NHS Patient Survey Programme

2018 survey of women's experiences of maternity care

Statistical release

Published January 2019

Independent data analysis

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Summary of findings

NHS maternity services provide care and support to women before giving birth (antenatal care), during the birth and in the 6-8 week period following the birth (postnatal care). Understanding the experiences of the women who use them is essential to providing high-quality care.

This maternity survey received responses from more than 17,600 women who gave birth during February 2018 (as well as January 2018 if trusts had smaller numbers of births during February). This is a response rate of 37%. We asked women about their experiences of care during labour and birth, as well as the quality of antenatal and postnatal support they received.

As in previous years, the report shows that overall, women reported many positive experiences of maternity care in 2018. However, while in 2017 we reported there had been small improvements across most questions from 2013 onwards, very few questions showed this trend continuing between 2017 and 2018, with some questions showing a decline.

In line with previous maternity surveys, results for questions on postnatal care, either in the hospital or once they returned home, remain less positive than other aspects of the maternity pathway. Though the 2017 survey saw some improvements, there has been little further change in 2018. Information provision and communication are areas where experiences could be improved, particularly around infant feeding.

We also analysed the results to look at the experiences of different groups of women. Results this year showed very few differences based on the variables that were tested. Continuity of carer (seeing the same midwife) did seem to affect average experience scores, suggesting that ongoing relationships can have a positive impact on women's experiences.

Positive results

Very few questions showed an improvement between 2018, and the last time the survey was carried out in 2017.

There have been improvements in the proportion of women who said that they were asked how they felt emotionally during their antenatal care, increasing from 57% in 2015 to 64% in 2017 and 68% in 2018.

The proportion of women who said that during their stay in hospital their partner or someone else close to them could stay with them as much as they wanted has increased from 63% in 2015, to 69% in 2017 and 71% in 2018.

While few questions had improved, there are several questions which continue to have positive results over time, with some of the best results seen for questions asking about interactions with staff. Most women said that during their antenatal check-ups the midwives 'always' listened to them (82%) and that they were 'always'

spoken to in a way they could understand (88%). Positive results continued when asking about labour and birth where 88% of women said that they were 'always' spoken to in a way they could understand; 85% said that all staff treating and examining them introduced themselves; 82% 'definitely' had confidence and trust in the staff caring for them and 88% said that they were 'always' treated with respect and dignity.

Other notable positive results are that more than nine in ten women said that during the pregnancy they had a telephone number for a midwife or midwifery team they could contact (97%); their partner or someone else close to them were able to be involved as much as they wanted to be during the labour and birth (96%); and that a midwife told them that they would need to arrange a postnatal check-up of their own health with their GP (92%).

Areas for Improvement

Choice

Questions asking about choices offered to women during their maternity journey had mixed results. While there have been some improvements over time, many women told us they are not being offered choices about aspects of their care asked about in the survey.

When asked if they were offered a choice about where to have their baby, the proportion of women who said they were offered a choice of giving birth in a midwife led unit / birth centre or a consultant led unit has increased each year. However, as in 2017, 15% said that they were **not** offered any choices. Most women were **not** offered a choice about where their antenatal care (68%) or their postnatal (58%) care would take place.

In previous reports we have highlighted the proportion of women who gave birth using stirrups. This is contrary to best practice guidance, which recommends that women can move about throughout labour unless they need assistance. In 2018, 36% of women said that they gave birth 'lying with legs in stirrups,' unchanged from 2017.

Seeing the same midwife (Continuity of carer)

Similarly, while there have been improvements in questions asking about continuity of carer, many women still do not receive this. Though the proportion of women who said they saw the same midwife every time for their antenatal check-ups increased from 34% in 2013, to 36% in 2015 and 38% in 2017, this trend did not continue in 2018 (also 38%). Over a quarter of women (28%) did not see the same midwife but would have liked to. Most women (85%) said that the midwives who cared for them during the labour and birth had not been involved in their antenatal care. Most women were not seen by the same midwife every time for their postnatal care at home (72%).

Almost a quarter of women (24%) said that the midwife or midwives that they saw did **not** appear to be aware of the medical history for them and their baby, and there has been a small increase since 2017 (23%) and 2015 (22%).

Information and communication

Women's experiences of information provision and communication could be improved, particularly during postnatal care and around infant feeding where results were less positive than for other aspects of the maternity pathway. For example, while 57% were 'definitely' given relevant information about feeding their baby by midwives during their antenatal care, this leaves more than two-fifths for whom this could be improved. Sixty-two per cent 'definitely' received help and advice from a midwife or health visitor about feeding their baby in the six weeks after the birth though this again leaves around two-fifths for whom this could be improved. A quarter of women (25%) said that if, during evenings, nights or weekends, they needed support or advice about feeding their baby, they were **not** able to get this, compared with 22% in 2017.

Fewer women in 2018 (56%) were 'definitely' given enough information about any emotional changes they might experience after the birth compared with 2017 (59%).

There has also been a decrease in the proportion of women who said that they were 'definitely' given enough information about their own physical recovery after the birth which was 57% in both 2015 and 2017 but 53% in 2018.

Postnatal contact at home

There has been a downward trend in the proportion of women reporting that they had been visited at home by a midwife following the birth of their baby, from 95% in 2013 and 2015 to 94% in 2017 and 93% in 2018.

In 2018 there has also been an increase in the proportion of women who said they would have liked to have seen a midwife 'more often' after they went home. This year almost a quarter (23%) said this compared with 21% in 2017.

How experience varies for different groups of women

Analysis of the experiences of different groups of women showed very few differences in 2018 based on the variables that were tested. Continuity of carer did seem to have an effect on average experience scores, suggesting that ongoing relationships can have a positive impact on women's experiences.

Scores were above average for women who saw the same midwife during their antenatal care and saw the same midwife during their postnatal care for three themes: confidence and trust (postnatal), information communication and education (antenatal), information communication and education (postnatal). Please note, this does **not** mean that these women saw the same midwife for both antenatal and postnatal care, though they might have done.

Introduction

NHS maternity services provide care and support to women before giving birth (antenatal care), during the birth and in the 6 to 8 week period following the birth (postnatal care). Having a baby is the most common reason for admission to hospital in England. Maternity services are unique as in many cases they support predominantly healthy women through a natural life event. Understanding their experiences is essential to providing high-quality care.

Maternity services are a key area of focus for the NHS. In March 2015, NHS England announced a major review of national maternity services as part of the NHS *Five Year Forward View*. In 2016, NHS England published the national Maternity Review Report *Better Births Improving outcomes of maternity services in England*, which assesses how maternity care is currently provided and considers how services should be developed to meet the changing needs of women and babies. Since then, resources have been shared with all 'Local Maternity Systems' (providers and commissioners of maternity systems in a geographical area) providing guidance on making changes that will help achieve national ambitions set out in the Better Births report. See more detail in policy context.

About the maternity survey

The maternity survey is part of a wider programme of NHS surveys, which covers a range of topics including peoples' experiences of care in adult inpatient, children and young peoples, urgent and emergency, and community mental health services. To find out more about the NHS Patient Survey Programme and to see the results from previous surveys, please see website links in the further information section (Appendix F).

The maternity survey first ran in 2007 with other surveys being carried out in 2010, 2013, 2015 and 2017. The 2018 maternity survey involved 129 NHS trusts[a] in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women who gave birth between 1 and 28 February 2018 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2018. Responses were received from more than 17,600 women, an adjusted response rate[b] of 37%.

Wherever possible, questions remain the same over time to measure change. However, when necessary they are amended to reflect changes in policy, methodological best practice, and to reflect feedback from stakeholders to make sure that questions stay relevant. Due to major redevelopment work in developing the 2013 survey, the 2018 survey is only comparable with 2013, 2015 and 2017.

[a] Three trusts were unable to take part as they did not have enough births. Please see Appendix A for more information.

[b] The 'adjusted' response rate is reported. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

For more information about changes to the questionnaire and survey development, see the 2018 maternity survey development report on the NHS Surveys website. Appendix A provides more information on the methodology, which covers how we developed the survey, analysed data, and compared results with previous surveys.

Respondent profile

The sociodemographic profile of respondents provides important context to help us to understand the findings. They are summarised in this section. Where available, we provide comparisons with other statistics as a broad indication[c] of how representative the survey is. The full results can be viewed in the open data on the CQC website.

In 2018, the majority (71%) of respondents were aged 30 and over, with 36% aged 30 to34 and 35% aged 35 and over. The remainder were aged 16-18 (0.3%), 19-24 (7%) or 25-29 (22%). This is consistent with national trends reported by the Office for National Statistics (ONS) which has found an increase in the average age of mothers (which was 30 years and 6 months in 2017).

More than half of women who responded had a previous pregnancy (58%) with 79% of these women giving birth to 1-2 babies previously and 7% three or more. This is consistent with trends reported by the Office for National Statistics for 2016[d] which found that 58% of all live births in England and Wales were to mothers who had given birth to at least one previous child.

There has been a small decrease in the proportion of women who said they did **not** have a long-term condition from 92% in 2013, 91% in 2015 and 2017 to 90% in 2018, leaving 10% who said they had one or more.

There have also been changes in the proportion of respondents indicating they have no religion (32% in 2013, 36% in 2015, 40% in 2017 and 42% in 2018). Ninety-five per cent of women described themselves as ‘heterosexual / straight’.

Eighty-six per cent of respondents were from a White ethic background, with 8% Asian / Asian British, 3% Black or Black British, 2% mixed ethnicity and 1% Arab or other ethnic group. This is higher compared with data for 2016[e] reported by the Office for National Statistics which found that 61% of live births for England and Wales occurred in the White British group.

Almost all women who took part in the survey gave birth to a single baby (99%). Most (93%) were 37 weeks pregnant or more when they gave birth.

[c] Please note figures are not directly comparable due to differences between data sets. For example, different time periods, different populations.
[d] This was the most recent data available at the time of writing this report.
[e] This was the most recent data available at the time of writing this report.

The importance of people's experiences

Alongside clinical effectiveness and safety, a good experience for people is seen as an essential part of an excellent health and social care service according to the Patient Experience Improvement Framework and NHS Outcomes Framework.[1,2] People's experiences provide key information about the quality of services across England. This information is used to encourage improvements both nationally and locally among providers and commissioners of services. This section summarises key recent policy in this area.

The NHS National Quality Board published the NHS Patient Experience Framework (2012) to highlight important elements of patient experience. This includes: respect and involvement, coordinated and integrated care, information and communication, and the involvement of family or friends.[3] The NHS Constitution (2012, updated in 2015) committed the NHS to encouraging feedback from patients to improve services.[4] The NHS Outcomes Framework (first published 2013/14) sets out high-level national outcomes that the NHS should be aiming to improve, and includes a focus on the need to make sure that people have a positive experience of care. This emphasis on good quality patient experience continued in *the Five Year Forward View* (2014),[5] which made a commitment to enabling people to have greater control of their own care. The Department of Health and Social Care's NHS Mandate for 2018/19 includes a goal for NHS England '*to ensure that the NHS meet the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality*'.[6]

NHS England sees shared decision-making as key to improving experience for those who use services. To achieve this, NHS England called for transformational changes, to embed shared decision making at different levels, including relationships between patients and staff, and in commissioning services.

Evidence from academic research suggests that when people are involved in their care, decisions are made more effectively and health outcomes improve.[7] Studies in this area also suggest that experience is positively associated with safety and clinical effectiveness.[8] All questionnaires used in the NHS Patient Survey Programme are designed to reflect these themes.

The maternity care women receive can have a lasting effect on their physical, emotional and psychological wellbeing.[9] The consequences of poor care can affect care needs of future generations as they are associated with wider social inequalities.[10] Women's experiences of care are dependent on the care that they receive from healthcare professionals.

Capturing the views of women who use maternity services through surveys such as this enables important insight into their experiences and the quality of the care they receive. This understanding can be used to encourage improvements both nationally and locally. Research suggests that the best maternity units have a clear interest in understanding and acting on the experiences of the women using their services.[11]

Policy Context

It is important to consider the landscape of maternity care in England at the time the survey was carried out. This section summarises the main recent policies, standards and guidelines.

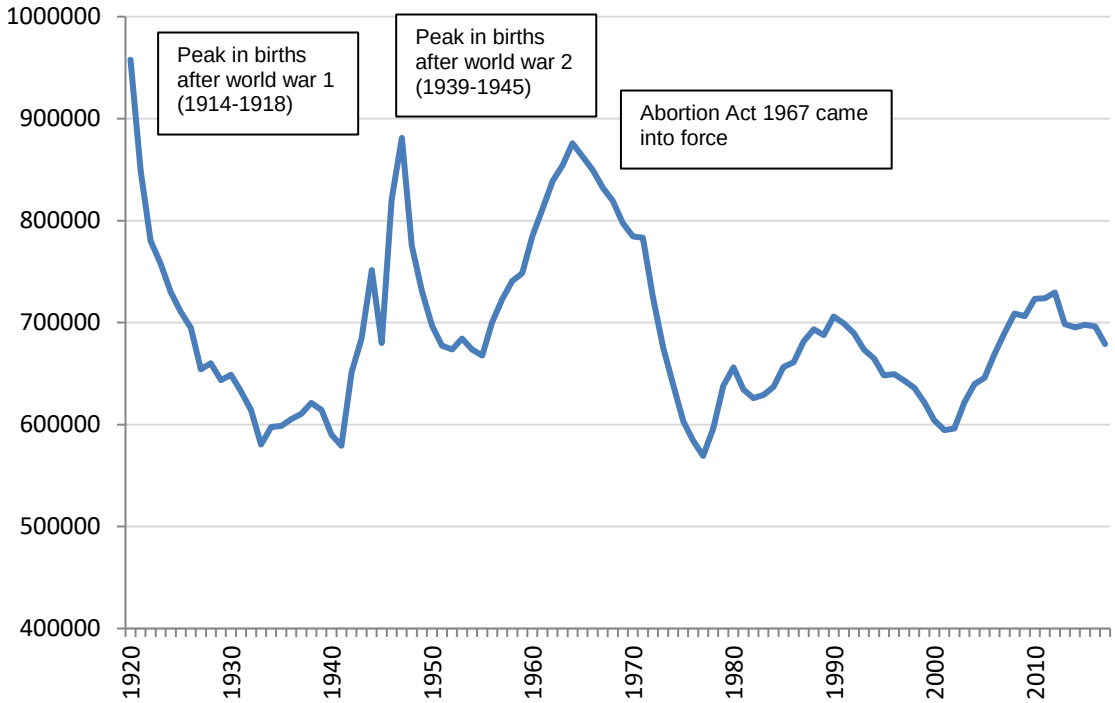
System pressures

It is generally accepted that the NHS is operating under increasing operational and financial pressures.[f] An aging population has seen an increase in chronic, complex and multiple conditions. Hospitals have seen an increase in inpatient admissions and A&E attendances. This in turn means that the healthcare staff working in the system are also under pressure.

There are around 700,000 births each year in England and Wales.[12] NHS England has estimated that the annual NHS cost for delivering maternity services is around £4.5 billion.[g] While most of these births are successful, in 2017/18 the NHS Litigation Authority reported that while the obstetrics speciality accounted for 10% of clinical claims received, this was 48% of total value.[13]

The chart below shows that there have been peaks and troughs in the birth rate over the years. The most recently published statistics from ONS show that birth rate decreased 2.5% between 2016 and 2017.

Live births in England and Wales 1920-2017



Source: Office for National Statistics

[f] See for example State of Care available at: www.cqc.org.uk/publications/major-report/state-care.
[g] The National Maternity Review 2016, Better Births – Improving outcomes of maternity services in England: A Five Year Forward View for maternity care www.england.nhs.uk/mat-transformation/mat-review/ (p94).

The demographic characteristics of mothers have changed over the previous few decades.[14] The number of live births to women born outside of the UK continues to rise, the average age of mothers has increased and the proportion of women with conditions such as diabetes has increased. The challenges of changing case mixes, with women giving birth later in life and with more complex health conditions has been cited by the Institute for Fiscal Studies (IFS)[15] as increasing the pressures and challenges for maternity services. Difficulties in providing care to an evolving case mix mean there are implications for staffing and resourcing if women need more complex care and over longer periods of time, and the IFS report warns that stretched and understaffed units will affect women's experiences.

In their report *State of Maternity Services 2018* The Royal College of Midwives has expressed concerns that despite this increase in complex cases, England remains short of midwives, estimating a shortfall of around 3,500 full-time midwives.[16]

Despite these challenges, most surveys show that women's experiences of maternity services are usually very positive.[h] An article by the National Perinatal Epidemiology Unit, University of Oxford investigating trends over time found a general upward trend between 1995 and 2014 with many positive changes in the provision of maternity care, though postnatal care was identified as an area where improvements could be made.[17]

Better Births

Maternity services are a key area of focus for the NHS. Like other sectors, services are in a period of transformation following the publication of the *Five Year Forward View,*[18] which set out a new vision of health care based around new models of care.

Women-centred care[i] is at the heart of recent modern government policy. Issues such as choice, continuity of carer[j], safety, reducing inequalities and understanding and improving experiences of services have become prominent.

In the maternity sector, the most recent drivers for change have come from *Better Births*[k] *Improving outcomes of maternity services across England*[19] the final report of the National Maternity Review which sets out the national strategy for improving maternity care. Key findings from the review are that despite increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved significantly over the previous decade.

The report also highlighted improvements in safety with declines in stillbirths, neonatal and maternal mortality. However, the review also found meaningful

[h] Please see appendix C for examples.
[i] NICE describe women-centred care as: women, their partners and their families should always be treated with kindness, respect and dignity; their views and beliefs being respected; being able to make informed decisions about their care in partnership with healthcare professionals and supported by information and communication that is evidence based and tailored to women's needs.
[j] Implementing better births: continuity of carer described continuity of carer as: providing for consistency of the midwife and/or obstetrician who cares for a woman throughout the pregnancy journey, to include antenatal care, care during labour and birth and postnatal care.
[k] This report is referred to many times in this statistical release and is abridged to 'Better Births'.

differences across the country, and highlighted further opportunities to improve the safety of care and reduce stillbirths. The report recognises the effect of inequalities on maternity outcomes, calling for services to support parents from all backgrounds.

Better Births identifies seven key themes for action which form the basis of its recommendations to drive its vision: personalised care (choice), continuity of carer, better postnatal and perinatal mental health care, a payment system, safer care, multi-professional working and working across boundaries. These are underpinned by two commitments: enabling women to make informed decisions, and ensuring that the system can offer the safest possible care.

The report sets out a vision for maternity services across England to deliver safer, kinder, personalised care for women with maternity staff supported to deliver care, in cultures which promote innovation, continuous learning, and a breakdown of organisational and professional boundaries. This vision is being delivered by the Maternity Transformation Programme, a five-year programme tasked with implementing the recommendations of Better Births from 2016-2021.

The Maternity Transformation Programme: implementing the vision of Better Births

Better Births recognises that the delivery of its vision is only possible through locally-led transformation. The Maternity Transformation Programme (MTP) is implementing the vision of Better Births, by coordinating action at a national level as well as supporting local transformation. Forty-four Local Maternity Systems (LMS) have been created, which have the same boundaries as Sustainability and Transformation Plan (STP) Footprints.[I] These LMS transcend local boundaries and involve providers, commissioners, and representation from women and their families through Maternity Voices Partnerships. They aim to co-create services that deliver on the vision of Better Births, particularly ensuring that women, babies and families can access the services they need and choose, in the community, as close to home as possible.

Seven 'early adopter' LMS's have led the way in testing new models of care outlined in Better Births, and have shared their learning nationally. All 44 LMS's have developed a plan[20] which shows how by the end of 2020/21 they will improve choice and personalisation of maternity services so that:

- All pregnant women have a personalised care plan.
- All women can make choices about their maternity care during pregnancy, birth and postnatally.
- Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
- More women can give birth in midwifery settings (at home and in midwifery units).

[I] STPs are five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical 'footprints.' These are geographic areas in which people and organisations will work together to develop plans to transform the way that health and care is planned and delivered for their populations. For more information please see:
www.england.nhs.uk/publication/sustainability-and-transformation-plan-footprints-march-2016/
www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

The plan also shows how they will improve the safety of maternity care so all services have:

- reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030
- are investigating and learning from incidents and sharing this learning through their Local Maternity System and with others
- fully engaged in developing and implementing the NHS Improvement Maternity and Neonatal Health Safety Collaborative.

Promoting safer care

Better Births found that safety was a key concern for women '… *most women who contacted the review said that the safety of their baby and themselves was their primary concern. They expected that the health services and professionals caring for them would also have their safety as their priority'*.

