NHS Patient Survey Programme

2019 survey of women's experiences of maternity care

Statistical release

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Independent data analysis

Contents

Summary of findings

NHS maternity services provide care and support to women before giving birth (antenatal care), during the birth and in the six to eight week period after 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 17,151 women who gave birth during February 2019 (as well as January 2019 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 2019. Last year, we reported that though there had been small improvements across most questions from 2013 onwards, very few questions showed this trend continuing between 2017 and 2018. However, in 2019, we have seen more improvements compared to the last year and the newly introduced control charts[a] demonstrate statistically significant trends across several areas of care, including involvement, interaction with staff and infant feeding. Less positive results were reported in continuity of carer, perinatal mental health and availability of staff outside of acute settings.

Positive results

Involvement

In their antenatal check-ups, the majority of women (83%) said that midwives 'always' listened to them. There was a meaningful change in this area over time as this proportion increased from 79% in 2013. There also was an increase in the proportion of women saying that midwives always listened to them during their postnatal care (76% in 2013 to 79% in 2019).

Partner involvement is also a key area that has improved significantly over time. In 2019, 97% of women said that during the labour and birth, their partner or someone else close to them was involved as much as they wanted, up from 94% in 2013.

The proportion of women who said that their partner or someone else close to them was able to stay with them as much as they wanted after their baby was born has also improved, rising from 63% in 2015 to 74% in 2019. Linked to this, the proportion who said that they were restricted by visiting hours has decreased from 30% in 2015 to 18% in 2019.

Interaction with staff

Women's experience of interacting and communicating with staff in maternity services continues to be positive, particularly during labour and birth. In 2019, 88% felt that they were given appropriate advice at the start of labour, compared to 86% last year. Most women (84%) also said that they felt their concerns were taken seriously when raised during labour and birth. This is an increase from 82% in 2018

[a] Please see Appendix A for more information on the methodology of the control-charts

and a meaningful change is visible over the longer period in this area. Further, a trend of improvement is visible in the proportion of women saying that they 'definitely' had confidence and trust in the staff caring for them during their labour and birth. It increased from 78% in 2013 to 84% in 2019.

There has also 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, which increased from 65% in 2013 to 76% in 2019.

Feeding choices

Meaningful improvements are also visible over the longer period in terms of women reporting that their feeding choices were being respected by health professionals. In 2019, 85% of respondents said that their decisions about how they wanted to feed their baby were 'always' respected by midwives, an increase from 80% in 2013. Encouragement and support for feeding also shows a positive trend. In 2019, 69% of women said they were 'always' given active support and encouragement about feeding their baby, an increase from 61% in 2013.

Areas for improvement

Seeing the same midwife (continuity of carer)

Continuity of carer is a policy initiative in the NHS Long Term Plan for maternity services, and Better Births, Improving outcomes of maternity services in England which recommends that '*Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally*'. The 2018-19 NHS Planning Guidance included a deliverable to '*Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally, so that by March 2019, 20% of women booking received continuity*'.

Questions specifically asked about the continuity of individual rather than care team, but it is important to note that continuity of carer models exist with varying focus on a single individual.[1]

The results show that in 2019 9% of women had the same midwife during their maternity journey; antenatal, labour and postnatal care. More than half of women (54%) said that none of the midwives involved in their postnatal care had been involved in either their antenatal care or their labour. Further, 37% of women said they saw the same midwife every time during their antenatal check-ups. Twenty-eight per cent of women said they saw the same midwife every time during their postnatal care.

It is important to note that continuity of care is not only measured by having the same midwife. Just over half of women (52%) reported that the team of midwives were always aware of their medical history at antenatal appointments. While this is higher than last year (50% in 2018), more than one in ten women (12%) still said their midwives were not aware of their medical history. Women's experience in this area is better postnatally, with 77% of women reporting that the midwife or midwifery team appeared to be aware of their and their baby's medical history.

