want someone else to choose for me, I wanted to make my own decisions there, so that was a point that I felt quite upset about it. But I had a conversation [with a consultant midwife] about the birthing choices, and then it went much better after that. (W114-A-EMCS)*
15. *And it was a bit of a battle for me to actually get any information around the statistics and the information around it. So I really had to kind of ask for the lead obstetrician there to come in and actually talk to me and be like, what are the pros and cons of doing an ECV? (W108-B-VBB)*
16. *Okay, so it was actually not their first choice when I was admitted to hospital. I'd been in there for about an hour, and the doctor came up to me and said, We're going to take you down for a caesarean because your baby's breech. So it wasn't even as soon as I went into hospital, it wasn't mentioned that I could have a natural birth at all. It was straight away, No your baby's breech, you're having a*

*caesarean. Because he was early anyway, it was all a bit of a shock. (W111-C-VBB)*

17. *I think for me it was, I think the NHS needs to have, like, when, like, a lot of the time I refer to the NHS websites for everything. And I think maybe having an article in there saying that it is possible for a plan breech birth, but you need to discuss this with your midwife and actually ask for it because then they can help you provide information. Because I don't think, as is right now on their like, website that they have anything about planned breech birth. You know, they just say usually you do get a C-section. And I think having just even one little sentence to say that it is actually possible, that would open the mind and it would get more people like thinking, Ok is this a possibility? And then, you know, having, being able to talk to a midwife that can then refer you. (W101-B-VBB)*
18. *As soon as I found out the baby was breech, immediately it became apparent that, you know, home birth wasn't an option, and then it was, Oh, you know, maybe birthing in a birthing centre wasn't kind of ideal. And then it was going straight onto like, well, caesarean. So it very quickly became what I didn't want . . . if you look at all the information leaflets they give you, they always give you the relative risk, they never give you the absolute risk. So if I say to you, like – I may have got this quite wrong, but like, Oh, breech birth at home triples your risk of infant mortality, you're going to want to vomit. You're going to panic. But if I tell you that the numbers are one in 1000 for cephalic births and two in 1000 for breech births, or whatever. You're like, Oh, well, actually, the sample size is 1000. Yes, you may be doubling it, but the absolute risk is still less than 0.01% or less than a percent. Right? So what I have noticed is the way you present information is so important because you're talking about risk. There's a variable factor there, people have different appetites for risk taking, right? (W108-B-VBB)*
19. *And I was like, oh my god, and we were trying to find information online but it is anecdotal evidence, there is nothing, you know – it's quite hard to find information about it and all you hear when you talk about breeched babies is C-sections. (W104-B-EMCS)*
20. *I'm trying to say . . . it was laborious. It was incredibly stressful. I was fortunate enough to be working from home. The company that I work for also, you know, no pressure was on me. So I was able to take maternity a few weeks earlier than I was intending to take it. And I had a lot of support and I had a doula, so I had someone dedicated there helping me find information. But I can see how other mums just maybe wouldn't know where to go. (W108-B-VBB)*
21. *[The breech specialist midwife] just talked me through what would happen in certain scenarios. Because I was really worried of, for example, the baby's head getting stuck, and she talked me through what she would do in that situation if it was going to happen. But the risk of it happening was very, very low. So it was – yeah, just the fact that she was so nice and caring and calm about it. And she seemed confident in her ability, so – and her experience. So that made me feel confident. (W107-D-EMCS)*
22. *I understood exactly how the birth should go, as a breech birth, that it kind of has to go to plan. And if it doesn't go to plan, then they start looking at a C-section quite, sort of, quicker than you perhaps would with a head down baby. And I completely understood that and I was, yeah, willing to give it a try, and try and get a natural birth if I could. (W102-B-EMCS)*
23. *She was very transparent about what she had and hadn't done. And she was very clear. And the rest of the team were very clear that they had done the kind of training days, like the OptiBreech physiological breech birth training day. But they haven't actually seen a breech birth themselves and so, yeah, definitely in the breech team there was a lot of confidence. (W112-C-VBB)*
24. *It's very annoying for me because it happens, exactly the very thing that they told me that it would happen, the entrapment of their head. And I said, I don't care the risks I think that is better. But I didn't know that it could happen to me, you know? (W110-A-FBB)*