Statistics show that the stillbirth and neonatal mortality rate has fallen over the previous decade with ONS reporting the lowest stillbirth rate on record in 2017. Despite this, stillbirth rates in the UK remain high compared with other European Countries. Better Births recognises that there are still wide regional variations in reducing stillbirths. Promoting safer maternity care is a key priority for the NHS in England and demonstrable progress to achieving this is set out in the NHS Mandate,[21] and is also a key work stream of the Maternity Transformation Programme.

In 2016, the Department of Health and Social Care announced a national ambition[22] to reduce the rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20 per cent by 2020, and by 50 per cent by 2030. In 2017, *Safer maternity care: progress and next steps*[23] adjusted this commitment to halve rates by 2025 and set an additional ambition to reduce the national rate of pre-term births (less than 37 weeks) from 8% to 6% by 2025. This is supported by measures including additional funding, leadership and training initiatives and the *Saving Babies Lives Care Bundle*[24], which brings together best practices to reduce stillbirths. An evaluation of the Care Bundle has found that trusts who adopted all the elements saw a 20% reduction in stillbirths.[25]

Choice and personalisation

A strong message in Better Births is ensuring that women are provided with meaningful choices, involved in their care and provided with the information and support to enable this. Choice should be available throughout the maternity pathway '*women should be able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing dialogue with professionals that empowers them'*.

Choice is made easier when care is personalised to the needs of the mother, baby and family, and when there is ongoing open communication with healthcare professionals. Better Births links personalised care to reporting better experiences.

The Royal College of Midwives[26] describe how policy does not always translate into practice. Though choice of provider, choice of location and choice of type of maternity care are advocated, choice is different across and in countries, regions and localities.

The implementing better births resource pack states that Local Maternity Systems will need to make sure that there is a range of safe and sustainable providers, offering a range of styles of care.

Continuity of Carer

Better Births describes the aim of providing continuity of carer is to '*ensure a woman will normally be looked after or supported by professionals she knows and trusts'*. The report recommends that the NHS in England should roll out continuity of carer to a much greater number of women than currently receive this. A continuity model of care should support women through the whole maternity journey: antenatal care, labour and birth and postnatal care. It is also hoped that this will help to ensure that women and babies needs are understood and met, and that it will help to develop relationships based on trust.

Both the Better Births and Safer Maternity Care reports strongly link safe care with personalised care and continuity of carer. This is supported by evidence such as a Cochrane[27] review which found better outcomes for women who had midwife led care. Researchers found that women who received continued care throughout pregnancy and birth from a small group of midwives were less likely to give birth pre-term and needed fewer interventions during labour and birth than when their care was shared between different obstetricians, GPs and midwives.

Guidance[28] on implementing continuity of carer describes how maternity services can deliver this. It sets out two models, 'team continuity' where each woman has an individual midwife, who is responsible for coordinating her care in a team of up to 6-8 midwives and 'full caseloading' where each midwife is allocated a certain number of women and arranges their working life around the needs of the caseload. Recent planning guidance[29] requires LMS to ensure that from March 2019, 20% of women are placed onto continuity of carer pathways.

Perinatal mental health

Perinatal mental health refers to mental health problems which occur during pregnancy or in the first year following the birth of a child.

Better Births called for '*...significant investment in perinatal mental health services*' to improve recognition and care. It describes how depression and anxiety affect around a fifth of women the year after the birth but around half of these cases go undetected. If left untreated, it can have serious and long-lasting effects on the woman and her family. It also noted that rates of perinatal depression are higher among women experiencing disadvantages such as poverty or social exclusion. The report found that many women did not receive treatment and the availability of this varied enormously across the country.

NHS England have subsequently committed to investment to transform perinatal mental health care, to ensure increased access to specialist perinatal mental health support in all areas of England by 2020/21. There is a specific focus on overcoming inequalities in access and enabling women and their families to access specialist services close to home when they need them.

Promoting health

Better Births recognises that maternity services have a role in promoting public health and reducing health inequalities. The report recommends that as part of delivering personalised care, information and support should be provided to help women make choices and reduce the inequalities associated with poor health.

The resource pack on implementing better births states that Local Maternity Systems must '*implement strategies and services to improve women's health before, during and after pregnancy, give every child the best start in life, and reduce health inequalities*'. This includes providing advice, support and information on issues such as the importance of smoking cessation, and maintaining a healthy weight and lifestyle.

Inequalities in care

Better Births recognised that there are differences in how care is provided across the country. This has also been highlighted in many other reports such as the National Maternity and Perinatal Audit[30] which found '*evidence of substantial variation in maternity care and outcomes among hospitals, as well as between women from different socio-economic and ethnic backgrounds*'.

The What Makes Mothers Sick[31] report describes how maternal health inequalities can originate from many different factors including socio-economic conditions such as poverty and unemployment. Some women such as young mothers, women from a minority ethnic background and women with pre-existing and long-term health conditions are at increased risk. The report concludes that pregnant women experiencing disadvantages are at a high risk of both mental and physical illness complications during pregnancy and childbirth, which can affect both her and her developing child.

The National Institute for Clinical Excellence (NICE) recognise that women with complex social factors may have additional needs and experience barriers to accessing services. Therefore, they may need greater support from healthcare professionals, highlighting the importance of personalised care.[32]

Quality Standards

NICE provide evidence based clinical guidance and quality standards for health care, many of which are linked to the policy outlined previously in this section. These help health professionals deliver effective maternity care.

NICE clinical guidelines and associated quality standards promote women-centred care. Central to this is enabling women to make informed decisions about their care and treatment in partnership with healthcare professionals. This is assisted by effective communication and information provision.

Many of the recommendations supported by the Maternity Transformation Programme, on safety, prevention, workforce, women's choice and the personalised care, are underpinned by NICE recommendations. A review by NICE found some positive progress in the uptake of their maternity recommendations for safe and personalised care. However, there is still scope for improvement in other areas.[33]

Results from the survey

This section presents the results[m] from the 2018 maternity survey and follows women's journeys through antenatal care, labour and birth and postnatal care. It highlights statistically significant differences[n] compared with 2013, 2015 and 2017 where possible. Survey results are organised under the following key themes:

1. Care while pregnant (antenatal care)
2. Care during labour and birth
3. Postnatal care in hospital
4. Infant feeding
5. Postnatal care at home

We have also included analysis that compares how different groups of women rated their maternity experiences. The NHS Constitution and the Equality Act 2010 both require healthcare providers to give '….*equal consideration to the needs, experiences, outcomes and aspirations of people with protected characteristics under equalities law'*. These protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act provides an important legal framework, which should improve the experience of all patients using NHS services.

The analysis modelled the mean scores of different subgroups – age, ethnicity, religion, sexual orientation, long-term health conditions, parity (whether women have had a previous baby or not), delivery type, stirrups usage and named midwife status (inferred from responses to two questions: B8 for antenatal care and F5 for postnatal care) – for a set of composite themes based on the NHS Patient Experience Framework.

We present these findings throughout the report, and provide a full summary of results in the subgroup analysis summary section. Appendix G presents charts and detailed information on the subgroups and themes used in the analysis.

1. Care while pregnant (antenatal care)

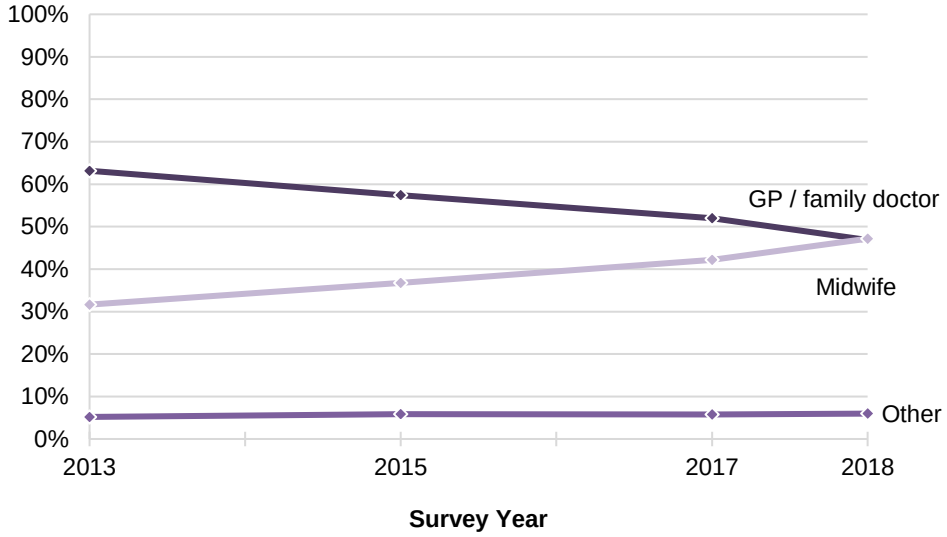
Access

A woman's choices begin when she first discovers she is pregnant and decides how to access care: through a GP practice or midwife service. Recent policy has focused on enabling women and their partners access to midwives directly. Choice in how to access maternity care was set out in the 2007 policy document Maternity Matters[34] which stated that '*self-referral into the local midwifery service is a choice that will speed up and enable earlier access'*.

[m] Responses to questions such as "don't know/could not remember" are not shown and excluded from percentage calculations. The wording for these responses is designed for when a respondent cannot remember, or does not have an opinion.
[n] 'statistically significant' means that the difference is very unlikely to have occurred by chance.

There has been a significant increase in the proportion of women directly accessing midwifery services (32% in 2013, 37% in 2015, 42% in 2017 and 47% in 2018) and a corresponding decrease in the proportion to first see a GP (63% in 2013, 57% in 2015, 52% in 2017 and 47% in 2018).

B1. Who was the first health professional you saw when you thought you were pregnant?

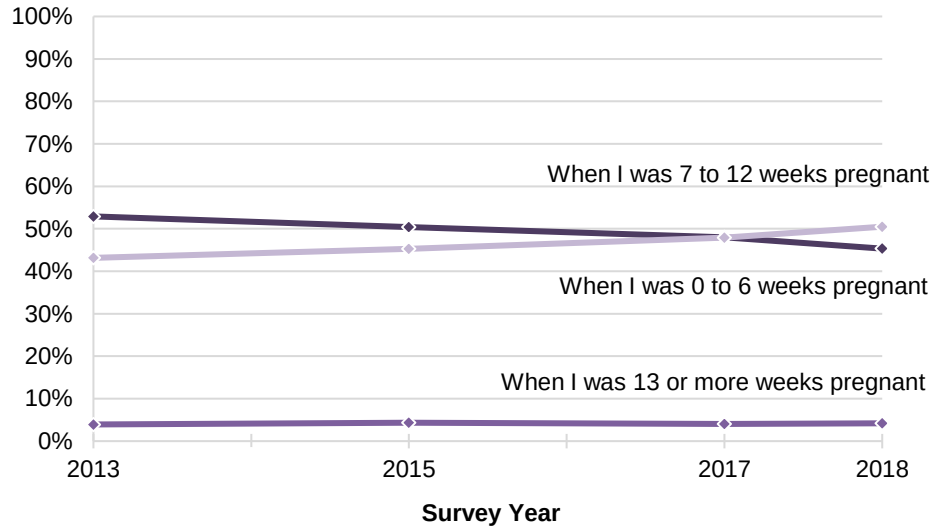


Number of respondents: 2013 (22,624) 2015 (19,653) 2017 (18,315) 2018 (17,516)
Answered by all.

Maternity Matters encourages early access to maternity services which can improve outcomes for women and babies, by enabling earlier assessment of their health and for care planning to begin earlier. The initial contact with the system when women first present as pregnant is usually followed by a 'booking appointment' where women are given their pregnancy notes and provided with the information they need.

Results show that there has been a significant decrease in the proportion of women who said they were 0-6 weeks pregnant when they first saw a health professional about their pregnancy (53% in 2013, 50% in 2015, 48% in 2017 and 45% in 2018). There has been a corresponding increase in the proportion who said this was when they were 7-12 weeks pregnant (43% in 2013, 45% in 2015, 48% in 2017 and 50% in 2018).

B2. Roughly how many weeks pregnant were you when you first saw this health professional about your pregnancy care?



Number of respondents: 2013 (22,332) 2015 (19,347) 2017 (18,013) 2018 (17,219)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

NICE recommend that women should be supported to access maternity services and that the booking appointment should be by 10 weeks. The benefits of having an appointment by this stage include: early provision of essential information around diet, nutritional supplements, exercise, lifestyle and the baby's development, as well as screening for health issues affecting both mother and baby. Data from NHS Digital shows that around 56% of women[o] have a booking appointment within their first 10 weeks of pregnancy though there is some regional variation.

The results show that most women who responded to the survey (82%) had their booking appointment by the time they were 10 or 11 weeks pregnant, but for around a fifth (18%) of women this was later. The most common response was 'when I was 8 or 9 weeks pregnant'.

[o] Based on data published 25 October 2018. Data range 1 July 2018 to 31 July 2018.

B3. Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given your pregnancy notes)?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
When I was 0 to 7 weeks pregnant	18%	18%	17%	17%			
When I was 8 or 9 weeks pregnant	42%	41%	44%	45%	↑	↑	
When I was 10 or 11 weeks pregnant	22%	22%	21%	20%	↓	↓	
When I was 12 weeks pregnant	11%	11%	10%	10%			
When I was 13 or more weeks pregnant	8%	9%	8%	8%		↓	

Number of respondents: 2013 (21,301) 2015 (18,404) 2017 (17,073) 2018 (16,220)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Choice

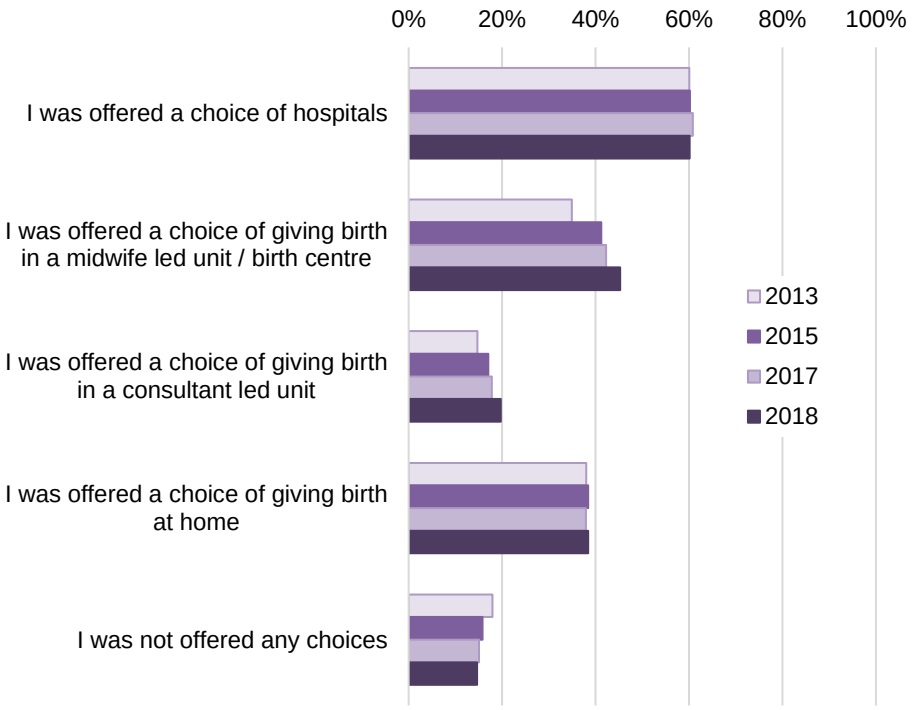
All recent national maternity policy has promoted women's choice of place of birth. Women's choice and personalised care is also one of the priorities of the Maternity Transformation Programme.

The NICE quality standard for Intrapartum Care states that women with uncomplicated pregnancies are given the choice of four birth settings: at home, in a midwife led unit that is either next to a hospital obstetric unit or in a different place, or in an obstetric unit ('labour ward'). However, Better Births discusses evidence showing that not all women are made aware of these options, and a National Audit Office report[35] describes how women's choices are in practice limited by service provision which is not equally distributed throughout the country.

Results show that in 2018, 15% of women said they were **not** offered any choices about where to have their baby. Looking at trends over time, though this improved between 2013 (18%) and 2015 (16%) it is unchanged from 2017.

There has been a corresponding increase over time in the proportion of women who said that they were offered a choice of giving birth in 'a midwife led unit / birth centre' or 'a consultant led unit'. The results for being offered a choice of hospitals and giving birth at home have remained stable over the survey years.

B4. Were you offered any of the following choices about where to have your baby?

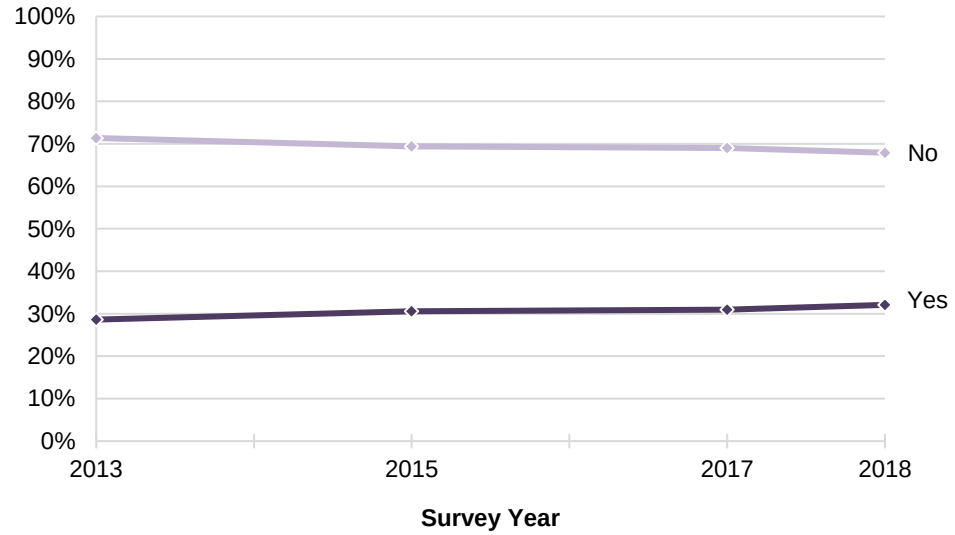


Number of respondents: 2013 (19,692) 2015 (17,052) 2017 (15,858) 2018 (15,187)
Answered by all.
Multiple response question – percentages may not sum to 100.
Respondents who stated that they didn't know or had no choices due to medical reasons have been excluded.

NICE guidelines on antenatal care for uncomplicated pregnancies recommend that antenatal care should be easily and readily accessible to all pregnant women. The importance of women's choice of care provider is emphasised in Better Births as choice is essential to personalised care.

Survey results show that while most women (68% in 2018) said they were **not** given a choice about where their antenatal check-ups would take place, this proportion has declined gradually over time (from 71% in 2013 and 69% in 2015 and 2017).

B7. During your pregnancy were you given a choice about where your antenatal check-ups would take place?



Number of respondents: 2013 (21,317) 2015 (18,519) 2017 (17,136) 2018 (16,351)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

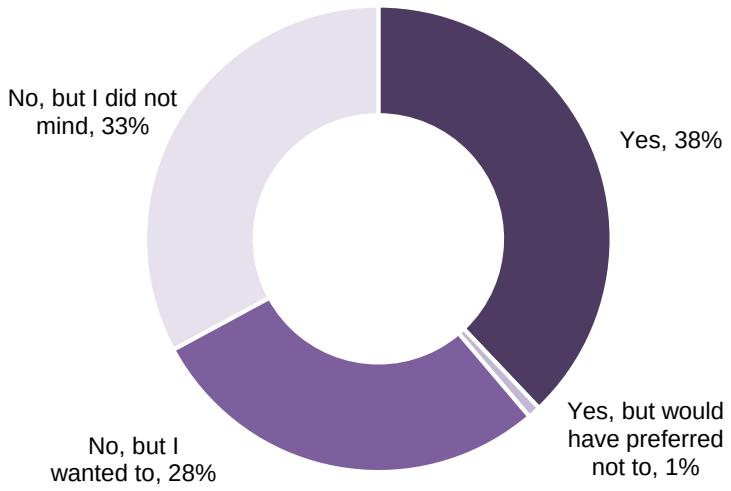
Continuity of carer

Continuity models of care are associated with better outcomes for mother and baby. The ambition of the Maternity Transformation Programme, in line with *Better Births*, is that women should have continuity of the person looking after them during their maternity journey. This is to help supportive relationships to develop, ensuring that they are looked after by someone they know and trust.

The NICE quality standard on antenatal care for uncomplicated pregnancies recommends that women should be cared for by a named midwife during pregnancy. A named midwife is *"a named registered midwife who is responsible for providing all or most of a woman's antenatal and postnatal care and coordinate care should they not be available".* The survey did not directly ask women whether they had a named midwife, but asked women if they saw the same midwife every time for their antenatal check-ups.