Perinatal mental health

Maintaining good mental health throughout the perinatal period (which covers pregnancy and one year after the baby's birth) is absolutely crucial to ensure good outcomes for women and their children in the long term. There has been substantial investment in the last decade to ensure all women feel supported and are signposted to appropriate services.

This year, results show that most midwives are specifically asking women about their mental health in appointments. Just over two thirds of women (67%) said that they 'definitely' had been asked about it during antenatal check-ups with a further 24% saying they had been asked this 'to some extent'. In addition, 95% of women said they had been asked this postnatally. However, the quality of information given needs to improve. Women were asked if they had been given information about any changes they might experience to their mental health after having their baby. One out of four (25%) said that they only received this information 'to some extent' and about one out of eight (12%) said they did not receive this information. In addition, 20% of women said they were not told who they could contact if they needed advice about the changes they might experience to their mental health after the birth.

In the postnatal appointment with a GP (six to eight weeks after birth), 30% of women said the GP did not spend enough time talking to them about their mental health, compared to 29% of women who said their GP did not spend enough time talking about their physical health.

Availability of staff

The results show that outside of the acute setting (a labour ward and/or birthing centre), women might not always have the access to support that they need. Antenatally, 2019 saw a decrease in the proportion of women saying they had a phone number for their midwives. The figure is 94%, so still high, but it dropped from 97% for the first time since 2013.

Less than two thirds (62%) of women said they were always able to get a member of staff to help them when they needed attention in hospital after the birth. Eighty-one percent reported that there were always able to get help from a member of staff when they needed it during labour, or that a member of staff was with them all the time.

Postnatally, a quarter of women said they would have liked to see a midwife more often after going home. This is an increase compared to 23% in 2018 and is mirrored by a decrease of the proportion of women saying they saw a midwife as much as they wanted. In 2019 70% of women felt they saw a midwife as much as they wanted, a proportion which has fallen to its lowest point since 2013.

Antenatal classes

This year, we asked women about the availability of NHS antenatal classes for the first time. Less than a third (30%) of women said that they were offered antenatal classes or courses provided by the NHS and did them. Forty-one per cent said they had been offered these classes but chose not to attend and 29% said they were not offered such classes.

Other notable findings

For the first time in the maternity survey, we specifically asked about induction. Forty-four per cent of women said their labour was induced. Research shows that induced labour may be more painful than spontaneous labour. In the survey, women whose labour was induced were more likely to have an epidural than women with spontaneous birth (47% of women whose labour was induced compared to 19% of women with a spontaneous birth).

Twenty-two per cent of respondents whose labour was induced gave birth via emergency caesarean section compared to 11% for respondents whose labour was spontaneous. The proportion of those whose delivery was assisted is also higher for respondents whose labour was induced (21% of respondents whose labour was induced compared to 14% of respondents whose labour was not induced).

Introduction

NHS maternity services provide care and support to women before giving birth (antenatal care), during the birth and in the six to eight week period following the birth (postnatal care). There were 657,076 live births in England and Wales in 2018, a decrease of 3.2% since 2017 and a 9.9% decrease since the most recent peak in 2012.[2] In 2018, the total fertility rate was 1.70 children per women, a slight decrease compared to 2017 (1.76 children per women).

As outlined in the NHS Long Term plan published in January 2019, maternity services remain a key area of focus for the NHS. Following the publication of the national maternity review report Better Births, Improving outcomes of maternity services in England in 2016, and the implementation of the Maternity Transformation Programme, the way maternity care is delivered is changing significantly. An important aspect of the programme is to share the implementation and resources with newly created 'Local Maternity Systems' (LMS). These are made of providers, commissioners and people who use services and are in charge of designing and organising local maternity services, and contribute to achieving the ambitions of *Better Births*. 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 people's experiences of care in adult inpatient, urgent and emergency, and community mental health services, as well as children and young people's experiences of care. 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, 2017 and 2018. The 2019 maternity survey involved 126 NHS trusts in England.[b] 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 2019 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Trusts with less than 300 births were able to take part in the survey on a voluntary basis. Fieldwork took place between April and August 2019. Responses were received from more than 17,151 women, an adjusted response rate of 37%.[c]

Wherever possible, questions remain the same over time to measure change. However, when necessary they are amended to reflect changes in policy,

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

[c] 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.