Access to skilled breech birth care

1. *It was very convenient because I think Naimh was based at the hospital that I was already getting my care from. So yeah, it was a case of, Oh, we have a breech consultant, let me just refer you to her. And it wasn't like I had to sort of do loads of research in finding a doctor or a consultant that would do this. She was already there, so, which was lucky for me. (W101-B-VBB)*
2. *I have the appointment with the doctor the same day that [the breech specialist midwife] was in the*

*hospital and they referred me immediately. (W110-A-FBB)*

3. *I was referred [to the breech specialist midwife] straight after my ECV. (W100-B-VBB)*
4. *My home birth midwife that explained that a vaginal breech birth is only risky when you have practitioners that aren't experienced in breech delivery, and that's where the sort of the riskiness comes in. But if you have somebody who is experienced in breech delivery, then they are much less likely to be a difficult birth. And she let us know that the consultant midwife at [OptiBreech site] was a breech birth specialist and that if we decided to go down a vaginal breech, she would caseload us so that she would become our midwife for the birth no matter what. (W102, B, EMCS)*
5. *And obviously you don't want to have that journey in labour. But I was like, I prefer to have that because I think she really understands what is happening and what I want to do. And she's not scared. This is for me really important. Because I felt everyone in [booking hospital] was a little bit scared of the breeched baby. Because they didn't have the specialist that you need for delivering a breech. Which is fair enough, but I wanted to have that type of person that was chill and relaxed and knew what was going on. Because it's really going to have an impact on your birth experience ... Because for me it was so – well I'm not religious but I'm very spiritual. So I knew that giving birth was like an opportunity to get closer to God and to my body, it was quite special. So she allowed me to give birth or allowed me to try to give birth in the conditions I wanted with my husband. So yeah, that was wonderful. (W104-B-EMCS)*
6. *And I think I wouldn't have felt confident enough to do it because of the added risk. I think having a team of people who really felt like experts meant that I felt safe and confident to try for that. I don't think I would have done, as much. I would have wanted to still go for it, but I might have been less likely to. (W106, C, EMCS)*
7. *So [the breech specialist midwife] kind of was open to me having the birth wherever I wanted. I met with her, I met with an obstetrician at [OptiBreech Hospital], I made a booking appointment there. [The breech specialist midwife] spoke through all of my questions that I had, she also shared with me lots of their research studies, and then I was able to make my decision. So within this time, I also basically went through all of the Royal College of Gynaecology, all of their studies. So I actually read up on that myself. So I understood all of the stats and data around it. And essentially, my research led me to conclude that the experience of the midwife or the obstetrician is the only factor really in determining my safety, considering I'm a low risk mum as well. And that's why I went with [this midwife], because I was like, if that's the only factor really that's going to make a difference, then I'll go with the midwife or the obstetrician that I think's got the most experience to help deliver the baby where I want to, which is at home. (W108-B-VBB)*
8. *So later that day, I had the ECV, which was fine. I'm glad I tried it. But her – I think she was just breech for so long, her bum was, like, deeply sort of engaged into my pelvis. So there was just, like, no budging her. She was quite happy throughout the process, like she didn't really notice it, but yeah, there was just no moving her. And that was fine because I had already made my decision what I wanted to do. And at this point, I knew like, because I met [the team at the OptiBreech hospital], like I knew that they were really good for, like, breech and stuff. So I felt like I was in good hands. And I felt comfortable with pursuing a vaginal breech birth as well, because I think that's an important aspect, having like a skilled practitioner. (W109-A-VBB)*
9. *I mean, they completely made that a possible option because, yeah, it really felt like we were taking a bit of a risk by choosing to have a home breech birth with the team that didn't have the experience. So finding [the breech specialist midwife] really found like a kind of defining moment of someone that we could trust and someone who was going to listen to us and support us. I mean, I guess maybe because Ebony's also the consultant midwife, but felt very confident, very, very empowering. So really, it was there, that game changer at that point. And so we were relieved to find Ebony. ... I think having like an experienced team of midwives on call was really important to me. So Ebony was available most of the time and sort of did really strive to make herself available. (W112-C-VBB)*
10. *When they told me that he was breech, I started looking at the NHS website to see what it meant to me and that this option was over there, although I didn't know exactly how it would work, if I could have*