Results show that in 2018, just under two-fifths of women (38%) answered 'yes' when asked if they saw a midwife for their antenatal check-ups, did they see the same one every time. This is the same as in 2017, but up from 34% in 2013 and 36% in 2015.

B8. If you saw a midwife for your antenatal check-ups, did you see the same one every time?



Number of respondents: 17,191
Answered by all.
Respondents who stated that they didn't know / couldn't remember, only saw a midwife once, or did not see a midwife have been excluded.

Better Births also highlights the importance of integrated care and different healthcare professionals working together efficiently and effectively. If a woman does not see the same professional every time, she needs to be confident that the person caring for her will be fully aware of her medical history and circumstances.

The NICE quality standard on antenatal care for uncomplicated pregnancies says that service providers should make sure that systems are in place to ensure accurate and complete records of women's maternity care.

Half of respondents (50%) said that during their antenatal check-ups, midwives were 'always' aware of their medical history, the same as in 2017 but up from 49% in 2015. Thirty-six per cent said this was 'sometimes' the case and 14% that this was not the case.

Information

Better Births sets out a vision for '*…personalised care centred on the woman, her baby and her family, based around their needs and their decisions where they have genuine choice informed by unbiased information*'.

To make informed choices and decisions about their care and where to give birth, women must have access to clear and accurate information. Research evidence for Better Births shows women want information to be evidence-based and available to them in a range of formats, including online. Information should also be accessible, include locally relevant information about the services available, and there should be time to discuss it with a healthcare professional.

NICE clinical guidance states that pregnant women should be offered evidence based information and support to enable them to make informed decisions about childbirth.

Though the proportion of women who felt they were 'definitely' given enough information from either a midwife or doctor to help them decide where to have their baby saw an upward trend between 2013 (55%) and 2017 (59%) this did not continue for 2018 (also 59%). Fourteen per cent said they were not (down from 17% in 2013).

Communication

Effective communication is also essential to help deliver the vision of personalised care set out in Better Births. NICE clinical guidelines on antenatal care for uncomplicated pregnancies recommend that, at each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, and should provide pregnant women with an opportunity to discuss issues and ask questions. We therefore asked women about their interactions with midwives during their antenatal check-ups.

Over three-quarters of women (77%) were 'always' given enough time to ask questions or discuss their pregnancy, the same as in 2017 but up from 74% in 2013. There was a corresponding decrease in the proportion who said they 'sometimes' were given enough time (20% in 2018, and 2017, 21% in 2015 and 22% in 2013) leaving 4% who said 'no' in 2018.

Most women (82%) said that during their antenatal check-ups the midwives 'always' listened to them, the same as in 2017 but up from 79% in 2013 and 2015. There was a corresponding decrease in the proportion who said they were 'sometimes' listened to, from 19% in 2013 and 2015 to 17% in 2017 and 2018, leaving 2% who said 'no'.

Most women (88%) said that they were 'always' spoken to in a way they could understand, and this figure has remained almost unchanged each year. Eleven per cent were 'sometimes' spoken to in a way they understood.

Our analysis of the experiences of different groups of women showed that quality of information, communication and education during antenatal care varied according to whether they had continuity of carer. Scores in these areas are above average for women who saw the same midwife during their antenatal care and saw the same midwife during their postnatal. Please note, this does **not** mean these women saw the same midwife for both antenatal and postnatal care, though they might have done.

In contrast, scores were below average for women who did not see the same midwife throughout their antenatal care and who did not see the same midwife throughout their postnatal care.

Involvement and support

Involving women in their care is essential to providing the personalised, women-centred care described in Better Births. Better Births states that '*women are more*

likely to report a positive experience of childbirth, regardless of the outcome, if their care is personalised, if they are treated with respect and if they are involved in decision making'.

Though the proportion of women who said that they were 'always' involved enough in decisions around their antenatal care saw an increase between 2015 (77%) and 2017 (80%), there was no statistically significant change between 2017 and 2018 (79%). In 2018 3% did not feel involved enough.

NICE clinical guidance on Intrapartum care for healthy women and babies recommends that during their antenatal care, women are given information on how to contact their midwifery care team and what to do in an emergency. Most women (97%) said that during their pregnancy they had a telephone number for a midwife or midwifery team that they could contact.

Of those who tried to contact a midwife during their pregnancy, just under three-quarters (73%) 'always' got the help that they needed and 20% 'sometimes' did. The results for this question have remained stable over time.

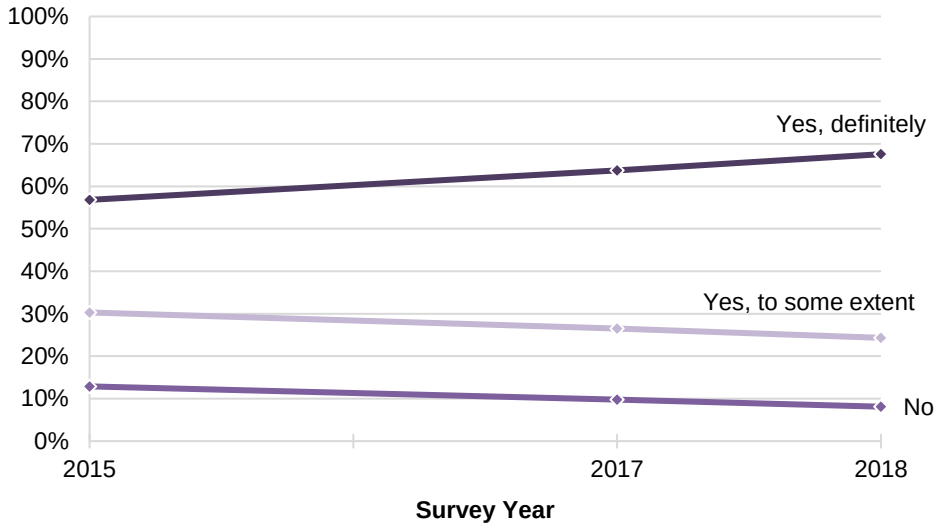
Emotional support

Better Births calls for better recognition and care of women with mental health conditions during pregnancy and after the birth, noting the key role maternity services can play in identification and support.

The NICE quality standard on antenatal and postnatal mental health recommends that women are asked about their emotional wellbeing throughout their pregnancy, and that during routine antenatal appointments women are asked questions around anxiety and depression.

Survey results show improvements in the proportion of women who said that during their antenatal check-ups, a midwife 'definitely' asked them how they were feeling emotionally. This has increased from 57% in 2015 to 68% in 2018. Corresponding decreases mean that by 2018, less than one in ten (8%) said this did not happen.

B12. During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?



Number of respondents: 2015 (19,078) 2017 (17,980) 2018 (17,235)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

2. Care during labour and birth

The start of labour can be an exciting but also stressful and frightening time. Women may have concerns determining when labour has started and the right time to go to the hospital.[36] Some studies[37] have shown that being admitted to hospital too early on in labour can cause certain complications, such as increased risk of caesarean section, and health professionals recommend that women stay at home until contractions become frequent. Therefore, it is important to provide advice and reassurance to women in early labour about how long they can stay at home.

Eighty-six per cent of respondents said that at the very start of their labour, they felt they were given appropriate advice and support when contacting a midwife or the hospital, leaving 14% who felt they did not.

C1. At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Yes	85%	86%	87%	86%	↑		↓
No	15%	14%	13%	14%	↓		↑

Number of respondents: 2013 (17,551) 2015 (14,944) 2017 (13,773) 2018 (12,480)
Answered by those who had a labour or did not have a planned caesarean.
Respondents who stated that they did not contact a midwife / the hospital have been excluded.

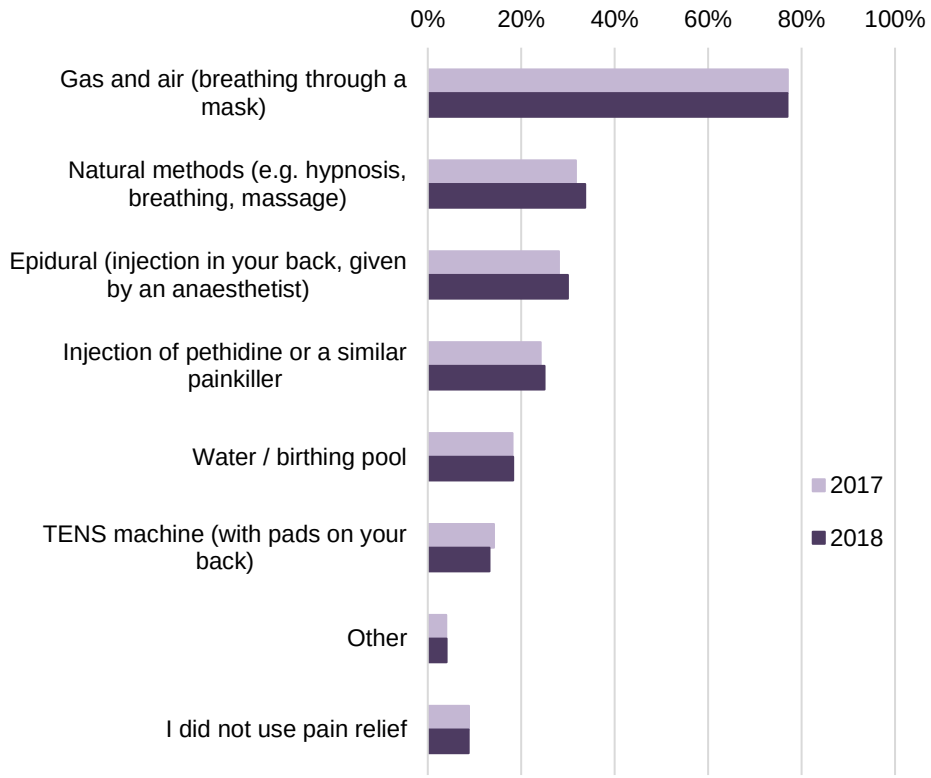
Choice

Better Births highlights the need for clear unbiased information to help women make decisions around labour and birth, such as around pain relief.

Guidelines from The Royal College of Midwives on pain relief during labour and birth[38] recommend that healthcare professionals give women information about the different options for pain relief, including how they work and any side effects.

The most common method of pain relief used was gas and air (77%). Between 2017 and 2018 there have been increases in the proportion of women who said they used natural methods (32% in 2017 and 34% in 2018) or an epidural (28% in 2017 and 30% in 2018) and a decrease in the proportion who said they used a TENS machine (14% in 2017 and 13% in 2018).

C4. During your labour, what type of pain relief did you use?



Number of respondents: 2017 (16,029) 2018 (14,821)
Answered by those who had a labour or did not have a planned caesarean.
Multiple response question - percentages may not sum to 100.

As in 2017, around two-fifths of women (42% in 2018) said that the pain relief they used changed from what they had originally planned (before going into labour). The most common reasons for not using planned pain relief were: medical reasons (29%), changing their mind (26%), there was not time and the planned pain relief did not work (both 20%).

NICE clinical guidance on Intrapartum care for healthy women and babies describes how women should be encouraged to move around and adopt whatever positions she finds most comfortable throughout labour.

Almost seven out of 10 women (68%) said that during labour they could move around and choose the position that made them most comfortable 'most of the time' which is down from 70% in 2017. The remainder said they could 'sometimes' (22%) or that they were not able to at all (10%).

The survey results have shown a gradual decrease over time in the proportion of women who said that they had 'a normal vaginal delivery' from 62% in 2013, 61% in 2015, 59% in 2017 to 58% in 2018. These figures are broadly similar with those published by NHS Digital for July 2018.

C7. Thinking about the birth of your baby, what type of delivery did you have?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
A normal vaginal delivery	62%	61%	59%	58%	↓	↓	↓
An assisted vaginal delivery	14%	15%	15%	14%			
A planned caesarean delivery	10%	11%	11%	12%	↑	↑	
An emergency caesarean delivery	15%	14%	15%	16%	↑	↑	↑

Number of respondents: 2013 (22,472) 2015 (19,530) 2017 (18,233) 2018 (17,446)
Answered by all.

Most women said that they gave birth on a bed (83%). Ten per cent said they gave birth in water / a birthing pool and 4% on the floor.

Giving birth in an upright position may be more comfortable to women. Research such as a Cochrane review[39] shows that while it is beneficial to give birth in an upright position, since gravity supports a normal birth, many women still give birth lying down, which is a position more convenient for medical professionals. NICE clinical guidelines on intrapartum care for healthy women and babies state that assisted or instrumental births are only recommended when further help is needed if mother or baby are experiencing difficulties. Birthing positions can have an effect on women's experience of labour and feelings of being in control. The Royal College of Midwives acknowledges that midwives should play a proactive role in supporting women to choose the most comfortable position for them.[40] [41]

Most women who responded to the survey gave birth lying down, either with their legs in stirrups (36%, consistent with 2017 but up from 32% in 2013) or lying flat / supported by pillows (24%, consistent with 2017 but down from 26% in 2013).

C9. What position were you in when your baby was born?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Sitting / sitting supported by pillows	18%	17%	15%	15%	↓	↓	
On my side	5%	5%	5%	5%			
Standing, squatting or kneeling	15%	15%	17%	16%	↑	↑	
Lying flat / lying supported by pillows	26%	25%	24%	24%	↓	↓	
Lying with legs in stirrups	32%	35%	36%	36%	↑		
Other	3%	3%	4%	4%	↑	↑	

Number of respondents: 2013 (16,953) 2015 (14,681) 2017 (13,548) 2018 (12,600)
Answered by those who had a vaginal delivery.

We looked at the question asking women what type of delivery they had by the question asking women what position they were in when the baby was born. As might be expected, a high proportion of women who had an assisted delivery gave birth lying with legs in stirrups (89%). However, almost a quarter (23%) of women who had an unassisted vaginal delivery gave birth lying with legs in stirrups. This is contrary to best practice guidance, which recommends that women can move about throughout labour unless they need assistance.

C7. What type of delivery did you have? BY C9. What position were you in when your baby was born?

		C9. What position were you in when your baby was born?					
		Sitting/ sitting supported by pillows	On my side	Standing, squatting or kneeling	Lying flat/ lying supported by pillows	Lying with legs in stirrups	Other
C7. What type of delivery did you have?	Normal vaginal delivery	18%	6%	21%	27%	23%	5%
	Assisted vaginal delivery	4%	0%	0%	6%	88%	1%

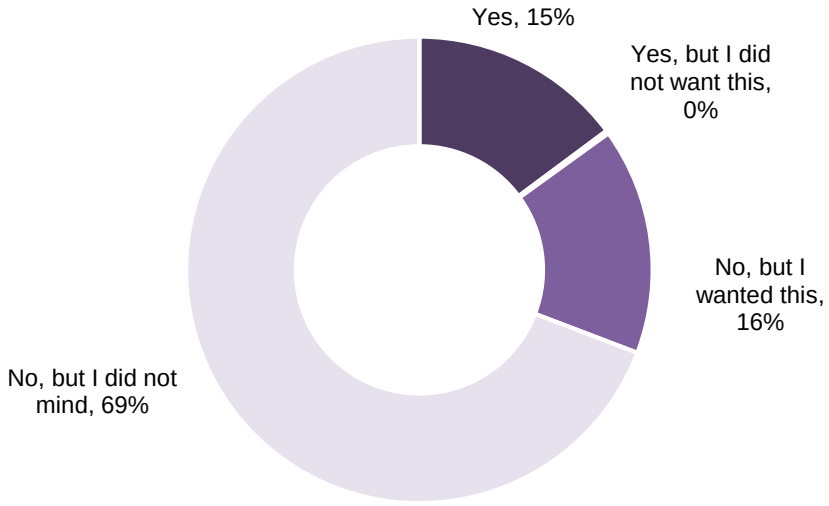
For analysis purposes these data have been weighted by population weight only.

Continuity of carer

Research evidence supporting Better Births shows it is important to women to be seen by the same midwife, or group of midwives, before the birth, and during labour (either by a known midwife, or by the same midwife throughout labour). Continuity of carer is also linked with safer and personalised care.

The survey asked women if any midwives who cared for them during labour and birth had been involved in their antenatal care. Fifteen per cent said that they had (unchanged from 2017), 16% said 'no, but I wanted this' (up from 14% in 2017) and 69% said 'no, but I did not mind' (down from 71% in 2017).

C13. Had any of the midwives who cared for you been involved in your antenatal care?



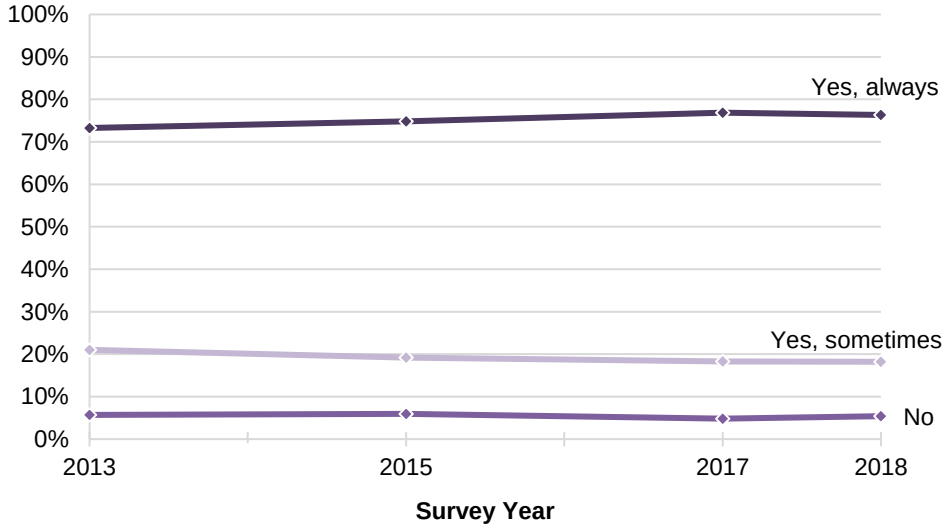
Number of respondents: 16,715.
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Involvement and support

All current national policy emphasises the importance of women feeling involved in their care. Research evidence supporting Better Births showed women want greater involvement in decisions. NICE clinical guidance on Intrapartum care for healthy women and babies notes the importance of ensuring that women feel in control and involved in what is happening to them. They should be involved in discussions and make informed decisions about their care. This might include discussions about their birth plan if they had one, different options for managing the stages of labour and discussions around any tests or interventions that might be suggested.

Just over three-quarters of women (76%) said that they were 'always' involved enough in decisions about their care during labour and birth. This is not a statistically significant change from 77% in 2017 but remains improved from 73% in 2013 and 75% in 2015.

C18. Thinking about your care during labour and birth, were you involved enough in decisions about your care?



Number of respondents: 2013 (21,801) 2015 (19,035) 2017 (17,728) 2018 (16,995)
Answered by all.
Respondents who answered that they didn't know / couldn't remember or did not want / need to be involved have been excluded.

Women should be encouraged to be supported by a companion of their choice. Guidance from the Royal College of Midwives describes how partners can provide important emotional support for women and their role should be encouraged.[42] Research evidence for Better Births found that some partners felt excluded and that their role was not recognised, and recommends that healthcare staff help to involve partners where appropriate.

Survey results were positive with most women (96% in 2018, up from 94% in 2013 and 95% in 2015) saying that their partner or someone else close to them was involved as much as they wanted.

All current national policy and guidance state that one-to-one midwifery care should be provided to women in established labour. A Cochrane review[43] looking at continuous support during labour suggests that this can improve outcomes for both mother and baby, for example, shorter duration of labour, and decreased caesarean birth, decreased instrumental vaginal birth.

Women were asked if they and / or their partner or a companion were left alone by midwives or doctors at a time when it worried them. Over three-quarters (77%) said this did **not** happen, unchanged from 2017 but still higher than 74% in both 2013 and 2015.

C14. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Yes, during early labour	14%	14%	12%	12%	↓	↓	
Yes, during the later stages of labour	10%	9%	8%	8%	↓	↓	
Yes, during the birth	2%	2%	2%	2%	↓	↓	
Yes, shortly after the birth	9%	9%	7%	8%	↓	↓	
No, not at all	74%	74%	77%	77%	↑	↑	

Number of respondents: 2013 (22,403) 2015 (19,521) 2017 (18,042) 2018 (16,956)
Answered by all.
Multiple response question - percentages may not sum to 100.

Just under two-thirds of respondents (65%) said that if they needed attention during labour and birth they were 'always' able to get a member of staff to help them within a reasonable time. Sixteen per cent said that they 'sometimes' could, 5% could not and 14% had a member of staff with them all the time.