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 2019 survey is only comparable back to 2013. In addition, there were significant amendments made to the questionnaire in 2019, resulting in some questions being deleted and some other questions not being comparable with previous years. A small number of questions were added.

For more information about changes to the questionnaire and survey development, see the 2019 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. Where available, we provide comparisons with other statistics as a broad indication of how representative the survey is.[d] The full results can be viewed in the open data on the CQC website.

In 2019, the majority (73%) of respondents were aged 30 and over, with 38% aged 30 to 34 and 35% aged 35 and over. The remainder were aged 16 to 18 (0.2%), 19 to 24 (6%) or 25 to 29 (20%). 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 (57%) with 78% of these women giving birth to 1 or 2 babies previously and 8% three or more. This is also consistent with trends reported by the Office for National Statistics for 2017, 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.[e]

In 2019, 85% of women said they did **not** have a long-term condition and 15% said they had one or more. Among women with one or more long-term condition, mental health was the most commonly cited condition (mentioned by 42% of women with one or more long-term conditions).

The proportion of religious groups represented remained largely unchanged compared to 2018, with 46% of women stating they were Christian, 41% they had no religion and 6% that they were Muslim. There were 2% or less of women indicating they were either Buddhist, Hindu, Jewish, Sikh or of another religion. Ninety-five per cent of women described themselves as ‘heterosexual/straight’.

The proportion of respondents from a white ethnic background has decreased slightly since last year (from 86% in 2018 to 84% in 2019) while the proportion of respondents from an Asian or Asian British background and Black or Black British has slightly increased (respectively 9% and 4% in 2019). Two per cent said they were from a multiple ethnicity background, and 1% said they were from Arab or other ethnic groups.

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

Almost all women who took part in the survey gave birth to a single baby (99%). Six per cent said they were less than 37 weeks pregnant when they gave birth, 49% were between 37 and 39 weeks and 45% were pregnant for 40 weeks or longer.

The importance of people's experiences

Alongside clinical effectiveness and safety, the Patient Experience Improvement Framework and NHS Outcomes Framework highlight that a good experience for people is an essential part of an excellent health and social care service.[3,4] 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.

NHS England sees shared decision-making as key to improving experience for those who use services, and this is particularly prevalent in maternity care as women are empowered to make informed choices about all aspects of their journey. 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.[5] Studies in this area also suggest that experience is positively associated with safety and clinical effectiveness.[6] All questionnaires used in the NHS Patient Survey Programme are designed to reflect these themes.