*it at all hospitals, because it was clear that the problem is I'd need to have a team that was prepared for that, and I thought that maybe it's not a reality everywhere. But then, . . . the midwife at birthing choices made me aware that I could try to have one, and that put me under control. (W114-A-EMCS)*

11. *Well, actually, she gave me the confidence that I could because I knew that I was going to do the vaginal breech birth, but meeting with her gave me the the confidence that I want, that I have a someone that knows how to do it. But she is an expert in in that kind of birth. (W110, A, FBB)*
12. *So [non-OptiBreech site] at that time weren't even aware of an obstetrician within their group that specialised a little bit more in breech. So it was really just kind of single-handedly with my husband making a lot of effort to find out what I could do. (W108-B-VBB)*
13. *We only agreed to the ECV, it was – we agreed to it before we met Ebony. So it was like, when it was very much like there wasn't really any option apart from having the ECV or having a C-section. And we were sort of led to believe it was going to be the consultant doing the ECV. And he mentioned that hospital they have about a 40% success rate. On the day the consultant was not available. It was just sort of – and we'd been waiting for hours just on the lay ward. It wasn't an ECV clinic and it was just sort of the reg [registrar] who was on that day, and she sort of didn't seem like she done an ECV before. She was talking about kind of success rate in Malta it being 60% but it just seemed like she was quoting like, you know, general stats, not her stats. And the ECV was really brutal. Really painful. It wasn't – at no point did it seem like the baby was actually gonna move. But she was so determined that she could get him to move because I met the like criteria for being a successfully ECV. He wasn't engaged. There wasn't the right amount of fluid and stuff. And she did four attempts. I think it was like 11 minutes in total. It was over what they were supposed to do and I couldn't really – because I was laid flat, I couldn't really see what she was doing. I just knew it was painful and because she was so adamant that she was getting the baby to move and it could get to work, I guess I kept saying, Yeah, OK, carry on. (W112-C-VBB)*
14. *It seemed like some other midwives we met in the unit – like we went into triage at one point and just a general midwife mentioned, "Oh, so have you booked a C-section because your baby's breech?" and we were like, "No, no, we're part of the project." So obviously it hadn't really filtered through the other staff kind of knew that was happening. And then, yeah, the screening midwife was very anti having a breech birth. (W112-C-VBB)*
15. *It was in the, you know, the paper that she gave me, the pamphlet. But she didn't tell me anything. She just told me that it was very risky. Gave me the information. Insisting the C section instead of that the vaginal breech that it was an option. And they have a team – she never told me about that the hospital have a special team for that. (W110-A-FBB)*
16. *For me the worst was cutting the cord too soon. . . So I understand that for her it was an emergency. So she did what she thought was better. I understand. But for me, I know that I couldn't change her mind right in that very moment. You know what I mean? That's something that she had to know before and she reacted in another way, bad. Anyway, for me, it was difficult to accept that that. Now I'm in a better place. I know that she did what she thought was better. (W110-A-FBB)*
17. *I just think maybe it would be good if the, I guess, the other doctors or consultants at the hospital were more aware of the breech clinic and that it is actually a safe option that is being offered by experienced people and that, you know, that it is a service of the hospital. (W103-A-VBB)*
18. *It was a bit inconvenient because, as I said, I have another child, he's at school already. So I had to kind of accommodate his being at school with me going to hospital, especially because it's not because the causes hospital to where I live. Also, I had to be driven over there a bit because it is a bit further away, but also because of the pandemic. I didn't want to get to public transport while pregnant, so my husband had to kind of stop working to drive me over there. (W114-A-EMCS)*
19. *The only thing I didn't get from being out of the catchment area was the continuity, I think, as I didn't see the same midwife. Maybe two weeks I think I saw the same person. But apart from that all my appointments, I saw someone completely different. So I guess if I had been to like my local hospital, I would have seen the same midwife or, you know, a couple of people. Whereas this felt bit more like, not personalised. Like I basically just saw whoever was there and no one really knew me. Someone*