NICE recommend that women are encouraged to have skin to skin contact (where the baby is placed naked, directly on their mothers naked chest or tummy) with their baby as soon as possible after the birth. Evidence suggests that this has a positive effect on mother and baby and can improve breastfeeding initiation and continuation rates.[44,45] Most women said this happened (92% in 2018, up from 89% in 2013 and 90% in 2015) leaving 7% who said this did not (down from 10% in 2013 and 9% in 2015)[p].

Communications and interactions

Better Births says that women's experiences of maternity services are a product of the quality of the care that staff provide. A good experience of care is therefore dependent on good relationships with staff. Effective communication will enable women to be involved in their care. Survey results in this area were generally positive with many women reporting good experiences.

The 'hello my name is' campaign encourages staff to introduce themselves as part of delivering personalised and compassionate care. Though the proportion of women who said that all staff treating and examining them introduced themselves increased between 2013 (82%), 2015 (83%) and 2017 (86%) the result for 2018 (85%) was not statistically significantly different from 2017.

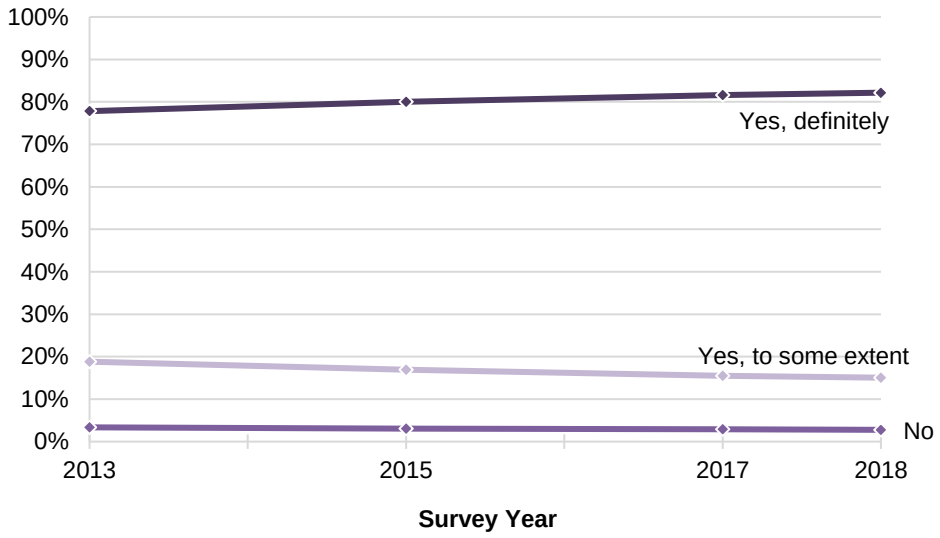
This year, just over four-fifths of women (82%) said that if they raised a concern during labour and birth it was taken seriously, meaning for 18% it was not.

[p] Respondents who stated that they did not want skin to skin contact with their baby or that this was not possible for medical reasons have been excluded.

Most women (88%) said that during labour and birth, they were 'always' spoken to in a way they could understand. Ten per cent 'sometimes' were and 1% were not. Figures have remained broadly static since 2015.

Most women (82%) 'definitely' had confidence and trust in the staff caring for them during their labour and birth, while unchanged from 2017 this remains up from 78% in 2013 and 80% in 2015.

C20. Did you have confidence and trust in the staff caring for you during your labour and birth?



Number of respondents: 2013 (22,463) 2015 (19,533) 2017 (18,194) 2018 (17,410)
Answered by all.
Respondents who answered that they didn't know / couldn't remember have been excluded.

The NICE quality standard for Patient experience in adult NHS services says people should be treated with '…*dignity, kindness, compassion, courtesy, respect, understanding and honesty*'. Most women (88%) said that they were 'always' treated with respect and dignity during labour and birth, while unchanged from 2017 this remains up from 85% in 2013 and 86% in 2015. In 2018 2% felt they were not treated with respect and dignity.

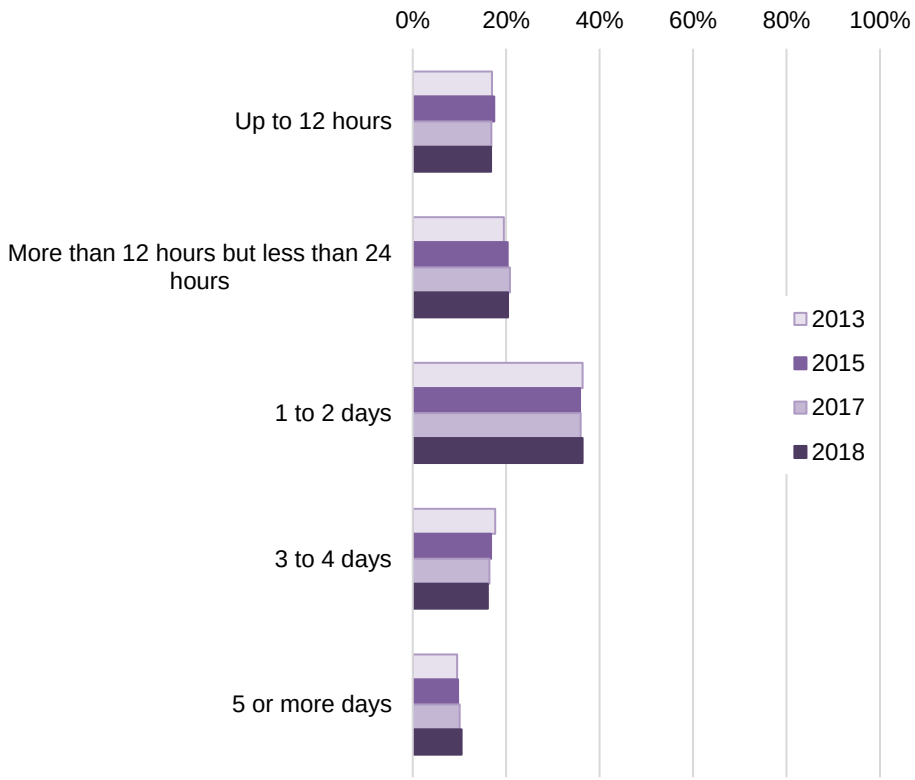
3. Postnatal care in hospital

Length of stay

The average length of stay in hospital for healthy women and babies has decreased over the previous few years with some women discharged six hours after the birth.[46] NICE clinical guidelines on Postnatal care up to 8 weeks after birth recommend that length of stay in hospital after the birth should be discussed with the woman, taking into account her health and the health of her baby, and the level of support available after discharge.

Most women (73%) who responded to the survey left hospital within two days of the birth.

D1. How long did you stay in hospital after your baby was born?



Number of respondents: 2013 (22,158) 2015 (19,289) 2017 (18,036) 2018 (17,120)
Answered by those who stayed in hospital after the birth.

Most women (72%) felt the amount of time spent in hospital following the birth was ‘about right’ with 11% feeling it was ‘too short’ and 17% ‘too long’. Results have shown almost no change between 2013 and 2018.

We looked at the question asking women how long they stayed in hospital after their baby was born by the question asking women how they felt about their length of stay in hospital. As the length of stay increases, the proportion of women who said it is ‘too long’ increases.

D1. How long did you stay in hospital after your baby was born? BY D2. Looking back, do you feel that the length of your stay in hospital after the birth was…

D2. Looking back, do you feel that the length of your stay in hospital after the birth was…	D1. How long did you stay in hospital after your baby was born?				
	Up to 12 hours	More than 12 hours but less than 24 hours	1 to 2 days	3 to 4 days	5 or more days
Too long	10%	14%	15%	23%	35%
Too short	15%	14%	13%	6%	3%
About right	75%	72%	73%	71%	63%

For analysis purposes these data have been weighted by population weight only.

More than two-fifths of women (45%) said that their discharge from hospital was delayed. Of the women who were delayed the main reason was waiting for checks to be done on the baby.

D4. What was the main reason for the delay?

	Survey year		Significant difference between 2018 and 2017
	2017	2018	
I had to wait for medicines	19%	21%	↑
I had to wait to see the midwife / doctor	23%	24%	
I had to wait for test results	10%	10%	
I had to wait for a check to be done on my baby	28%	27%	
Something else	19%	17%	↓

Number of respondents: 2017 (7,322) 2018 (7,039)

Answered by those who stayed in hospital after the birth and whose discharge was delayed.

Care and communication

NICE clinical guidelines on Postnatal care up to 8 weeks after birth states that postnatal care should be a continuation of the personalised care received antenatally and during labour and birth, with women having choice and involvement in decision making. Women should be able to talk about their experiences and ask questions.

The survey therefore asked questions about whether women received the care and information they needed while in hospital after the birth.

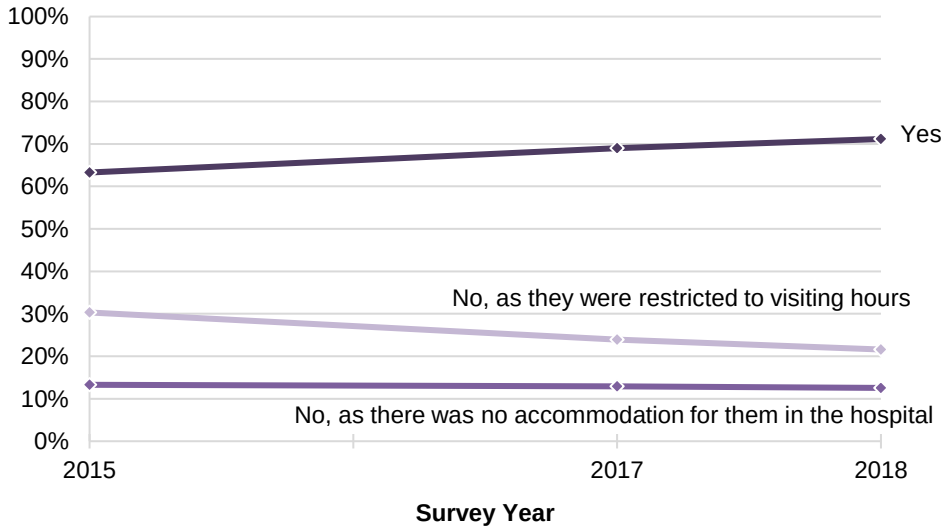
Though the proportion of women who said that that they were ‘always’ able to get a member of staff to help them in a reasonable time if they needed it increased between 2015 (54%) and 2017 (59%), this remained unchanged in 2018 (also 59%). In 2018,10% did not feel they could get help when they needed it, a figure which has remained the same since 2017; though has decreased since 2015 (13%).

Though there had been an upward trend in the proportion of women who said that while in hospital after the birth, they were ‘always’ given the information or explanations they needed, from 58% in 2013, to 62% in 2015 and 66% in 2017, this was not sustained with a small dip in 2018 to 65%. There was a corresponding decrease in the response for ‘yes sometimes’ (30% in 2013, 28% in 2015 and 26% in both 2017 and 2018). This leaves 9% who responded ‘no’ in 2018.

Similarly, though there had been an upward trend in the proportion of women who said that while in hospital after the birth, they were ‘always’ treated with kindness and understanding, from 65% in 2013, to 70% in 2015 and 74% in 2017, this remained unchanged in 2018 (also 74%). In 2018, 4% said they had not been treated with kindness and understanding.

There have been improvements in the proportion of women who said that their partner or someone else close to them were able to stay with them as much as they wanted, rising from 63% in 2015 to 69% in 2017 and 71% in 2018. There were associated decreases in the proportion who said they were restricted by visiting hours, decreasing from 30% in 2015, to 24% in 2017 and 22% in 2018.

D8. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?



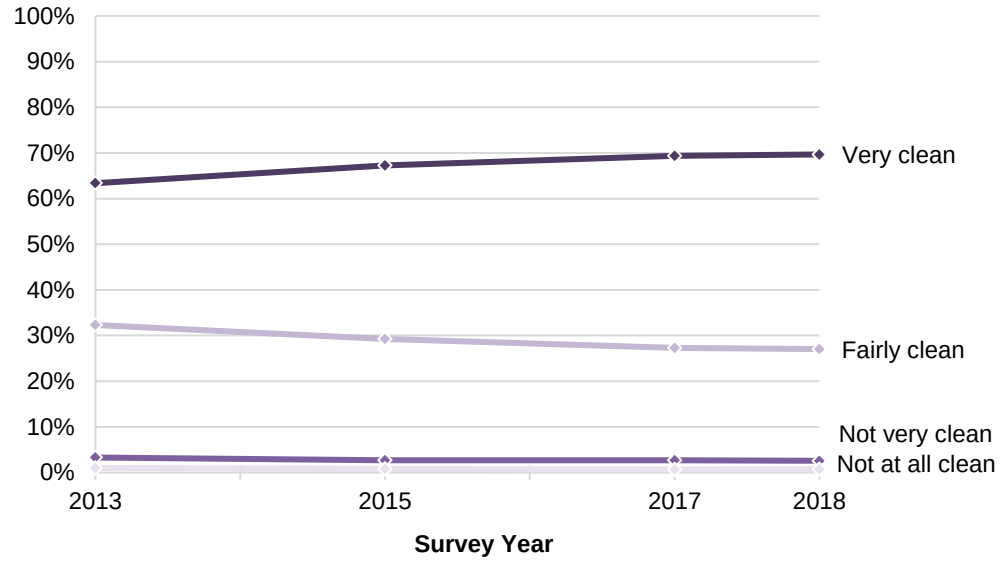
Number of respondents: 2015 (18,355) 2017 (17,129) 2018 (16,147)
Answered by those who stayed in hospital after the birth.
Multiple response question - percentages may not sum to 100.
Respondents who stated that their partner / companion was not able to stay for another reason, or that they did not have a partner / companion with them have been excluded.

Cleanliness

Cleanliness is essential to good infection control. The Code of Practice on the prevention and control of infections, under the Health and Social Care Act 2008 states that good infection prevention (including cleanliness) is essential to make sure that people who use health and social care services receive safe and effective care.[47] This is also reflected in the NHS Constitution, which states that people have the right to be cared for in an environment that is clean and safe.

Most women rated their hospital room or ward as 'very clean' (70%). While this is not a statistically significant change from 2017, it is higher than 2013 (63%) and 2015 (67%).

D9. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?



Number of respondents: 2013 (22,062) 2015 (19,192) 2017 (17,915) 2018 (17,017)
Answered by those who stayed in hospital after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded.

4. Infant feeding

There is evidence supporting the benefits of breast feeding which can have health benefits for both mother and baby. Therefore, national policy and guidelines promote breastfeeding. The NICE quality standard on breastfeeding recommends that women should be made aware of these benefits and those who choose to breastfeed should be supported to do so.

NICE clinical guidelines on antenatal care for uncomplicated pregnancies recommends breastfeeding should start during antenatal care at the booking appointment as well as later on in the pregnancy.

Just under three-fifths of women (57%) said that during their pregnancy midwives 'definitely' provided relevant information about feeding their baby. Twenty-eight per cent said they did 'to some extent' and 15% that they did not.

The first few hours and days after birth are critical for midwives providing new mothers with the care and support they need to breastfeed successfully.[48] Guidance from the Royal College of Midwives describes how midwives have a valuable role in providing support and advice to new mothers to encourage breast feeding such as by helping them to find a new position and adopting an 'enabling' approach.[49] To support this the World Health Organisation (WHO) have published 10 steps to improve breast feeding bringing together current evidence and best practice.

In the first few days after their baby was born, 58% of women fed them with breast milk only, 22% with both breast and formula (bottle) milk and 20% with formula (bottle) milk only.

Over half of respondents (56%) said that they 'always' received consistent advice about feeding their baby from midwives and other health professionals, which is a small decrease from 57% in 2017 though still higher than 54% in 2013. Seventeen per cent did not receive consistent advice (16% in 2017) and two per cent said that they did not receive any advice at all.

Just under two-thirds (63%) said that midwives and other health professionals 'always' gave them active support and encouragement about feeding their baby, a small decrease from 64% in 2017 though this remains higher than the 61% in 2013. Eleven per cent of women did not receive active support and encouragement about feeding their baby.

While new parents should be informed of the benefits of breastfeeding, women's choices about how to feed their baby must be respected. If they choose not to breastfeed, the position of the Royal College of Midwives is that they should be supported to feed their baby formula. [50]

Most respondents felt that their decisions about how to feed their baby were 'always' respected by midwives, while this showed an upward trend between 2013 (80%), 2015 (81%) and 2017 (83%) this was unchanged for 2018 (also 83%). Thirteen per cent responded 'sometimes' (15% in 2013 and 2015) and 4% said 'no'.

We looked at the question asking how women fed their baby in the first few days after the birth by the question asking if their decisions were respected by midwives. A higher proportion of women who breastfed felt that their decision was 'always' respected by the midwives.

E1. In the first few days after the birth how was your baby fed? BY E2. Were your decisions about how you wanted to feed your baby respected by midwives?

		E1. In the first few days after the birth how was your baby fed?		
		Breast milk (or expressed breast milk) only	Both breast and formula (bottle) milk	Formula (bottle) milk only
E2. Were your decisions about how you wanted to feed your baby respected by midwives?	Yes always	90%	67%	79%
	Yes sometimes	8%	26%	16%
	No	2%	8%	5%

For analysis purposes these data have been weighted by population weight only.

Evidence shows that though a high proportion of women start breastfeeding, very few continue for the six-month period which is recommended by the World Health Organisation (WHO). For example, the Infant Feeding Survey (2010)[51] reported that while 81% of mothers breastfed at birth, this dropped over time to 69% at one week, 55% at six weeks and to 34% at six months. It is therefore important that women continue to receive support in the early weeks after leaving hospital.

Sixty-two per cent of women said that in the six weeks after the birth of their baby they 'definitely' received help and advice from a midwife or health visitor about feeding their baby, a decrease from 64% in both 2015 and 2017. There was a corresponding increase in the proportion who said they received this help 'to some extent' (29% in 2018, 27% in 2017 and 26% in 2015) and 9% said they did not.

Over half of women felt that if they needed support or advice about feeding their baby during evenings, nights or weekends they could 'always' get this (54%). However, a quarter (25%) said they could not get this help, an increase compared with 2017 (22%).

5. Postnatal care at home

With a decline in the time spent in hospital following the birth, it is important that women receive quality care and support at home.

Better Births calls for more support for women at home after the birth, describing the current provision as *'under-resourced and overlooked and, in the view of the Chief Medical Officer, unfit for purpose. Commissioners and providers must attach sufficient importance to securing high-quality neonatal and postnatal care in order to give women and their babies the best start in family life*.' Personalised care should

continue at home with health professionals providing comprehensive support to new mothers and their babies.

This is supported by surveys of women which consistently report less positive experiences for care at home after the birth.[q]

NICE has set out quality standards for postnatal care needed by women and their babies in the six to eight-week period (longer if needed) following childbirth. This should include providing appropriate advice and support and assessing the health and needs of both the mother and baby.

Most women will be discharged from midwifery care to a health visitor in the few days following the birth. Local policy on this will vary but this is usually after ten days, though it might be later if the mother and / or baby need this support for longer. Though discharged, women may still be able to contact the midwife for advice if needed for up to 28 days after the birth. Therefore, some questions in this section of the questionnaire also ask about care from other health professionals.

Postnatal contact at home

NICE recommend that women and their babies should receive the number of postnatal contacts appropriate to their care needs. At these contacts women should be able to talk about their experience during labour and birth and be provided with relevant and timely information about their own and their babies' health and wellbeing.

The majority of women (95%) had been visited at home by a midwife though 2% said they had to ask for this. The proportion who received a visit without needing to request it has decreased over time from 95% in 2013 to 93% in 2018. The proportion of women who said they saw a midwife in a clinic remains small but has increased.

[q] For examples please see for appendix C.