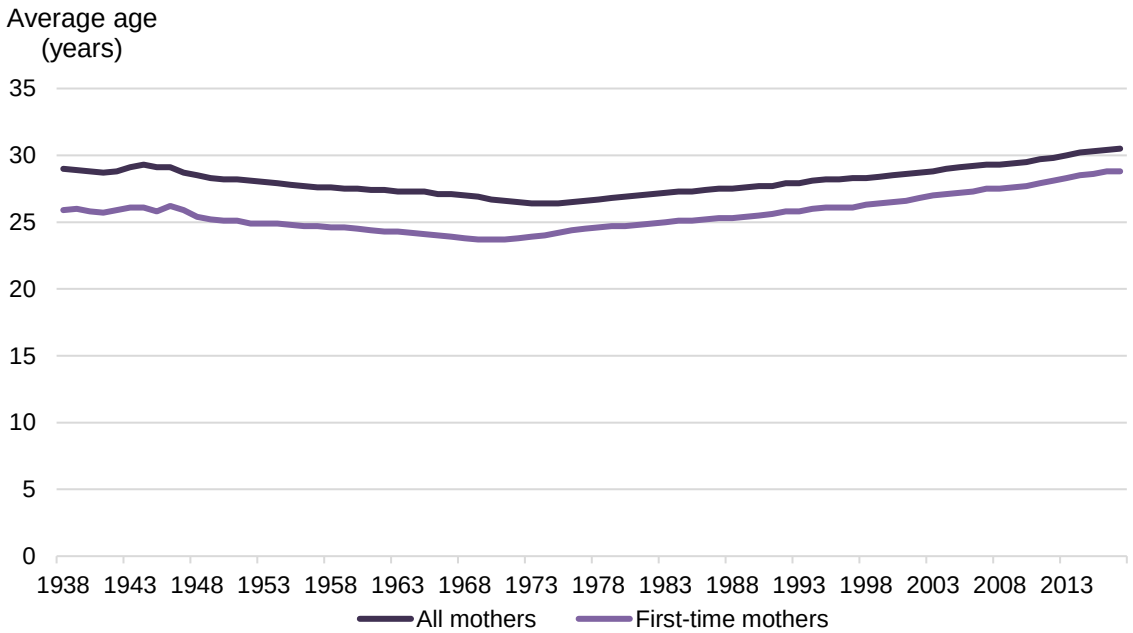
The maternity care women receive can have a lasting effect on their physical, emotional and psychological wellbeing.[7] Women's experiences of care are dependent on the care that they receive from healthcare professionals. Capturing the views of women who use maternity services through surveys such as this one enables important insight into their experiences and the quality of the care they receive.

Policy context

The way maternity care is delivered to women in England has changed significantly in the last few years. Changes in policy and increased awareness, for example around the effects of smoking on pregnancy and the importance of mental health care for women in the perinatal period, have increased demand on NHS services and redefined the roles of maternity and perinatal services.

The demographics of mothers have also changed over time with, for example, the average age of pregnant women increasing, meaning that services have to adapt to meet new care needs (figure 1). The Royal College of Midwives (RCM) has highlighted that older mothers (35+) will, on average, need more care and support, and has highlighted the potential impact of this on the workforce.[8] In addition, the RCM has expressed concern about the shortfall of midwives (estimated to be around 2,500 in 2019)[9] and about challenges in terms of ensuring continuous staffing for an ageing workforce characterised by high rates of part-time work.[8] As new demands can create pressures, the National Maternity and Perinatal Audit 2019 recommended a new evaluation of medical and midwifery staffing requirements, taking into account the range of national ambitions, to fund services accordingly.

Figure 1: Average age of mothers at the birth of their child in England and Wales, 1938 to 2017



Source: Office for National Statistics, Birth characteristics in England and Wales: 2017, 2019

Inequalities in care

The provision of maternity services varies across England. For example, a survey by the Royal College of Obstetrician and Gynaecologists in 2016 found that levels of referral to specific mental health services varied greatly across England, as well as the time it took to be seen after referral.[10]

Outcomes for women and babies also vary across the country. For example, data from the Office for National Statistics (ONS) shows variations in the rates of stillbirth across England. However, geography is not the only factor in rates of stillbirth – the *Better Births* report (2016) noted that a higher number of stillbirths occurred in those areas with more deprived populations. This is supported by ONS data which shows that the stillbirth rate is 5.5 per thousand births in the most deprived areas of England compared to 3.0 in the least deprived.[11]

In November 2018, Saving Lives, Improving Mothers' Care raised concerns about variation in care for different ethnic and social groups. It highlighted that "research was urgently needed to understand why black women are five times more likely and Asian women twice as likely to die compared to white women" during or after pregnancy. They also noted that maternal mortality is increasingly a problem for women with multiple vulnerabilities.[12]

This supports the 2010 guidance from the National Institute for Clinical Excellence (NICE) which noted that complex social factors vary both in type and prevalence across different populations. The guidance highlighted the importance of recognising that women with complex social factors, such as poverty, homelessness, substance misuse and difficulty speaking or understanding English, may have additional needs and experience barriers to accessing services.[13]

Better Births

Following the publication of the NHS Five Year Forward View, NHS England conducted a comprehensive review of national maternity services in 2016. The report of this review, Better Births, Improving outcomes of maternity services in England made a number of recommendations on how services should be redeveloped to meet the changing needs of women and babies.