*different each time. (W111-C-VBB)*

20. *Just have more places to be available because, you know, I had to go across [the city] to get it. And I cannot imagine how it would be for people who live outside [the city]. Like I don't think there is an option for people outside [the city] to do that. Like [a different big city] or something, maybe there is. (W104-B-EMCS)*

Shared responsibility

1. *When I first found out he was breech, it really upset me, like I was really upset by the whole thing. I thought I'd sort of done something wrong or some, you know, things could have, I think I was really quite hung up on having a positive birth experience and it really bothered me. I didn't feel it would be. But the minute I spoke to Niamh, I just felt so different. That's sort of like, the relief I felt almost in knowing that I could have a positive experience. And I think that was a real turning point for me. (W100-B-VBB)*
2. *I did feel a lot of guilt, initially, before Niamh, before having like done more research. I did feel a lot of guilt of like am I being selfish in planning a breech birth? Where it is just safer for me and the baby to plan a C-section? Because if it was to come down to it, they say that a lot of mistakes can be made from an unplanned C-section because of like, human error and stuff. And it's like, am I putting myself and my baby in a position of it not being safe. And that was a lot of like, a burden to me until I did like meet with the breech team and discuss that. (W101-B-VBB)*
3. *I don't know why I feel hurt, but I think people don't understand the amount of strength it takes to go against the norm. Like, when you're faced with adversity, you really have to have a mantra of, I know what I'm doing is the right thing. I know I read the data. I read the statistics on it. I am like, competent enough to make this decision and stick by it. You really have to reinforce that because the system is telling you to have a caesarean. The system is telling you that you shouldn't be doing what you're doing, and I've had to put so many people in awkward situations of house swapping, and you just have to really be strong. So even after you've done it, people – you just kind of feel like, oh, people don't see how you see it, and that's okay. And then you just – the moment's gone, you don't want to keep – you don't want to preach about it, basically, so, yeah. It's just, you really have to be quite strong when it's just not the norm. Like anything, I guess. (W108-B-VBB)*
4. *She, like, didn't actually know any of the statistics, which was terrible, she was just like, It's 10%, or what did she say – I think she was like, There's no risk in a Caesarean. And she said, There's 0 risk. And we were like, That's complete – that's not true. Like, you can't say that. And she kind of made us feel like we were going to, I don't know – like, do you want to take the risk with your baby by doing a breech vaginal delivery? And she made it sound, you know, as if it was kind of irresponsible of us to be doing that. (W103-A-VBB)*
5. *The people that I spoke to when I got to the hospital, or like the person who did the scan, it's kind of like – the sentiment was, Oh, you're gonna have a Caesarean now because you have a breech baby. So had it – and I must say, also from like my family as well, like, Oh, you've got a breech baby, you must be having a Caesarean. So I did feel like, you kind of feel like, am I doing the wrong thing, because, like the institution of, like, the hospital and, like, your family, who you trust so much, like everyone's, kind of, reaction was a bit, like, shocked that I was gonna have a normal birth even though my baby was breech . . . It was honestly, very, very emotional just because, you know, like, I am gonna – if something happens to my baby like, well I'll never forgive myself, but then you could have a Caesarean and something could happen to your baby or you could have a normal birth and, you know, something could happen to your baby. (W103-A-VBB)*
6. *I started to feel that I was being stubborn and maybe I was not doing the right thing for my baby a little bit . . . It was great but they were treating that as, I don't know, as a red flag or something. And I was like, it's not a red flag. (W104-B-EMCS)*
7. *It was generally kind of family, and friends were kind of going, That is extra risky and are you quite sure and you do look quite big. And, you know, quite a lot of worry about it, I think. I think because it's rare and has got some extra level of risk to it, that – yeah, so family and friends, I got a little*