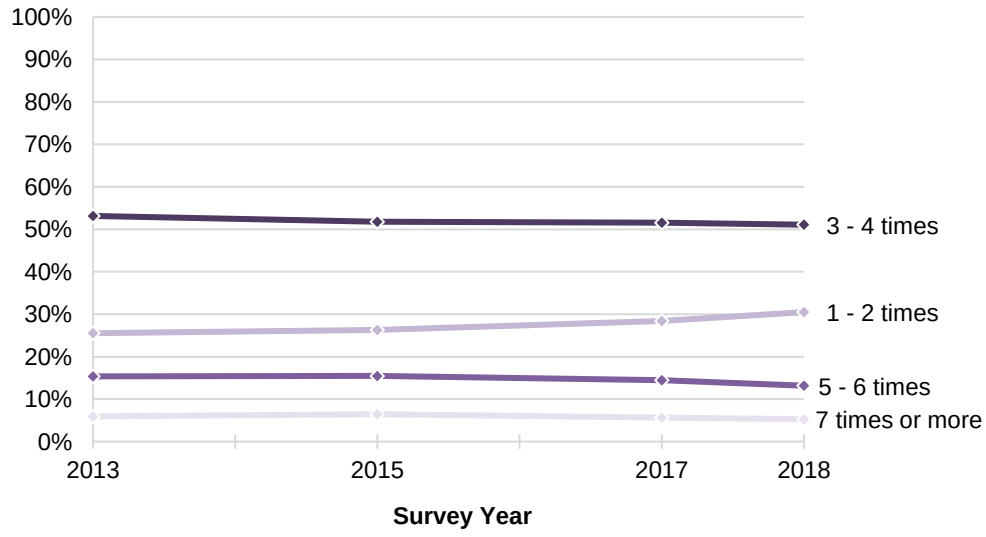
F4. Since your baby's birth have you been visited at home by a midwife?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Yes	95%	95%	94%	93%	↓	↓	↓
Yes, but I had to contact them to ask them to visit	2%	2%	2%	2%			
No, I visited the midwife / saw a midwife in clinic	1%	2%	2%	3%	↑	↑	↑
No, I was not offered a visit	0%	0%	0%	1%	↑	↑	
No, I was visiting or staying near my baby in a neonatal unit (NNU, NICU, SCBU)	1%	1%	1%	1%			
No, for another reason	0%	0%	0%	0%	↑		↑

Number of respondents: 2013 (22,551) 2015 (19,564) 2017 (18,258) 2018 (17,425)
Answered by all.

The survey results show an increase in the proportion of women who saw a midwife once or twice after going home, and a decrease in those seeing a midwife five or six times. Around half of women in 2018 (51%) saw a midwife three or four times.

F6. How many times in total did you see a midwife after you went home?



Number of respondents: 2013 (21,695) 2015 (18,684) 2017 (17,518) 2018 (16,621)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Just under three-quarters of women (73%) said that they saw a midwife as much as they wanted, a decrease from 75% in 2015 and 2017. There have been corresponding increases in the proportion of women who said they would like to see a midwife more often (20% in 2015, 21% in 2017 and 23% in 2018). Four per cent would have liked to have seen a midwife 'less often'.

We looked at the question asking how many times women saw a midwife after they went home by how they felt about the frequency that they saw the midwife. A higher proportion of women who saw a midwife 5-6 times, or 7 or more times, said that they saw the midwife as much as they wanted.

F6. How many times in total did you see a midwife after you went home? BY F7. Would you have liked to have seen a midwife...

		F6. How many times in total did you see a midwife after you went home?			
		1-2	3-4	5-6	7 or more
F7. Would you have liked to have seen a midwife...	More often	36%	20%	11%	8%
	Less often	2%	4%	8%	13%
	I saw a midwife as much as I wanted	62%	76%	81%	79%

For analysis purposes these data have been weighted by population weight only.

Choice

Good postnatal care should enable women to take part in the decision about where it takes place. Current policy emphasises choice and Better Births calls for women to have choice across the whole maternity pathway including during postnatal care. NICE guidance describes how appointments may occur in the woman or baby's home or another setting such as a GP practice or children's centre.

However, over half of the women who responded (58%) said that they were not given a choice about where their postnatal care would take place, up from 56% in 2017.

Continuity of carer

Better Births set out a vision for continuity of carer, and describes how each woman should be supported by a small team of midwives throughout her pregnancy and that this should continue into postnatal care. As discussed earlier in this report, Better Births links continuity of carer with safer care, individualised care and better relationships based on mutual trust.

The survey included a question asking if women saw the same midwife every time for their postnatal contacts. In 2018 just over a quarter of women (27%) saw the same midwife every time.

F5. Did you see the same midwife every time?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Yes	27%	29%	28%	27%		↓	
Yes, but would have preferred not to	1%	0%	0%	0%	↓		
No, but I wanted to	26%	26%	25%	26%			↑
No, but I did not mind	46%	45%	47%	46%		↑	

Number of respondents: 2013 (21,310) 2015 (18,439) 2017 (17,193) 2018 (16,318)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn't know / couldn't remember, only saw a midwife once, or did not see a midwife have been excluded.

Two-fifths (40%) of the women surveyed said that the midwives who cared for them postnatally had also been involved in their labour and/or antenatal care: Thirty-two per cent said they had been involved for their antenatal care only, 7% for their antenatal care and their labour and birth, and two per cent for their labour only. The remainder said that this did not happen, of whom 18% would have liked this continuity while 42% stated they did not mind.

Multi-professional working is a key theme in Better Births which calls for health professionals to work across boundaries to support women's choices and deliver safer personalised care. Research evidence supporting Better Births found that women wanted communication between healthcare professionals to be consistent and for them to communicate effectively with each other. Women did not want to have to repeat their story but for the healthcare professionals to have read their notes and to be aware of their medical history.

The survey included a question asking if the midwife or midwives they saw were aware of the medical history for them and their baby. Results have fluctuated slightly over time, but in 2018 the proportion of women saying their midwife was aware of medical histories was slightly lower than in any of the previous three surveys (76%).

F8. Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?

	Survey year				Significant difference between 2018 and		
	2013	2015	2017	2018	2013	2015	2017
Yes	77%	78%	77%	76%	↓	↓	↓
No	23%	22%	23%	24%	↑	↑	↑

Number of respondents: 2013 (20,674) 2015 (17,910) 2017 (16,690) 2018 (15,922)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Personalised care

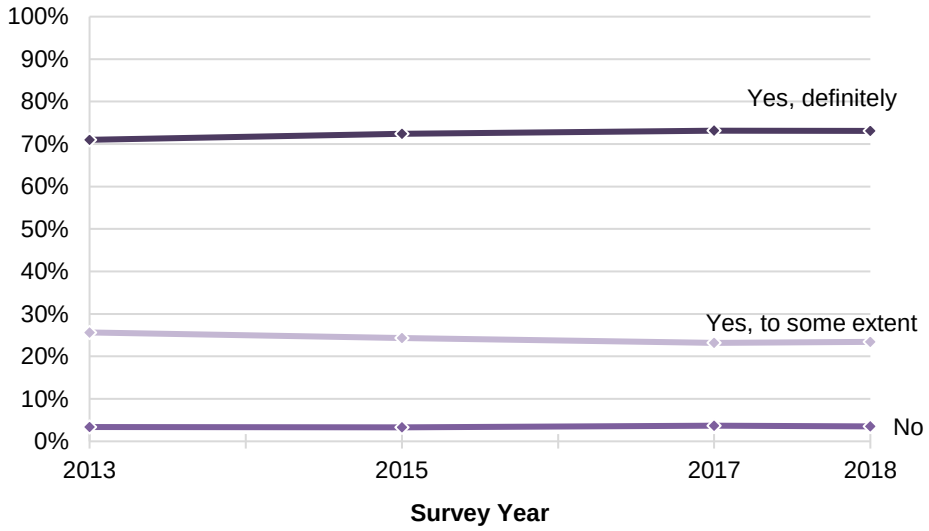
Current national maternity policy emphasises the importance of personalised care that is tailored to women's individual needs and circumstances.

More than three-quarters of women (78%) felt that the midwife or midwives they saw 'always' listened to them, which is the same as in 2017 though remains higher compared with 2013 (76%) and 2015 (77%). Three per cent of women did not feel listened to.

Three-quarters of women (75%) said that the midwife or midwives they saw 'always' took their personal circumstances into account when giving them advice. Though this increased between 2015 (73%) and 2017 (76%) the difference between 2017 and 2018 was not statistically significant. This leaves 20% in 2018 who responded 'sometimes' and 5% who felt the advice they were given did not take their personal circumstances into account.

Just under three-quarters of women (73%) 'definitely' had confidence and trust in the midwives they saw after going home, while this is higher than 71% in 2013, there has been no statistically significant improvement since then.

F11. Did you have confidence and trust in the midwives you saw after going home?



Number of respondents: 2013 (22,123) 2015 (19,177) 2017 (17,904) 2018 (17,037)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Analysis which compared the experiences of women in different subgroups asking whether they had confidence and trust in the midwives they saw at home showed that scores varied according to whether there was continuity of carer. Scores were above average for women who saw the same midwife during their antenatal care and saw the same midwife during their postnatal care. Please note, this does **not** mean these women saw the same midwife for both antenatal and postnatal care, though they might have done. In contrast, scores were below average for women

who did not see the same midwife throughout their antenatal care and who did not see the same midwife throughout their postnatal care.

Information

The NICE quality standard on postnatal care recommends that women should be offered information on how to contact a health professional if needed. The survey asks specifically about a contact number for a midwife or midwifery team and found that almost all women (96%) had a telephone number, unchanged from 2017.

Of the women who contacted a midwife or midwifery team, 76% 'always' got the help they needed, 18% 'sometimes' did, 3% did not and 3% said they were unable to make contact.

NICE clinical guidelines on Postnatal care up to 8 weeks after birth recommend that healthcare professionals give relevant and timely information to women so they can look after their own and their babies' health and wellbeing.

There has been a decrease in the proportion of women who said that they were 'definitely' given enough information about their own physical recovery after the birth from 57% in both 2015 and 2017 to 53% in 2018.

Seventy per cent of women said that in the six weeks after the birth of their baby they 'definitely' received help and advice from health professionals about their baby's health and progress. Just over a quarter (26%) said they received this 'to some extent' with 4% saying that they did not receive this.

NICE quality standards on contraception recommend that women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within seven days of delivery. Eighty-eight per cent were given information or offered advice from a health professional about contraception, leaving 12% who were not.

Ninety-two per cent were told by a midwife that at around 6-8 weeks after the birth they would need to arrange a postnatal check-up of their own health with their GP.

Overall, women who had one consistent midwife for antenatal care, and another consistent midwife for postnatal care were more positive about the information and communication they received for postnatal care than average.

Scores were above average for women who saw the same midwife during their antenatal care and saw the same midwife during their postnatal. Please note, this does **not** mean these women saw the same midwife for both antenatal and postnatal care, though they might have done.

Emotional support

Health professionals seen by women during their postnatal care have a key role in identifying mothers who are at risk or are suffering from any mental health problem, and ensuring they get any support or care they need.[52]

NICE clinical guidelines on Postnatal care up to 8 weeks after birth recommend that at each postnatal contact, women should be asked about their emotional wellbeing and support networks, and encouraged to talk about this with the health professional.

Almost all women (98%) said that a midwife or health visitor asked them how they were feeling emotionally, unchanged from 2017.

Fifty-six per cent were 'definitely' given enough information about any emotional changes they might experience after the birth, though this is down from 59% in 2017. Thirty-one per cent felt they received this 'to some extent' (29% in 2017) and 13% said that they did not receive this.

Over three-quarters of women (77%) said that they were told who to contact if they needed advice about any emotional changes they may experience after the birth, a small decline from 78% though up from 74% in 2015. This leaves almost a quarter of women (23%) in 2018 who were not told this.

6. How experience varies for different groups of women: subgroup analysis summary

This analysis compares how different women rated their experiences by using a multi-level model analysis. The subgroup analysis compares the mean scores for a subset of questions by different groups and allows us to explore the relationships between women's characteristics and their experiences.

The subgroups used in the analysis were: age, named midwife (this is inferred from responses to two questions: B8 for antenatal care and F5 for postnatal care), parity (whether women have had a previous baby or not), type of delivery (question C7), stirrups usage (question C9), ethnicity, religion, sexual orientation and long-term conditions. Please see Appendix G for more detail on the subgroups.

The themes used in the analysis and the questions these included are detailed below. They were selected as being key themes based on recent national policy, good practice guidance and the NHS Patient Experience Framework, which outlines elements important to a good patient experience.

The composites are:

- Choice (B4 and B7)
- Respect for patient-centred values (D7 and C19)
- Shared decision making – antenatal (B16)
- Shared decision making – labour and birth (C18)
- Involvement of partners or someone else close to them (C11 and D8)

- Confidence and trust – labour and birth (C20)
- Confidence and trust – postnatal (F11)
- Feeding support (E3, E4 and F15)
- Information, communication and education – antenatal (B6 and B10)
- Information, communication and education – labour and birth (C17 and D6)
- Information, communication and education – postnatal (F14 and F17)
- Staff availability (C14 and C16)

Subgroup analysis results

In this report, differences that are equivalent to at least **0.1** standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

Analysis of the experiences of different groups of women showed very few noteworthy differences. The only notable findings were for 'named midwife' suggesting the value ongoing relationships can have on certain aspects of women's experiences.

Appendix A provides more information about how the analysis was completed and the methodology of the subgroup analysis.

Appendix G provides more information about the questions used and the charts.

Named midwife status

Scores were above average for women who saw the same midwife during their antenatal care and saw the same midwife during their postnatal care for three themes: confidence and trust (postnatal), information communication and education (antenatal), information communication and education (postnatal). Please note, this does **not** mean these women saw the same midwife for both antenatal and postnatal care, though they might have done.

In contrast, scores were below average for women who did not see the same midwife throughout their antenatal care and who did not see the same midwife throughout their postnatal care for two themes: confidence and trust (postnatal), information communication and education (antenatal).

Religion

Scores were below average for women from the Jewish religion for one theme: feeding support.

Appendix A: Survey Methodology

This appendix summarises the survey methodology covering questionnaire design, sampling, fieldwork and analysis. For more detailed information, and for information on data limitations, please see the Quality & Methodology Report.

Questionnaire design

To make sure that the questionnaire is up-to-date and in line with current policy and practice, we review the questions before each survey to determine whether any new questions are needed.

Questionnaire development work makes sure that questions are important to people who use services and to other stakeholders who use the survey data in their work. More information on how survey stakeholders use the data is provided in Appendix D.

Wherever possible, questions remain the same over time to measure change. However, when necessary, we make changes to reflect changes in policy and methodological best practice, and to reflect feedback from stakeholders to make sure that questions stay relevant. The 2018 questionnaire was kept as similar as possible to that used in 2017 to enable comparisons. We added one new question to the 2018 questionnaire, and removed one question to create space. This new question aimed to assess continuity of carer across the maternity care pathway and asked women if any of the midwives who cared for them postnatally had also been involved in their labour and antenatal care. We made several minor amends to the question wording and response options for other questions.

All changes are detailed in the Survey Development Report.

Comparability with previous years

The maternity survey first ran in 2007 with other surveys being carried out in 2010, 2013, 2015 and 2017.

The survey questionnaire went under a major redevelopment ahead of the 2013 survey so results for 2018 are **only comparable** with 2013, 2015 and 2017.

Survey method

As with most surveys in the NHS Patient Survey Programme, the maternity survey used a postal methodology. However, to make the questionnaire as accessible as possible, people could complete it over the phone in a language other than English.

Sample members received their first survey pack containing a questionnaire, covering letter, leaflet offering guidance on multi-language options for completing the questionnaire, and a flyer outlining the value of the data to CQC. This was followed by a reminder, then a final reminder containing another survey pack. The average

time between each mailing was three weeks, allowing time to remove those who had since died or had opted-out from mailings.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between April 2018 and August 2018.

Sampling

Women aged 16 and over at the time of delivery were eligible to complete the survey if they had a live birth during the month of February 2018. Trusts with samples smaller than 300 were required to include women who gave birth during January 2018 also, starting with deliveries on 31 January and working back across the month until the sample size of 300 was achieved. Only women receiving care from an NHS trust were eligible.

Certain groups of women were excluded from the survey before providers drew their samples, including women whose baby had died, women who had a concealed pregnancy and women whose baby has been fostered or adopted.

Find more detailed information on the sampling for the survey in the instruction manual.

All NHS trusts providing maternity services and that had enough births were eligible to take part in the survey. Three trusts were unable to take part as they did not have enough births in January or February:

- South Tyneside NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Weston Area Health NHS Trust

No trusts were excluded from analysis because of sampling errors.

Analysis

Data cleaning

'Data cleaning' refers to all editing processes carried out on survey data once the survey has been completed and the data have been entered and collated. This is done to make sure that this is comparable across trusts. For further information please see the data cleaning document.

Weighting

Two weights were calculated for the England level data for the 2018 Maternity Survey:

1. A 'trust weight', which aims to weight responses from each trust to make sure that they have an equal influence over the England average. This means that the 129 trusts that participated contribute equally to the overall results for England regardless of differences in response rates.
2. A 'population weight', which aims to weight the results for each individual trust to that trust's eligible sample profile, with the intention of making each trust's results

representative of their own population. This involved weighting by age groups so that the weighted proportions in each age group in the respondent population match those in the sampled population. Therefore, increased weight given to groups that had a lower propensity to respond.

Both sets of weights are then multiplied together to produce a single combined weight for the data tables that underpin the analysis.

The demographic questions discussed in the 'who took part' section of this report (G1-G7 in the questionnaire) are not weighted, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than to adjust figures.

Rounding

The results present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%. Please note that rounding up or down may make differences between survey years appear bigger or smaller than they are.

Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2018 compared with the surveys conducted in 2017, 2015 and 2013.

A 'z-test' set to 95% significance was used to compare data between survey years. A statistically significant difference means that there is a less than 5% chance that we would have obtained this result if there was no real difference.

However, due to the relatively large number of respondents, small changes in results may show to be statistically significant. Such small changes do not necessarily indicate a longer-term trend.

Subgroup analysis and methodology

The multi-level analysis of subgroups highlights the experiences of different demographic sub-populations. Results for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a linear mixed effects model. These means were compared within themes, derived from composites of results from specific questions. This model considers trust-level effects, as trusts are likely to have an effect on reported patient experience at an England-level. Predictor variables were checked for multicollinearity to ensure coefficients could be accurately estimated. Differences of at least 0.1 standard deviations from the overall mean of the target variable, and with 95% confidence intervals that do not include the grand mean, are treated as being noteworthy.

Composites were created with questions relating to the NHS Patient Experience Framework. See Appendix G for the charts.

Appendix B: Other sources of data related to the key findings

There are multiple sources of data on maternity care. The information below provides links to some of these.

Please note that these data sources do not measure patient experience and are therefore not directly comparable with findings presented in this report. However, they provide useful contextual information.

NHS Outcomes Framework

The NHS Outcomes Framework provides national-level accountability for the outcomes that the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS.

The framework sets out the national outcome goals that the Secretary of State uses to monitor the progress of NHS England. It does not set out how these outcomes should be delivered.

Data from the NHS Patient Survey Programme are used to monitor Domain 4 'Ensuring that people have a positive experience of care'. This looks at the importance of providing a positive experience of care for patients, people who use services and carers.

For more information please see: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework

Staffing

Statistics on staffing numbers are provided in NHS Digital's statistical release on NHS Workforce Statistics. Please note this data covers all trust types (not just acute trusts with maternity services).

For more information, please see: http://digital.nhs.uk/workforce.

The Maternity and Children's Data Set

The Maternity and Children's Data Set has been developed to achieve better outcomes of care for mothers, babies and children.

It captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests.

For more information, please see: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-and-children-s-data-set.

Hospital Episode Statistics (HES Data)

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

The maternity publication describes activity in England and includes national and provider level information on delivery, mother's age, complications and more.

For more information please see: http://content.digital.nhs.uk/hes.

Live Births

The Office for National Statistics (ONS) publish annual statistics on live births by age of mother/father, sex, marital status, country of birth, socio-economic status, previous children and area.

For more information please see: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths.

National Perinatal and Maternity Audit

The National Maternity and Perinatal Audit (NMPA) is a national audit of the NHS maternity services across England, Scotland and Wales. It began in 2016 and was initially commissioned for three years.

The audit aims to produce high-quality information about NHS maternity and neonatal services which can be used by providers, commissioners and users of the services to benchmark against national standards and recommendations where these exist, and to identify good practice and areas for improvement in the care of women and babies.

For more information please see: www.maternityaudit.org.uk/pages/home.

Patient experience

NHS England publishes results from the Friends and Family Test (FFT). This is a single question feedback tool, which asks people whether they would recommend the service they have received to friends and family who need similar treatment or care.

For more information please see: www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/.

Appendix C: Other maternity surveys

There are many other surveys of maternity care and this appendix provides information about some of these.

Please note that different surveys use different methodologies, different questionnaires, have different aims and purposes and have been carried out at different points in time. This means that direct comparisons to this survey are not recommended.

England

The National Perinatal Epidemiology Unit *(*NPEU*)*

The NPEU has conducted a survey of women's experiences of maternity care in 2006, 2010, 2014 and 2018.[r] The aims of the survey are to inform policy in maternity care, support implementation and change and provide a further point of comparison for local surveys of user views and experiences in individual trusts.

It is a national population based survey and uses a random sample of 10,000 women giving birth in England over a two-week period, selected by the Office for National Statistics (ONS) from birth registration records. Women whose babies had died and new mothers less than 16 years of age were not included. The response rate was 47%.