It set out a clear vision: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances. It also called for all staff to be supported to deliver care which is women-centred, working in high performing teams, in organisations which are well-led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.[14]

The Maternity Transformation Programme

The Maternity Transformation Programme (MTP) was created to deliver the vision set out in *Better Births*. The programme coordinates action at a national level as well as supporting local transformation. Out of the nine workstreams of the programme, two (supporting local transformation and increasing choice and personalisation) are specifically designed to be local drivers for change.

Local Maternity Systems (LMS) have been created to implement change at a local level. They aim to ensure that women, babies and families can access the services they need and choose, in the community, as close to home as possible. LMS include representatives from providers, commissioners, and women and their families through Maternity Voices Partnerships (MVPs).

LMSs are required to develop their own local Maternity Transformation Plan, which states how they will deliver the vision set out in *Better Births*, by 2020/21. This includes how they will ensure that:

- all women have a personalised care plan
- all women are able to 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 are able to give birth in midwifery settings (at home and in midwifery units).

Maternity Transformation Plans should also include the objectives of *Safer Maternity Care* developed by the Department of Health and Social Care (see below), namely:

- Reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020 and are on track to make a 50% reduction by 2025
- 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.

The Maternity Transformation Programme also involves a piloting component by which new innovative models of care should be tested by early-adopting LMSs. Seven early-adopter LMSs across England volunteered to implement specific aspects of *Better Births* (e.g. continuity of carer or provision of mental health care throughout the perinatal period) and their learnings were shared nationally ahead of the roll-out to the whole of England.

Safer Maternity Care

In 2015 the Department of Health and Social Care published a national maternity safety strategy, Safer Maternity Care. This set objectives to reduce the number of stillbirths, neonatal deaths, maternal deaths and brain injury that occur during birth or shortly after birth by 20% by 2020, and by 50% by 2030. In 2017, the targets of Safer Maternity Care were reviewed and the commitment to halve rates was moved forward to 2025.

These objectives have been embedded into the Maternity Transformation Programme, with a push to collect data and produce guidelines on these topics. At the local level, the new objectives are required to form part of the LMS plans.

NHS Long Term Plan

Maternity and perinatal health is one of the key priorities of the NHS Long Term Plan. It renews the commitment to implement the objectives of the Safer Maternity Care strategy, and the ambitions of the Maternity Transformation Plan. It also commits to the digital transformation of maternity services, with the aim to roll out maternity digital care records to all pregnant women by 2023/24.

The following sections focus on specific themes at the core of the MTP and developed throughout the *Better Births* report, Safer Maternity Care and the NHS Long-term plan.

Choice and personalisation

Better Births places women's choice over their care at the centre of the new care model to be developed through the MTP. Women should be offered a choice at all stages and in all aspects of their pregnancy. This includes: choice of provider for antenatal, intrapartum and postnatal care; choice of birth setting; choice of pain management during the birth; choice regarding the involvement of their birth partner; and choice of how to feed their baby.

Choices made by women regarding their pregnancy should be recorded in a personalised care plan. This would help ensure that choices are respected and continuity of care is sustained, even though different healthcare professionals or providers may be involved in the woman's care.

Better Births also highlights that women should be able to make informed choices that are based on evidence, as well as open and honest conversations with their health professionals. This information should be delivered in a way that is accessible and takes into account individual circumstances and needs (for example, a limited understanding of English, or cultural factors).

However, evidence suggests that choice is not always possible in practice as the availability of service varies across England. Also, some women might not be aware that they are able to make the choice by themselves (i.e. that the choice should not be made by the health professional).[15]

Continuity of carer

The principle of continuity of carer, as described in *Better Births,* is based on the idea that it ensures safer care based on a relationship of mutual trust and respect in line with the woman's decision. During the review for *Better Births*, women expressed their confusion at seeing too many midwives and doctors over the course of their pregnancy, with a lack of clarity regarding who they were and what their roles were. Good relationships can have a positive effect on women's experience and outcomes; the fact that women's care was delivered by different carers meant that there was less opportunity to build the rapport that it requires.