*bit of – and not you shouldn't do that. But just, Are you sure about the decision you're making? (W106-C-EMCS)*

8. *And it was really reassuring to kind of hear that breech was just an alternative, like a new normal almost I guess, because I think, speaking to friends and relatives, when you mentioned it everyone just kind of goes, Ooh, you better have a C-section really. And for me, that wasn't something I was overly keen on, especially already having another child. (W100-B-VBB)*
9. *I think my mom was, like, a bit nervous before she knew. But then once she knew about, like, everything, once she kind of – she knew about Janet, she knew how good the team was– my mom she also trusts my judgement with these sort of things because she knows, like, as someone who wants to be a midwife like I really do, like, my research kind of thing. Yeah. So, like, basically, everyone trusted my judgement, and it was fine. (W109-A-VBB)*
10. *Well, to be honest, I didn't speak much about it with almost anyone, because I knew it would happen, and I didn't want other opinions, especially opinions that were not scientifically based, that didn't have certain knowledge involved in that. I spoke to my mother at some point, but she was okay with the information that I gave to her that I had at that point. But I kind of avoided speaking to too many people about it because I didn't want to have negative opinions about this. I speak with my doula, I have a doula, and she was positive about it. My midwife was as well, she said it is, unfortunately, a few weeks ago, it wouldn't be a possibility but it is now. And I also found a group on Facebook about women who had breeched babies, and many of them went for vaginal breech birth although not all of them. But many of them were successful, so it was good. (W114-A-EMCS)*
11. *Yeah, so I felt incredibly well supported when I was choosing to have a vaginal breech birth. They were so knowledgeable and I think Ebony, you know, Ebony just – she made it feel like it was a possibility and a safe possibility. And the consultant [in the breech clinic], I can't remember her name, which is awful, but she was lovely as well. Really knew what she was talking about. Could answer every question. (W106-C-EMCS)*
12. *[CS] would never be my preference. I think having to build up that kind of relationship of trust with someone very quickly, is very difficult. So we had complete faith and complete trust in Ebony, and it would have been amazing had we needed labour care, if she was there. And it was really great that we could phone her when going into the hospital, I think, yeah that really made me feel relaxed and calm going in knowing that she was going to be there as well. (W112, C, VBB)*
13. *And as soon as she came in, I just, everything was just like okay, there was a weight lifted because I knew that someone was, knew so much about breech birth, and that was her speciality, and she was there to help me. Rather than like having the normal midwives or even just the doctor who sort of didn't really know what he was doing. (W101-B-VBB)*
14. *I think, for me, the main thing is, was having, like, a key person who, on the team of the breech clinic. So for me, that was Janet. (W103-A-VBB)*
15. *I would just contact Niamh because she's leading up the team. Niamh is having other midwives train with her so that she would either come in and observe or she'd help out, but her goal there is to train the team, to not need her to be able to birth them anymore. (W108-B-VBB)*
16. *I started looking into it around 34-35 weeks. I think when I joined the Facebook group and I could see a lot of people having positive experiences, and I also – I think I searched my hospital name in this Facebook group and I – that's when I learned about like Janet and like she seemed to do some really good work. So I felt really encouraged that I was at a hospital where she was working because I felt like I was in good hands and I would feel comfortable like, giving birth with that sort of team around me. (W109-A-VBB)*
17. *Yeah. I think because they were, like, so willing to, like, fulfil what I wanted to do, I guess because it was reasonable what I wanted as well, I felt like it was a safe option and I felt in good hands. They were very willing to listen to me instead of, I know in other trusts across the country, some people are like shut down with what they wanted to do. The team seemed to be very much on the same page as me, so that made me feel safe and encouraged. (W109-A-VBB)*
18. *So the feeling was that if that it couldn't be facilitated, then we would go ahead with the C-section*