The questionnaire used in 2014 is much longer than compared with the NHS Maternity Survey (26 pages) though the structure is similar and takes women through their pregnancy, labour and birth and postnatal care and allowed them to describe the care they had received. It included several additional sections on topics not included in the NHS Maternity Survey such as specialist neonatal care and partner involvement.

The 2018 survey results were not available at the time of writing this report. However, high level findings from the 2014 survey include that:

- Compared with earlier surveys in 2006 and 2010, women are realising they are pregnant and seeing a health professional earlier, with almost all respondents having sought care by 12 weeks.
- Postnatal hospital stays are continuing to get shorter and the number of postnatal visits is declining.
- Overall satisfaction with care remains high. However, as in earlier surveys, satisfaction with postnatal care is lower than that for antenatal care and care during labour and delivery.

For more information please see: www.npeu.ox.ac.uk/maternity-surveys

[r] Results due to be published early 2019

National Childbirth Trust (NCT)

The Women's Institute (WI) and the National Childbirth Trust (NCT) have carried out two surveys looking at women's experiences of maternity care. The second survey providing insights into key aspects of the experiences of 2,500 women who gave birth in England or Wales in 2014, 2015, and the first half of 2016. Findings are used to press for improvements in maternity services.

High level findings include that:

- Women are generally positive about the maternity care they receive and many praised the kindness and professionalism of the staff who cared for them.
- Half of all women surveyed had experienced a 'red flag event' such as not receiving one-to-one care during established labour or having to wait more than an hour to be washed or receive stitches after birth.
- Postnatal care remains an area of concern with no improvement in the percentage of women saying they were not able to see a midwife as much as they needed post-birth.

For more information please see:
www.nct.org.uk/sites/default/files/related_documents/Support_Overdue_2017.pdf

Infant Feeding Survey (IFS)

The IFS was conducted every five years since 1975. The 2010 IFS was the eighth and final. The main aim of the survey was to provide estimates on the incidence, prevalence, and duration of breastfeeding and other feeding practices adopted by mothers in the first eight to ten months after their baby was born.

For 2010 an initial representative sample of mothers was selected from all UK births registered during August and October 2010. A total of 10,768 mothers completed and returned three questionnaires which were sent when babies were 4-10 weeks old, 4-6 months old and 8-10 months old.

High level findings included that:

- Even though a high proportion of women start breastfeeding, very few continue for the six-month period which is recommended by the World Health Organisation (WHO): while 81% of mothers breastfed at birth, this dropped over time to 69% at one week, 55% at six weeks and to 34% at six months.
- Mothers who recalled receiving information on the benefits of breastfeeding were more likely than mothers who had not, to plan to breastfeed (77% compared with 66% respectively) and were more likely to initiate breastfeeding (83% compared with 73% of those who did not recall receiving information).

For more information please see: https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-uk-2010

Scotland

The Maternity Care survey carried out by the Scottish government is very similar to the CQC Maternity survey and covers the maternity care journey from antenatal care through to care at home after the birth. The questionnaire uses many of the questions from the English survey and has a similar methodology. The survey has run in 2013, 2015 and 2018.

The organisation and monitoring mechanisms of the maternity services in Scotland differ in some ways from those in England. However, policy aspirations for the quality of care remain the same: safe, effective and women centred maternity care.

The 2018 survey results were not available at the time of writing this report. However, high level findings from the previous survey published in 2015 were that:

- The survey found a very positive picture of women's experience of maternity care overall with very few differences in the findings from 2013.
- In most instances women report experiencing excellent care from staff who are listening to them and sensitive to their needs.
- As in 2013, postnatal care both in hospital and at home was rated less highly than other stages.

For more information please see:
www.gov.scot/Topics/Statistics/Browse/Health/careexperience

Wales

The first Maternity Survey for Wales (*Your Birth – We Care*) was published in October 2017. It was carried out as part of a plan to refresh the Strategic Vision for Maternity Services in Wales.

The results included responses from 3,968 mothers from all over Wales. It aimed to understand how women could best be supported to give birth outside of an obstetric unit by evaluating how well the current service provision prepared women for labour, birth and parenting.

High level findings included that women would like:

- to build relationships with knowledgeable, compassionate and kind midwives, to not only make women feel safe but enabling them to trust the information given to them;
- to have more information about the birthing options available to them, so that they can decide where to give birth, not health professionals;
- improved access to classes that adequately prepare them for birth;
- to have their choices respected, wherever they give birth.

For more information please see:
https://gov.wales/topics/health/professionals/nursing/early/?lang=en
https://gov.wales/newsroom/health-and-social-services/2017/maternity/?lang=en

Northern Ireland

The Women's Experiences of Maternity Care in Northern Ireland details the experiences of 2,722 women who gave birth between October 2014 and December 2016.

The questionnaire used was very similar to that developed by the National Perinatal Epidemiology Unit (NPEU) for their 2014 survey.

High level findings include that:

- Overall, women were largely positive about their experience of care.
- Areas for concern include that caesarean section rates remain high with just over half of these planned. Breastfeeding rates remain low and women identified many support mechanisms they used that could be built on in future services.
- Initial comparisons between Northern Ireland and England show that women's experiences are largely similar. However, there are some interesting differences, and overall women in Northern Ireland were less likely to report feeling involved in decision-making but were more satisfied with their postnatal care.

For more information please see:
www.npeu.ox.ac.uk/maternity-surveys/news/1123-survey-of-women-s-experiences-of-care-in-northern-ireland

International Surveys

This section highlights maternity surveys carried out by other countries. While results are not directly comparable because of different healthcare systems, and different survey methodologies, these other surveys may be of interest and a selection are briefly summarised below.

Australia

The Maternity Care Survey was carried out in New South Wales in 2015 and 2017 and covers the maternity care journey from antenatal care through to care at home after the birth.

For more information please see:
www.bhi.nsw.gov.au/nsw_patient_survey_program/maternity_care_survey
www.bhi.nsw.gov.au/media/2017/women_review_maternity_care_in_nsw_public_hospitals

Canada

The Maternity Experiences Survey (MES) is a national survey of Canadian women's experiences, perceptions, knowledge and practices before conception and during pregnancy, birth and the early months of parenthood. Surveys were carried out in 2006 and 2007.

For more information please see: www.canada.ca/en/public-health/services/injury-prevention/health-surveillance-epidemiology-division/maternal-infant-health/canadian-maternity-experiences-survey.html

Appendix D: Main uses of the survey data

This appendix lists known users of data from the maternity survey and how they use the data.

Care Quality Commission (CQC)

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data is used in CQC Insight, an intelligence tool that indicates potential changes in the quality of care to support decision-making about our regulatory response. Survey data will also form a key source of evidence to support the judgements and inspection ratings published for trusts.

For more information please see:
www.cqc.org.uk/what-we-do
www.cqc.org.uk/guidance-providers/nhs-trusts/how-we-monitor-inspect-nhs-trusts

Department of Health and Social Care

The government's strategy sets out a commitment to measure progress on improving people's experiences through Domain 4 of the NHS Outcomes Framework 'ensuring people have a positive experience of care', which includes results from the maternity survey, among other data sources.

The Framework sets out the outcomes and corresponding indicators that the Department of Health and Social Care uses to hold NHS England to account for improvements in health outcomes, as part of the government's Mandate to NHS England. The Outcomes Framework survey indicators are based on the standardised, scored trust level data from the survey (like that included in CQC benchmark reports), rather than the England level percentage of respondent's data that is in this report.

For more information please see: www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

NHS England

NHS England use data from the maternity survey to produce two indicators in the Clinical Commissioning Group (CCG) Improvement and Assessment Framework. The indicators form part of an overall assessment of CCGs and the results are published on MyNHS (more information is available at www.england.nhs.uk/commissioning/ccg-assess/). The Maternity Transformation Programme has recently developed a set of National Maternity Indicators, which will feature as part of upcoming maternity data viewer to help maternity providers identify unwarranted variation.

NHS Improvement

NHS Improvement will use the results to inform quality and governance activities as part of its Oversight Model for NHS Trusts.

For more information please see: https://improvement.nhs.uk/

NHS trusts and commissioners

Trusts, and those who commission services, use the results to identify and make the changes they need to improve the experience of people who use their services.

Patients, their supporters and representative groups

The survey data is made available on CQC's website for each participating NHS trust, under the organisation search tool. The data is presented in an accessible format to enable the public to examine how services are performing, alongside their inspection results. The search tool is available at: www.cqc.org.uk.

Appendix E: Revisions and corrections

CQC publishes a Revisions and Corrections Policy relating to these statistics. Maternity Survey data is not subject to any scheduled revisions as it captures the views of women about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised.

This policy sets out how CQC will respond if an error is identified in any survey and it becomes necessary to correct published data and/or reports.

Appendix F: Further information and feedback

Further information

Results for NHS trusts can be found on CQC's website. You can also find a 'technical document' here, which describes the methodology for producing trust level results, and a 'quality and methodology' document, which provides information about survey methodology.

The **results for England** from previous maternity surveys that took place in 2007, 2010, 2013, 2015 and 2017 are available at www.nhssurveys.org/surveys/299.

The **trust results** from previous maternity surveys are available at:
2007: www.nhssurveys.org/surveys/312
2010: www.nhssurveys.org/surveys/575
2013: www.nhssurveys.org/surveys/734
2015: www.nhssurveys.org/surveys/876
2017: www.nhssurveys.org/surveys/1132

Please note: The questionnaire went under a major redevelopment in 2013 meaning the England and trust level results for 2018 are only comparable with 2013, 2015 and 2017.

Full details of the methodology for the survey, including questionnaires, letters sent to women, instructions on how to carry out the survey and the survey development report, are available at www.nhssurveys.org/surveys/1168.

More information on the NHS Patient Survey Programme, including results from other surveys and a schedule of current and forthcoming surveys can be found at www.cqc.org.uk/surveys.

Further questions or feedback

This summary has been produced by CQC's Survey Team and reflects the findings of the maternity survey 2018. The guidance above should help answer any questions about the programme and you are advised to review that information carefully. However, if you wish to contact the team directly, please contact Tamatha Webster, Survey Manager, Patient.Survey@cqc.org.uk.

We welcome all feedback on the survey findings and the way we have reported the results, particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how this publication could be improved, please contact Patient.Survey@cqc.org.uk.

CQC will review your feedback and use it as appropriate to improve the statistics that we publish across the NHS Patient Survey Programme.

If you would like to be involved in consultations or receive updates on the NHS Patient Survey Programme, please subscribe here: www.cqc.org.uk/ surveys.

National Statistics Status

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

It is a producer's responsibility to maintain compliance with the standards expected of National Statistics, and to improve its statistics on a continuous basis. If a producer becomes concerned about whether its statistics are still meeting the appropriate standards, it should discuss its concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

Appendix G: Subgroup analysis charts

The Equality Act 2010 requires that public bodies have due regard to eliminate discrimination, and to advance equality of opportunity by fostering good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, marriage, and civil partnership. The Act provides an important legal framework that should improve the experience of all people using NHS services.

We include additional analysis to compare how different groups of people using maternity services rated their experience by using a multilevel model analysis.

This subgroup analysis compares the mean scores for a subset of questions by different groups. With this model, we can more effectively explore the relationships between respondent characteristics and their experiences.

The analysis modelled the mean scores[s] of different subgroups for a set of composite questions based on the NHS Patient Experience Framework.

The subgroups used in the analysis were:

- **Age group:** 16 - 26 year, 27 - 32 year and 33+ year olds
- **Named midwife** (derived from questions B8 and F5): saw the same midwife for antenatal care and saw the same midwife for postnatal care (answered 'yes to both B8 and F5. Please note, this does **not** mean these women saw the same midwife for both antenatal and postnatal care, though they might have done), saw the same midwife for antenatal care only (answered 'yes' to B8 only) saw the same midwife for postnatal care only (answered 'yes' to F5 only) did not see the same midwife (did not respond 'yes' at B8 or F5).
- **Parity:** whether women have had a previous baby 'multiparous' or not 'primiparas'
- **Type of delivery** (question C7): a normal vaginal delivery, an assisted vaginal delivery (e.g. with forceps or ventouse suction cup, a planned caesarean delivery or an emergency caesarean delivery
- **Stirrups usage** (question C9): delivered without stirrups or delivered in stirrups
- **Ethnicity**: White, Mixed, Asian or Asian British, Black or Black British, Arab or other ethnic group, Not known
- **Religion:** No religion, Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, Other, I would prefer not to say
- **Sexual orientation:** Heterosexual / straight, Gay / lesbian, Bisexual, Other, I would prefer not to say
- **Long-term condition:** Deafness or severe hearing impairment, Blindness or partially sighted, A long-standing physical condition, A learning disability, A mental health condition, A long-standing illness, No long-standing illness

[s] The sum of question scores divided by the number of questions in the composite.

The composites are:

Choice

- B4: Were you offered any of the following choices about where to have your baby?
- B7: During your pregnancy were you given a choice about where your antenatal check-ups would take place?

Respect for patient-centred values, preferences, and expressed needs

- D7: Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
- C19: Thinking about your care during labour and birth, were you treated with respect and dignity?

Shared decision making (antenatal)

- B16: Thinking about your antenatal care, were you involved enough in decisions about your care?

Shared decision making (labour and birth)

- C18: Thinking about your care during labour and birth, were you involved enough in decisions about your care?

Involvement of partners or someone else close to them

- C11: If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- D8: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as they wanted?

Confidence and trust (labour and birth)

- C20: Did you have confidence and trust in the staff caring for you during your labour and birth?

Confidence and trust (postnatal)

- F11: Did you have confidence and trust in the midwives you saw after going home?

Feeding support

- E3: Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?
- E4: Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?
- F15: In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Information, communication and education (antenatal)

- B6: Did you get enough information from either a midwife or doctor to help you decide where to have your baby?

- B10: During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Information and communication (labour and birth)

- C17: Thinking about your care during labour and birth, were you spoken to in a way you could understand?
- D6: Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Information and communication and (postnatal)

- F14: Were you given enough information about your own physical recovery after the birth?
- F17: In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

Staff availability

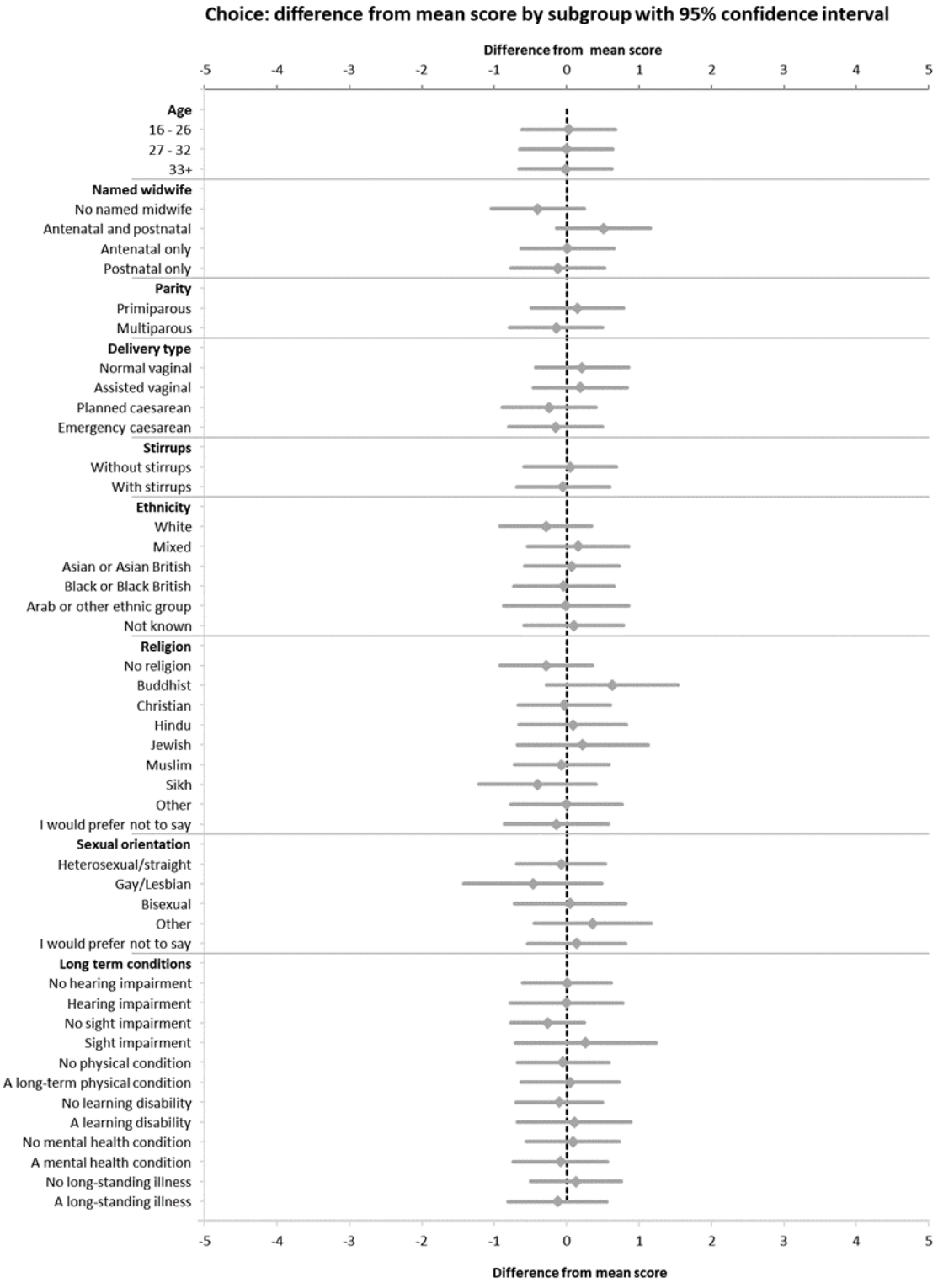
- C14. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? (Cross ALL that apply)
- C16. If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time?