This is supported by a 2016 Cochrane review. This looked at midwife-led care, and found that women who received consistent 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.[16]

The NHS Long Term Plan also notes that continuity of carer is linked to significant improvement in clinical outcome for women from Black, Asian and Minority Ethnic (BAME) groups and those living in deprived areas. Guidance on implementation of continuity of carer also mentions evidence suggesting that women with complex social needs benefit disproportionately in terms of outcomes from continuity of carer.

According to *Better Births*, continuity of carer should eventually be rolled-out to all women and involves a midwife, who is part of a small team of 4 to 6 midwives, who would normally provide continuity throughout a woman's journey (if that is what she and her partner want). To organise this, the midwife would be supported by a small team of midwives with an identified obstetrician to advise them on issues as appropriate. The woman should also be able to have a midwife she knows at the birth, ideally her own midwife and where appropriate an obstetrician she knows. However, *Better Births* also notes that such an organisation of care couldn't be delivered through the current staffing models (particularly to accommodate the high incidence of part-time work in the workforce) and would require extensive changes to the way the services are delivered.

Two main models of continuity of carers have been described, and the guidance offered to LMS to implement them notes that they might need to be mixed when adapted at local level.[17] In the 'team continuity' model, each woman would have an individual midwife responsible for coordinating her care and relying on a team of four to eight midwives as back-up. In this model, the woman would get to know all the members of the team. In comparison, in the 'full caseloading' model, each midwife is allocated a certain number of women and arranges their working life around the needs of the caseload.

Perinatal mental health

It is estimated that up to 20% of women experience perinatal mental health problems, which if left untreated can have long lasting effects on mother, babies and families.[18] Perinatal mental health refers to mental health problems that occur during pregnancy or in the first year following the birth of a child, the most common being depression and anxiety. Anxiety disorders and psychosis can occur or re-emerge. Existing mental health issues can be exacerbated or re-emerge during pregnancy and in some cases they can be experienced for the first time during pregnancy or after the birth.

Mental health was a key area of focus of *Better Births* and is part of the Maternity Transformation Programme, with the aim to improve access to perinatal mental health services for women. The challenge is not only to provide services, but also to improve recognition and early detection of women suffering from mental ill-health during pregnancy by health professionals. *Better Births* notes that disadvantaged women, for example those experiencing poverty or social exclusion, have higher rates of perinatal depression. It also highlighted that the provision of perinatal mental health services varied enormously across the country.

The NHS has committed to transforming perinatal mental health care, to ensure increased access to specialist perinatal mental health support in all areas of England by 2020/21. Funding of £365m has been allocated to enable 30,000 women to have access to improved perinatal mental health support by 2020/21 and a further 24,000 women by 2023/24.[19]

Promoting health and wellbeing

Women's health in pregnancy can be affected by many factors, including age, lifestyle and social factors, such as occupation and deprivation status.[20] As part of their local Maternity Transformation Plans, Local Maternity Systems have to include a public health component to "*improve women's health before, during and after pregnancy, give every child the best start in life, and reduce health inequality"*.[21] This includes providing advice, support and information on issues such as the importance of stopping smoking and maintaining a healthy weight and lifestyle.

In addition, conditions such as gestational diabetes, pre-eclampsia or mental health issues can develop during pregnancy. These all require additional care and treatment.

Quality Standards

The National Institute for Health and Care Excellence (NICE) provides evidence-based clinical guidance and quality standards for health care, which 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 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.[22]

Results from the survey

This section presents the results from the 2019 maternity survey and follows women's journeys through antenatal care, labour and birth and postnatal care.[f] It highlights statistically significant differences between 2018 and 2019 results where possible.[g]

For the first time in the maternity survey, we are using control-charts to display trends for five time-points (2013, 2015, 2017, 2018 and 2019) to illustrate where there have been notable changes in results over time. Where control-chart results are not reported in the text of the report, this is because the change over time was not significant (the line of result does not cross the limit lines) or because not enough data points are available to produce reliable results. Please refer to the Appendix A for more details on the control charts.