*because of the uncertainty as to whether other team members would respect our choices. So we knew Ebony would. But if Ebony wasn't available, for whatever reason, or we arrived at the hospital and saw another midwife or other doctors before Ebony got there, were we going to kind of be bullied or coerced into making other choices or – not even necessarily coerced into making other choices but made to feel like we were making bad choices and and that would then make labour feel very stressful and make you know, in my opinion, labour much less likely to be successful. (W112-C-VBB)*

19. *[The breech specialist midwife] was lovely. She was respecting all the time and before the labour. She helped me a lot with my decision, and she helped me with the hospital and the hospital actually said sorry to me because thanks to her, I felt pressure, but I didn't know what to do. Just say no to the hospital. I didn't know. I don't want to do that. And thanks to her, the hospital decided to call another doctor. The doctors say, Sorry and they say they wanted to respect my decision. (W110-A-FBB)*
20. *I was emailed a sheet before I went to the Breech Clinic about the what the service does and the – like it did on the sheet it did say about having a vaginal birth versus a caesarean. And there were the risks and the benefits on that on that sheet. So I was given a bit of information. But that wasn't until probably week 36 probably 36. When I went to the Breech Clinic, And apart from that, I wasn't, everyone whenever I went to my appointments they said, Oh, don't worry, baby will turn baby turn like it wasn't a big deal for them. Whereas for me, I felt like I was getting closer and closer, and baby wasn't turning. And just because of my birth preferences, that was kind of stressing me out a bit. (W111-C-VBB)*
21. *The only thing that really sticks in my mind and it has done ever since, is the kind of the attitude of the doctor. It was almost as if, like, Right you tried we're going now. And like, he didn't really want to even consider me having a natural birth. And that made me really upset, the fact that he was just like, Right we're going now, you'll be done within the hour. It was almost as if it was just a quick and easy way to do it. Like he didn't really think about how I was feeling. So that was the only kind of I'd say the downside of it was like his attitude, but everyone else supporting me and was really good. (W111-C-VBB)*
22. *She said that she had spoken to each member of staff, she actually mentioned each member of staff's name. I didn't obviously know who they were, but she said this lady has had experience before. This lady has worked with the breech team before. So she kind of went through each team member that she's spoken to. And she gave me confidence that they were happy knowing what they were doing . . . I felt quite confident after she'd been away and spoken to them all. I think if that hadn't happened, I wouldn't have felt as confident. But the fact that she came back to me and went through literally every member's name and then said, this is what experience they've got that was really, like It was so useful, and it was really helpful. (W111-C-VBB)*
23. *And then [the breech specialist midwife] went on annual leave for a couple of weeks, and we had a really difficult time with the foetal medicine unit at [the hospital] because they were really worried about the antibodies and basically told me I had to have a C section for [baby] being breech, because of the risk of brain injury, not being able to resuscitate him, etcetera. And this was kind of disguised or kind of justified as being worried about the antibodies. But yeah, basically had really awful, awful experience with the screening foetal medicine side of stuff, neonatal unit and then got back in touch with [the breech specialist midwife], who was on her annual leave, but kind of sent some emails, sorted this out for us and made it all a bit better. And then I think everybody realised they actually had to start being a bit nicer and start supporting our choice not to have a C-section. So because of okay and part of the breech project, I assume. Then it got to 41 weeks pregnant and we reluctantly agreed to have a C section, although Ebony was very clear that she would continue supporting us, whatever our choice was. But we just felt like it was going to be difficult to have a relaxed, normal physiological birth on the unit with that kind of background. So booked a C-section . . . (W112-C-VBB)*

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process-evaluation