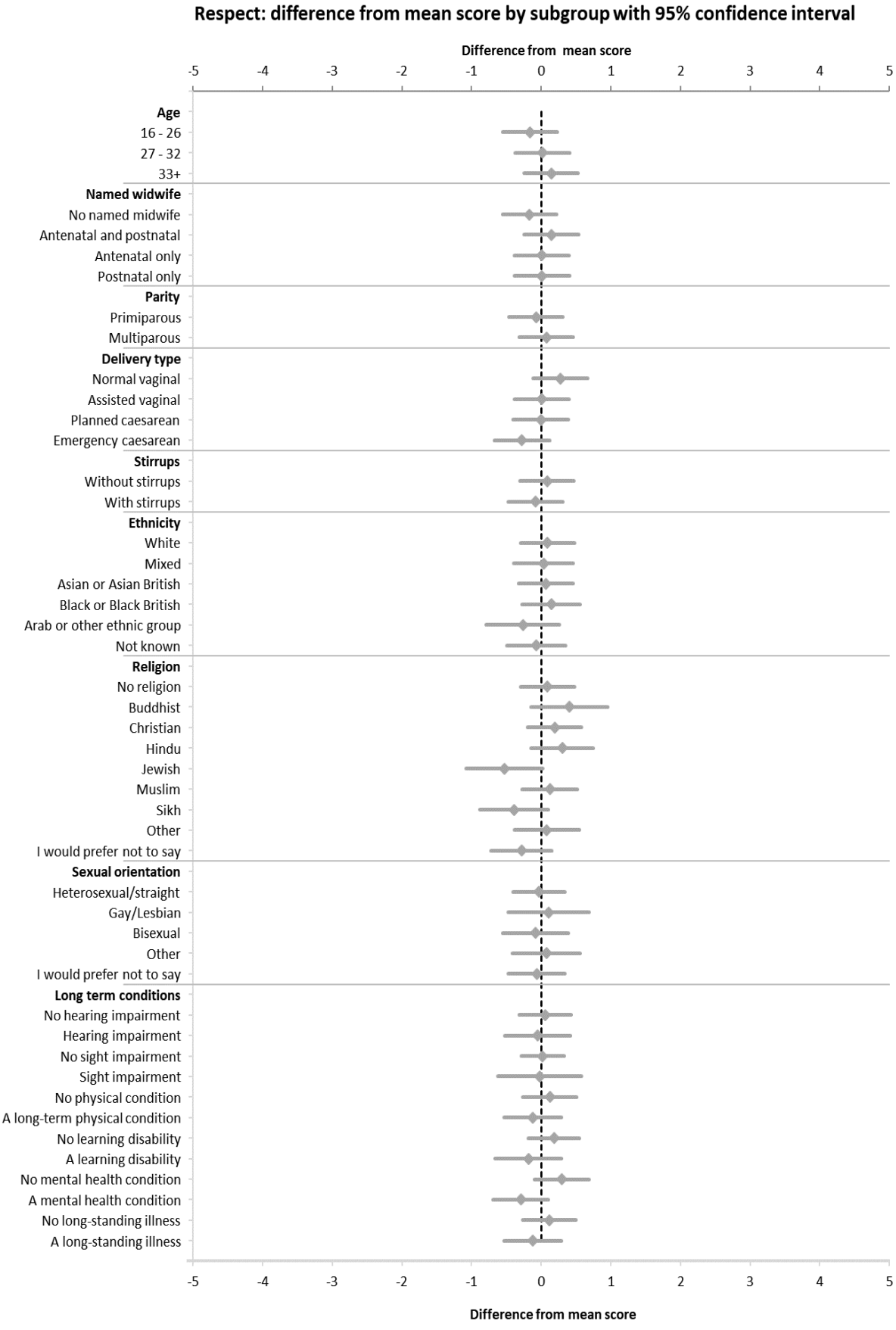
Interpreting the charts

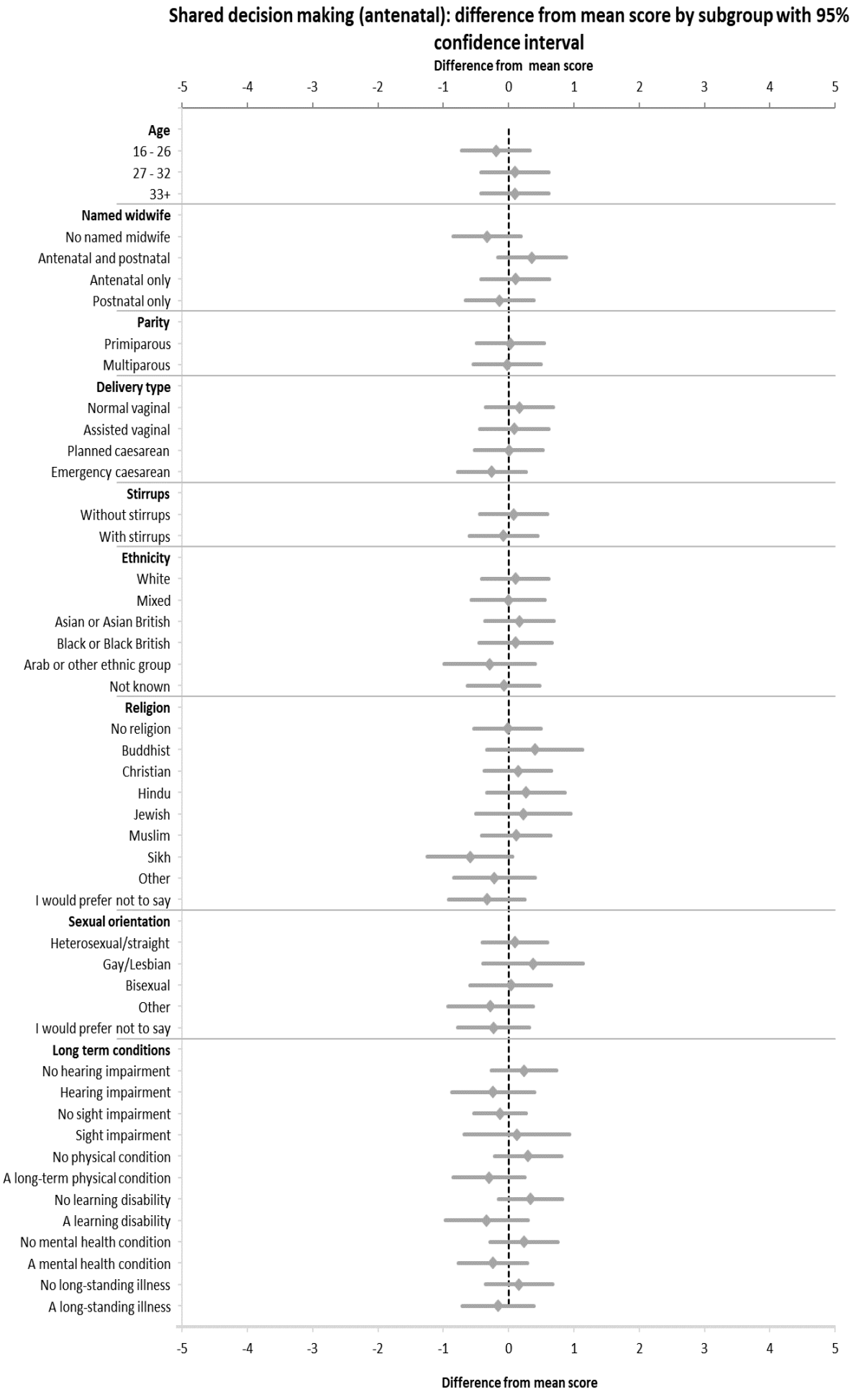
In this report, differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

For more information about how the analysis was completed or about the methodology of the subgroup analysis, see Appendix A.

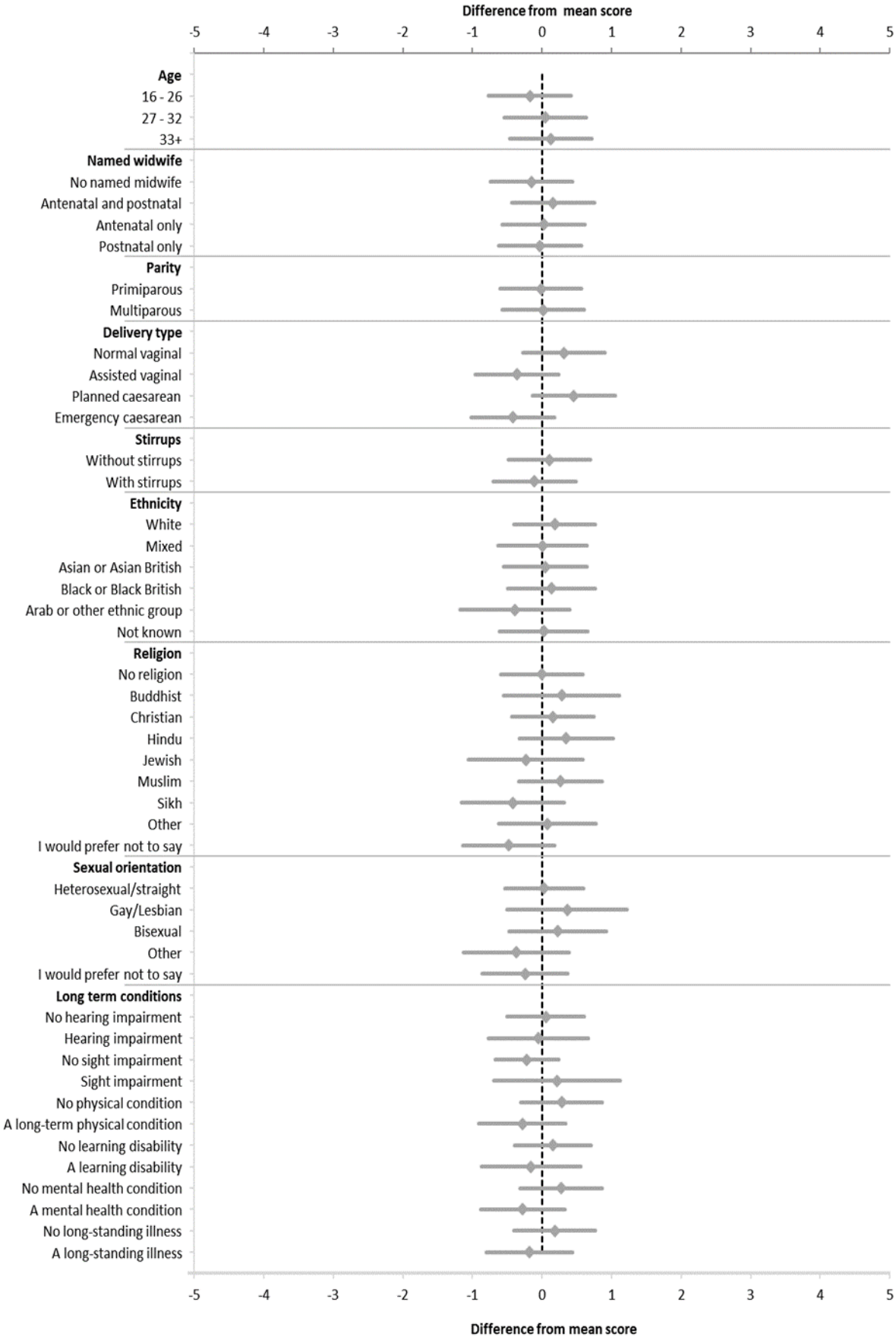
The graphs in this section highlight better than average experiences that are significant in green. Significant worse than average experiences are highlighted in orange.


Choice: difference from mean score by subgroup with 95% confidence interval
Difference from mean score
-5
-4
-3
-2
-1
0
1
2
3
4
5
Age
16 - 26
27 - 32
33+
Named widwife
No named midwife
Antenatal and postnatal
Antenatal only
Postnatal only
Parity
Primiparous
Multiparous
Delivery type
Normal vaginal
Assisted vaginal
Planned caesarean
Emergency caesarean
Stirrups
Without stirrups
With stirrups
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/Lesbian
Bisexual
Other
I would prefer not to say
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No long-standing illness
A long-standing illness
Difference from mean score

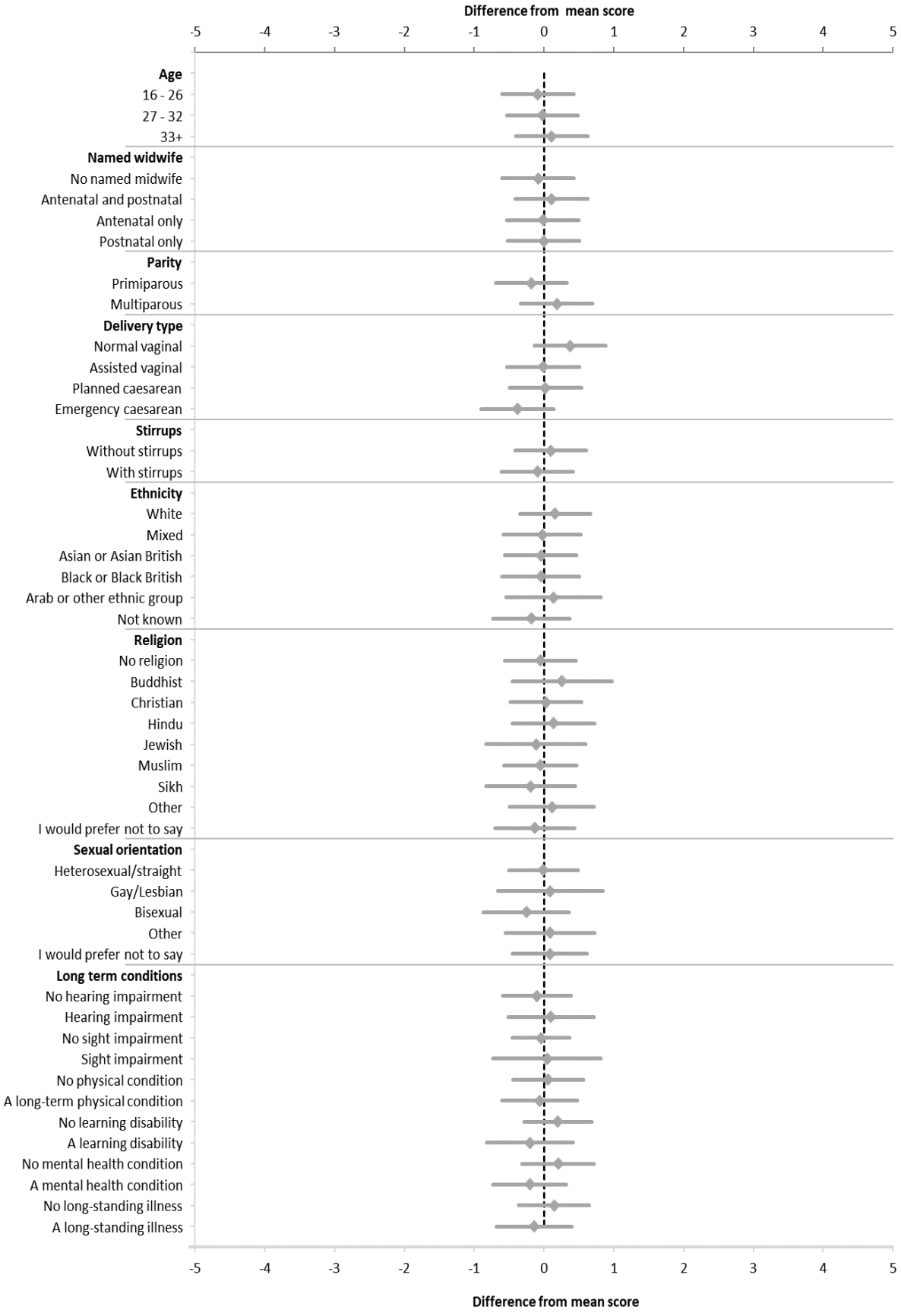

Respect: difference from mean score by subgroup with 95% confidence interval
Difference from mean score
-5
-4
-3
-2
-1
0
1
2
3
4
5
Age
16 - 26
27 - 32
33+
Named widwife
No named midwife
Antenatal and postnatal
Antenatal only
Postnatal only
Parity
Primiparous
Multiparous
Delivery type
Normal vaginal
Assisted vaginal
Planned caesarean
Emergency caesarean
Stirrups
Without stirrups
With stirrups
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/Lesbian
Bisexual
Other
I would prefer not to say
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No long-standing illness
A long-standing illness
Difference from mean score


Shared decision making (antenatal): difference from mean score by subgroup with 95% confidence interval
Difference from mean score
-5
-4
-3
-2
-1
0
1
2
3
4
5
Age
16 - 26
27 - 32
33+
Named widwife
No named midwife
Antenatal and postnatal
Antenatal only
Postnatal only
Parity
Primiparous
Multiparous
Delivery type
Normal vaginal
Assisted vaginal
Planned caesarean
Emergency caesarean
Stirrups
Without stirrups
With stirrups
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/Lesbian
Bisexual
Other
I would prefer not to say
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No long-standing illness
A long-standing illness
Difference from mean score

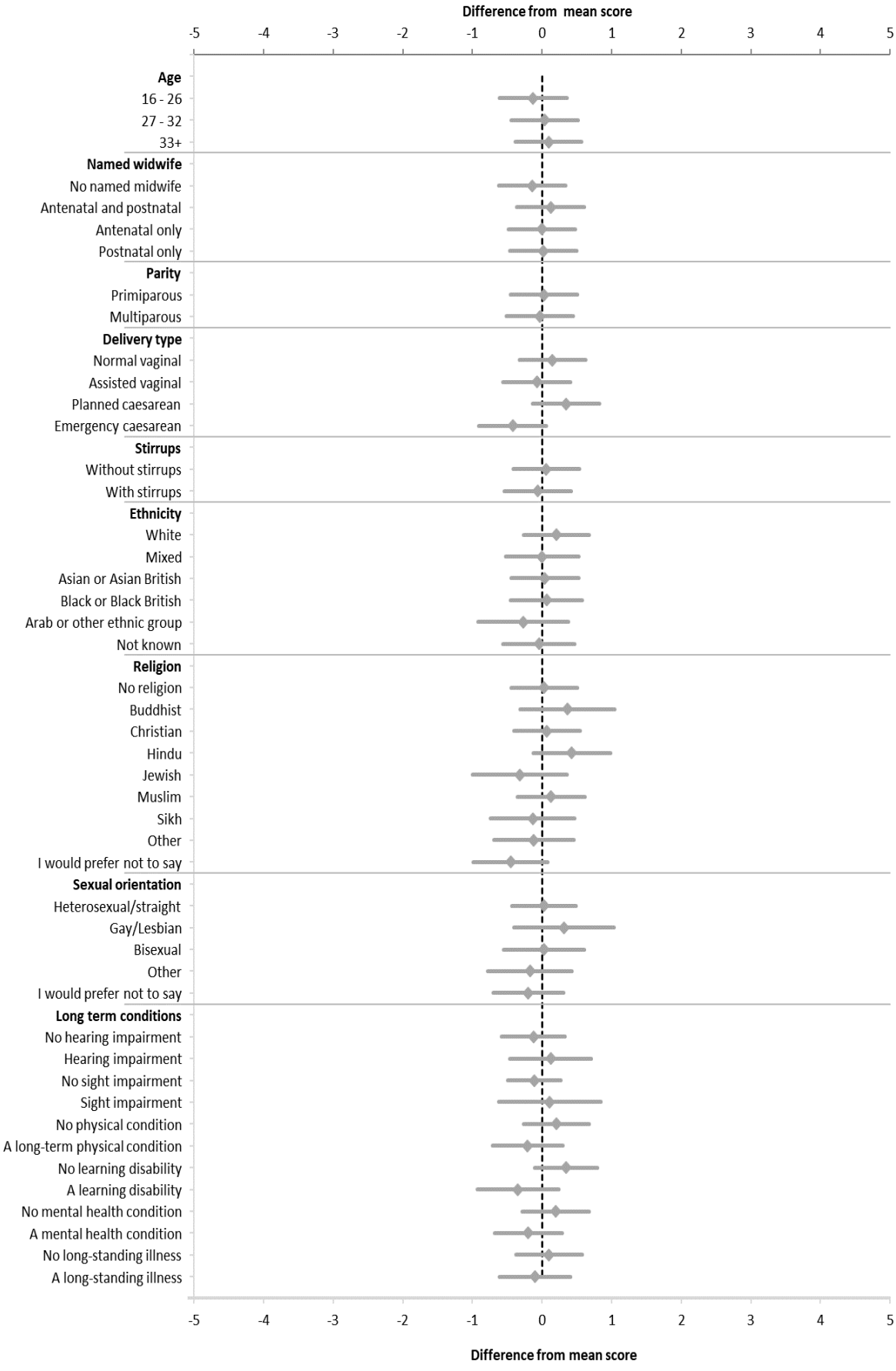
Shared decision making (labour and birth): difference from mean score by subgroup with 95% confidence interval



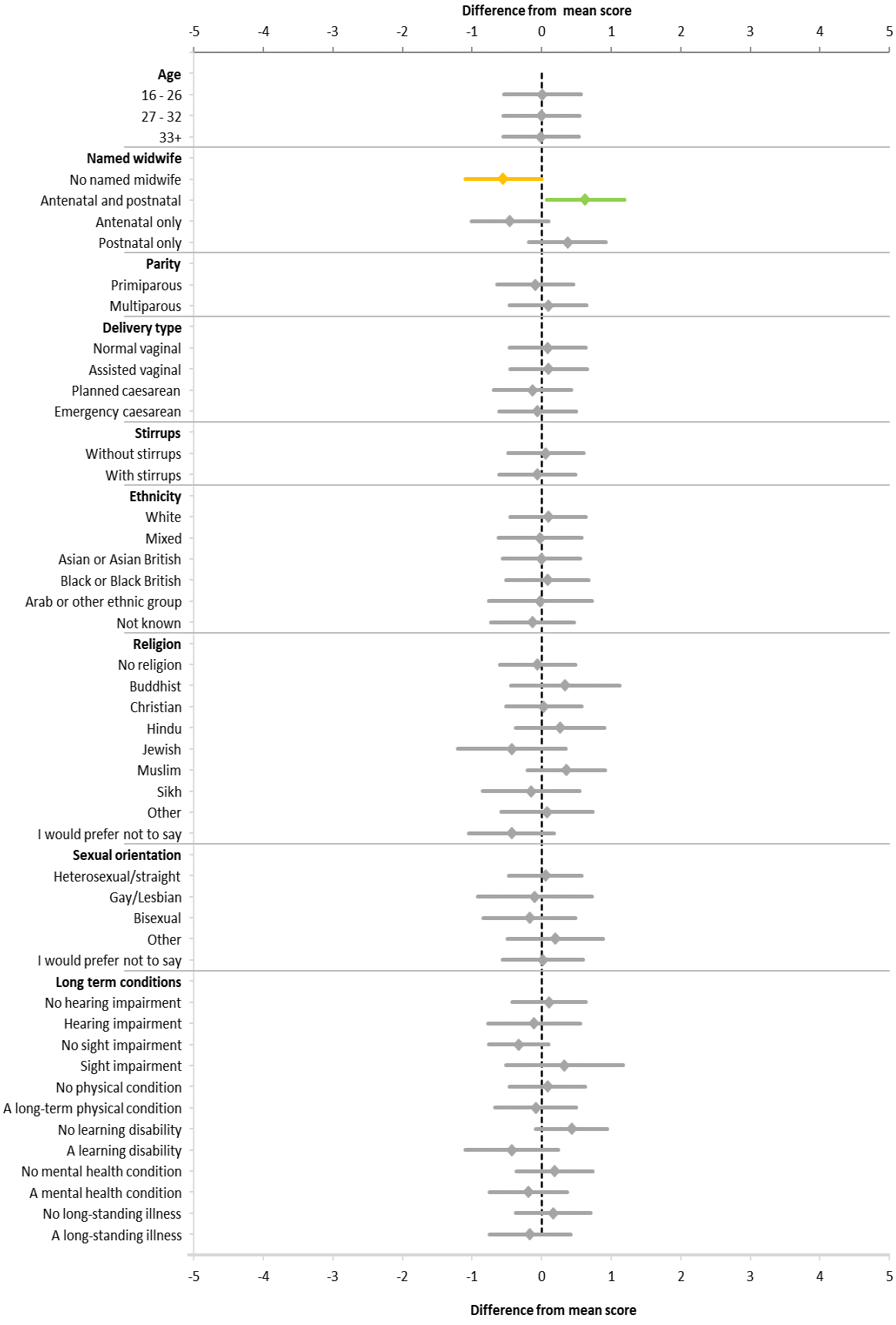
Involvement: difference from mean score by subgroup with 95% confidence interval



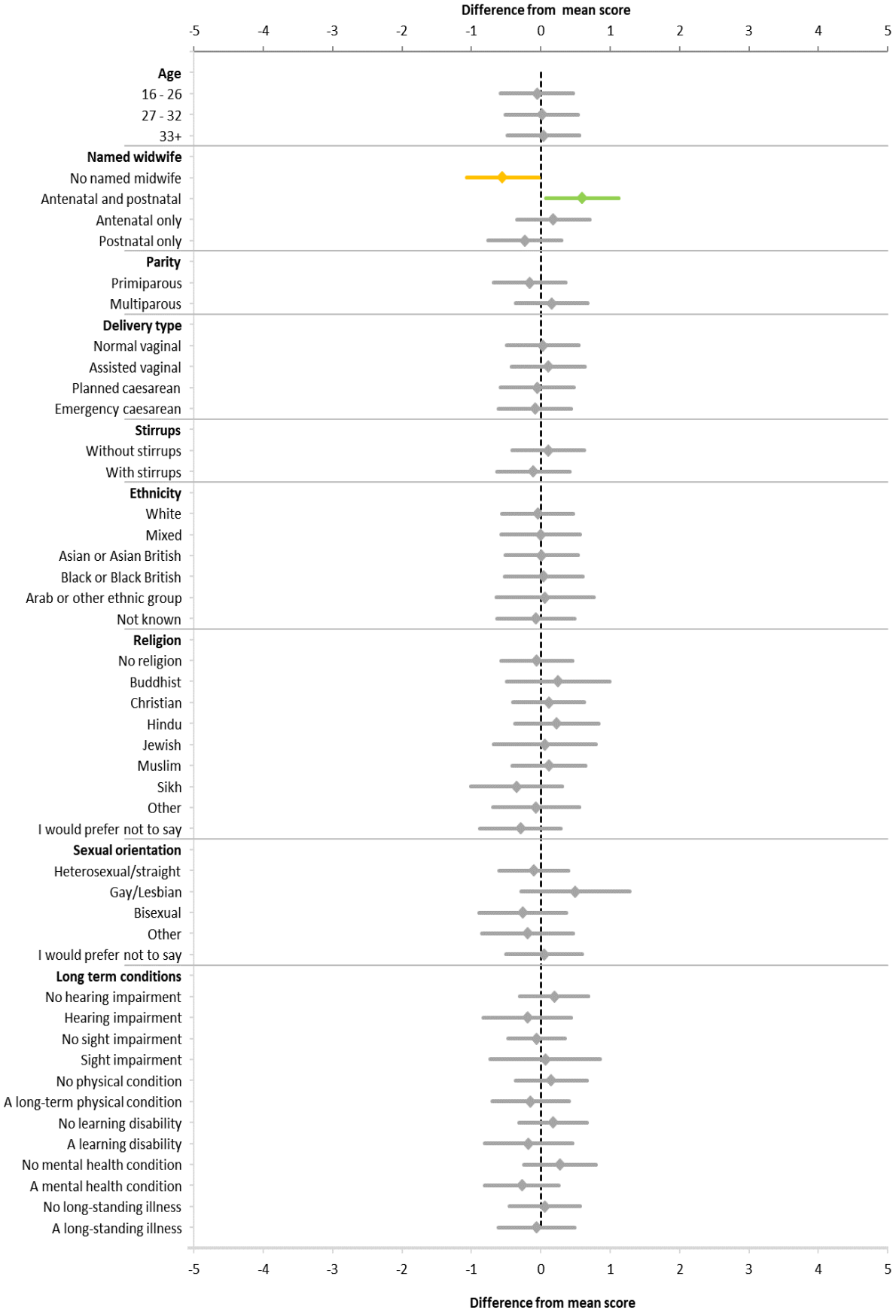
Confidence and trust (labour and birth): difference from mean score by subgroup with 95% confidence interval



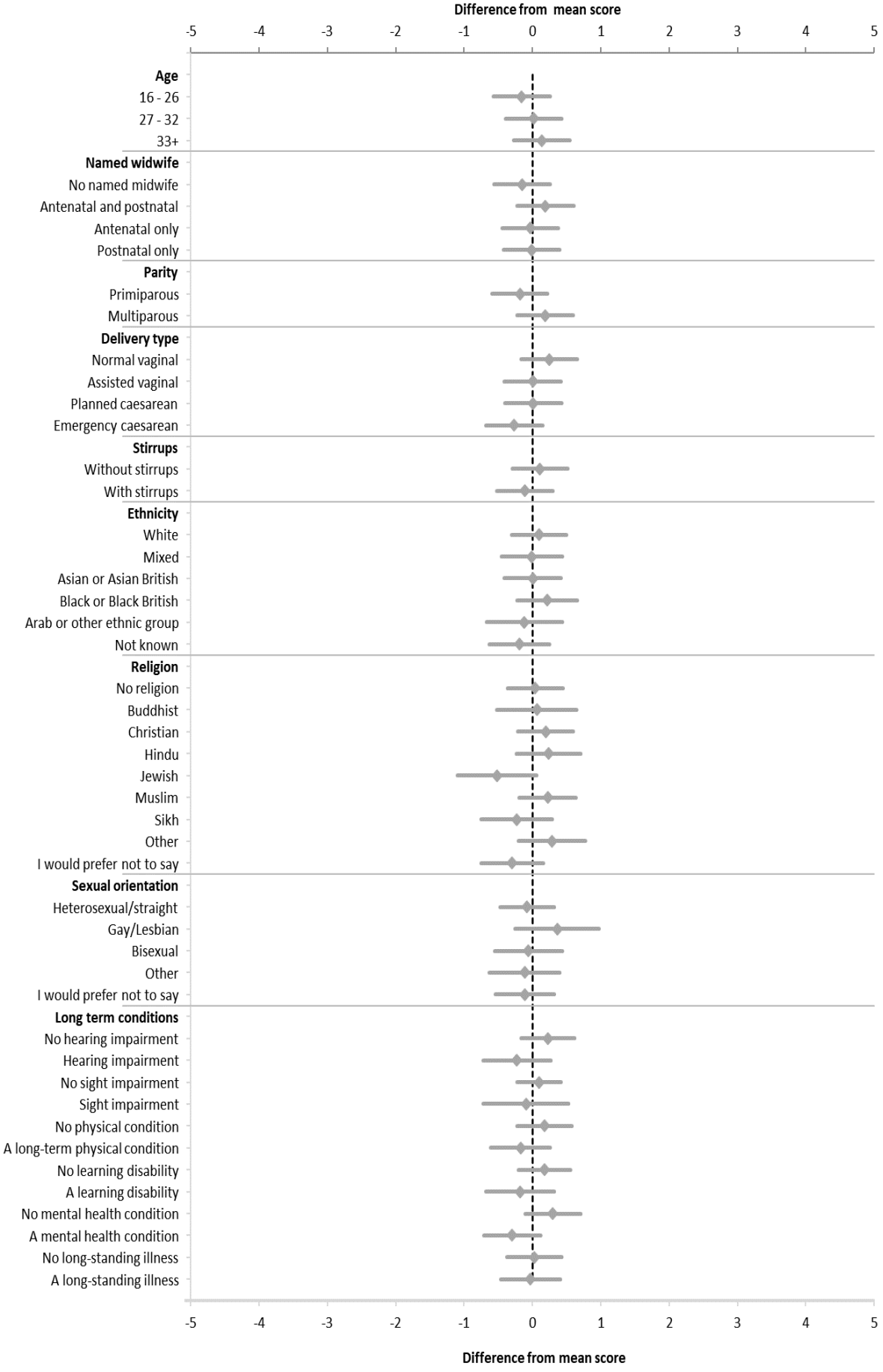
Confidence and trust (postnatal): difference from mean score by subgroup with 95% confidence interval



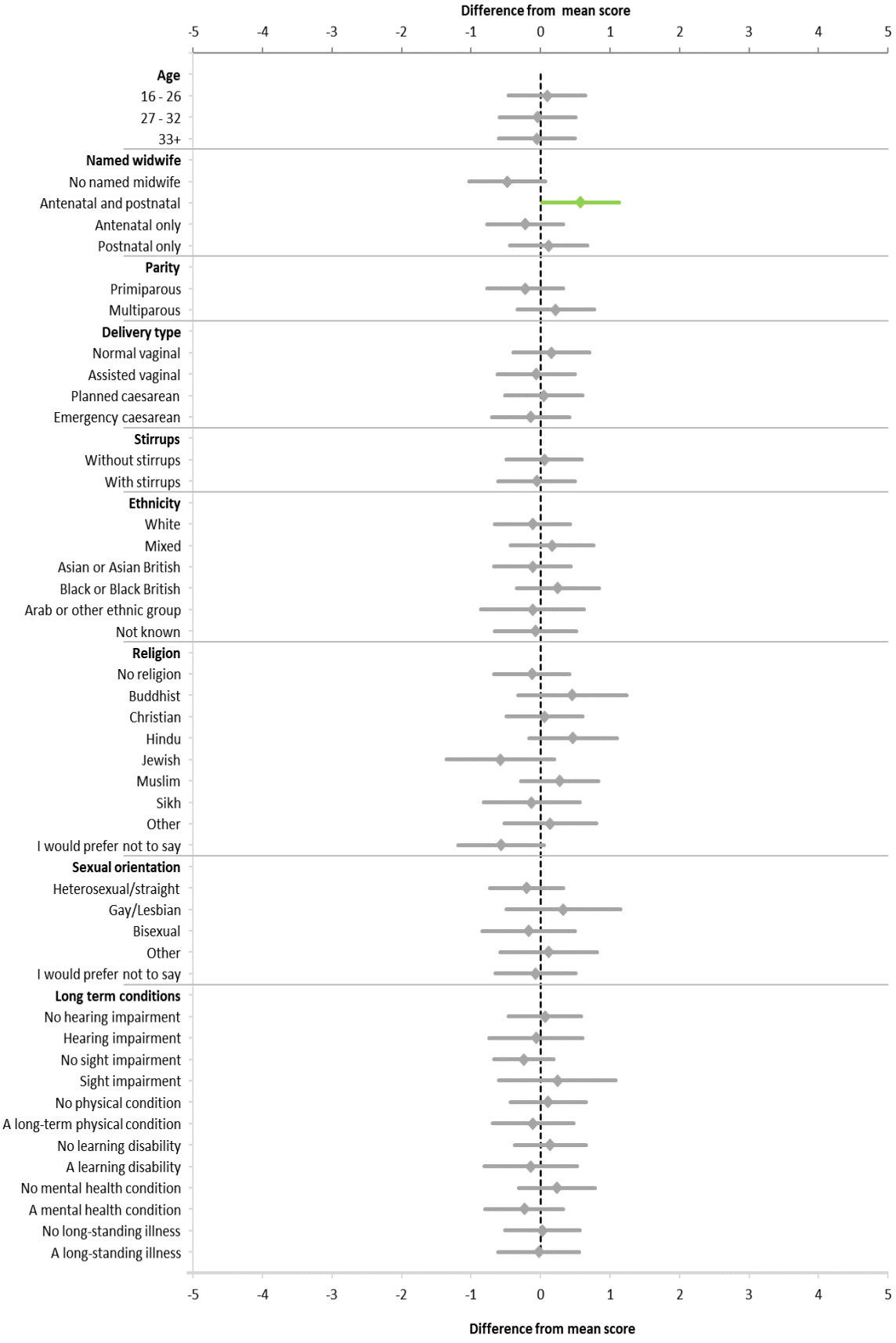
Information, communication and education (antenatal): difference from mean score by subgroup with 95% confidence interval



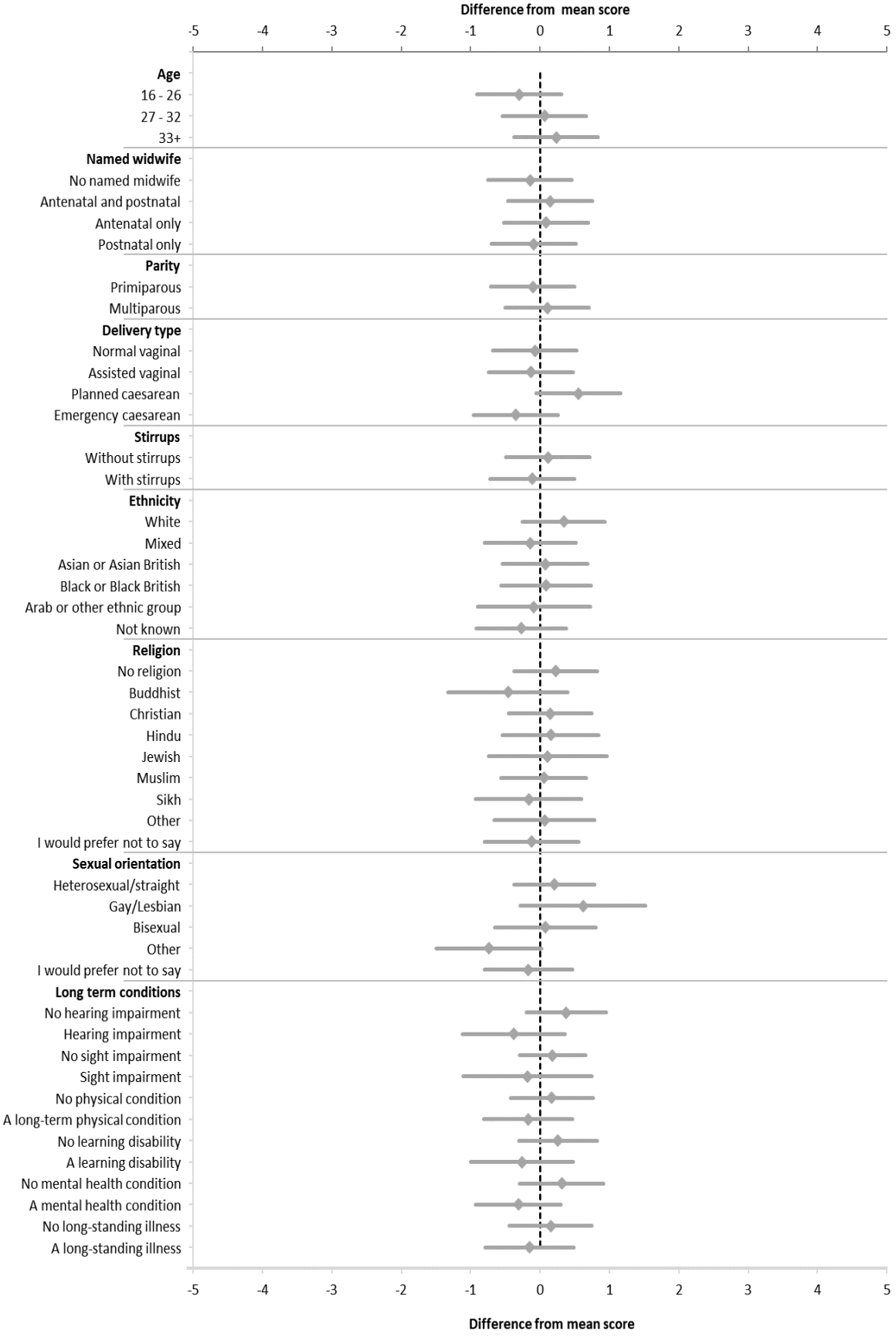
Information, communication and education (labour and birth): difference from mean score by subgroup with 95% confidence interval



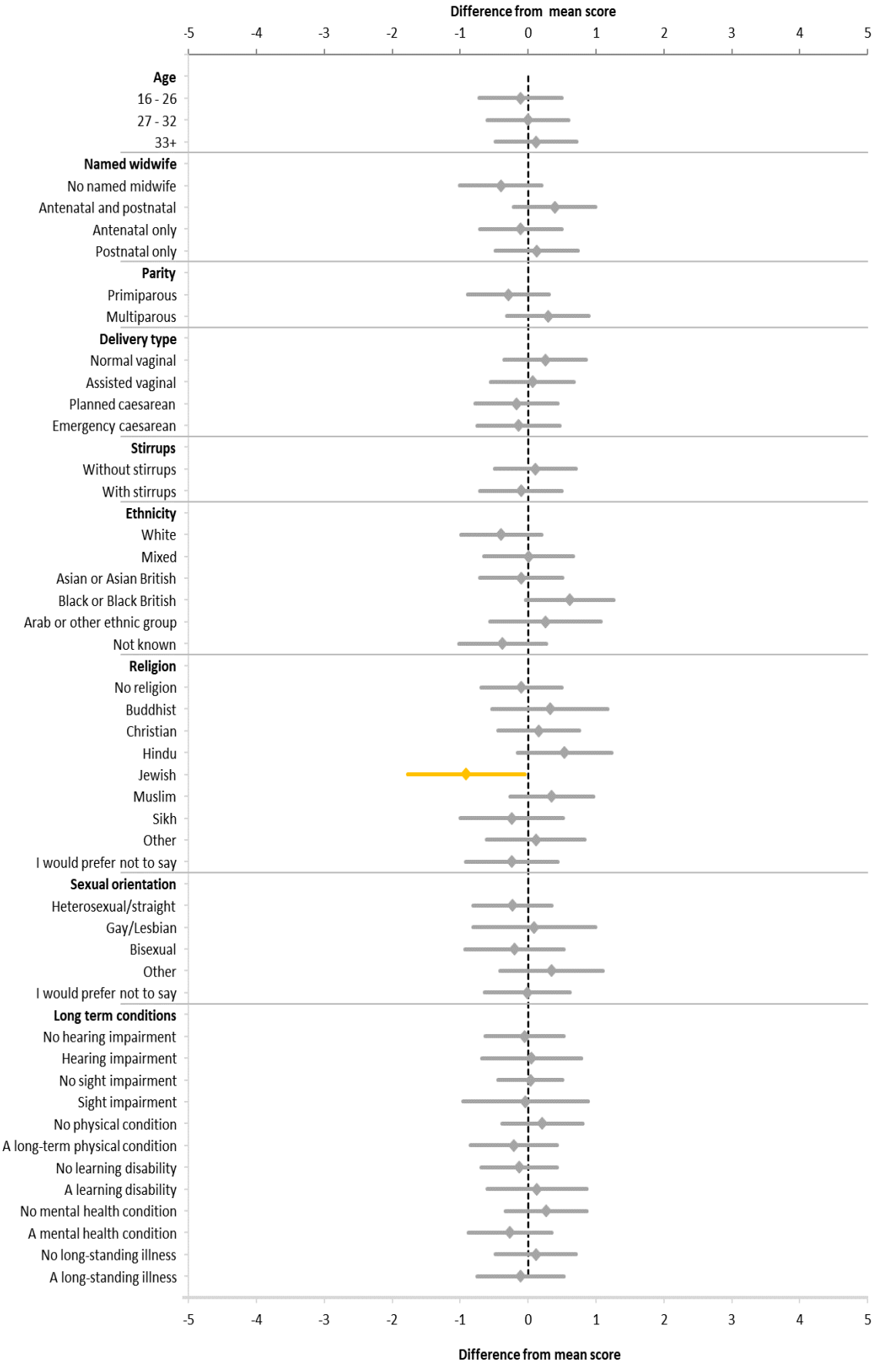
Information, communication and education (postnatal): difference from mean score by subgroup with 95% confidence interval



Availability of staff: difference from mean score by subgroup with 95% confidence interval



Feeding support: difference from mean score by subgroup with 95% confidence interval



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