An analysis that compares how different groups of women rated their maternity experiences is also presented.

1. Care while pregnant (antenatal care)

Access

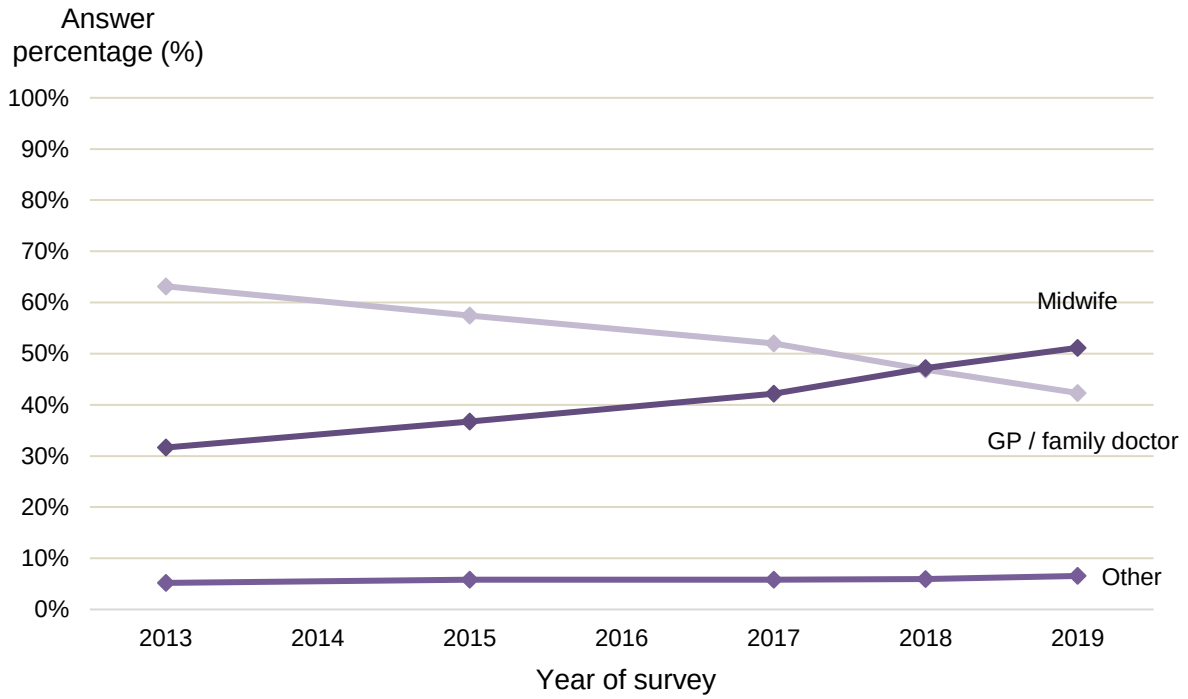
When a woman finds out she is pregnant, she can choose to first consult either her GP or a midwifery service through self-referral. Although historically GPs have been the first point of contact for women discovering they are pregnant, this changed in the 1990s with policy documents stating for the first time the possibility of self-referral.[23] Maternity Matters published by the Department of Health in 2007, encouraged self-referral to midwives, stating 'self-referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services'.

There has been a significant increase in the proportion of women directly accessing midwifery services over time. While until 2017, women were more likely to contact their GP rather than a midwife, this is now the opposite. In 2019, 51% of women self-referred to a midwife while 42% contacted a GP. The proportion of those consulting other health professionals slightly increased compared to 2018 (from 6% to 7%)

[f] Responses to questions such as "don't know/can't~~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.

[g] With this approach, there is 5% or less probability that the result could have been observed when there has been no underlying change.

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) 2019 (17,047)[h]
Answered by all.

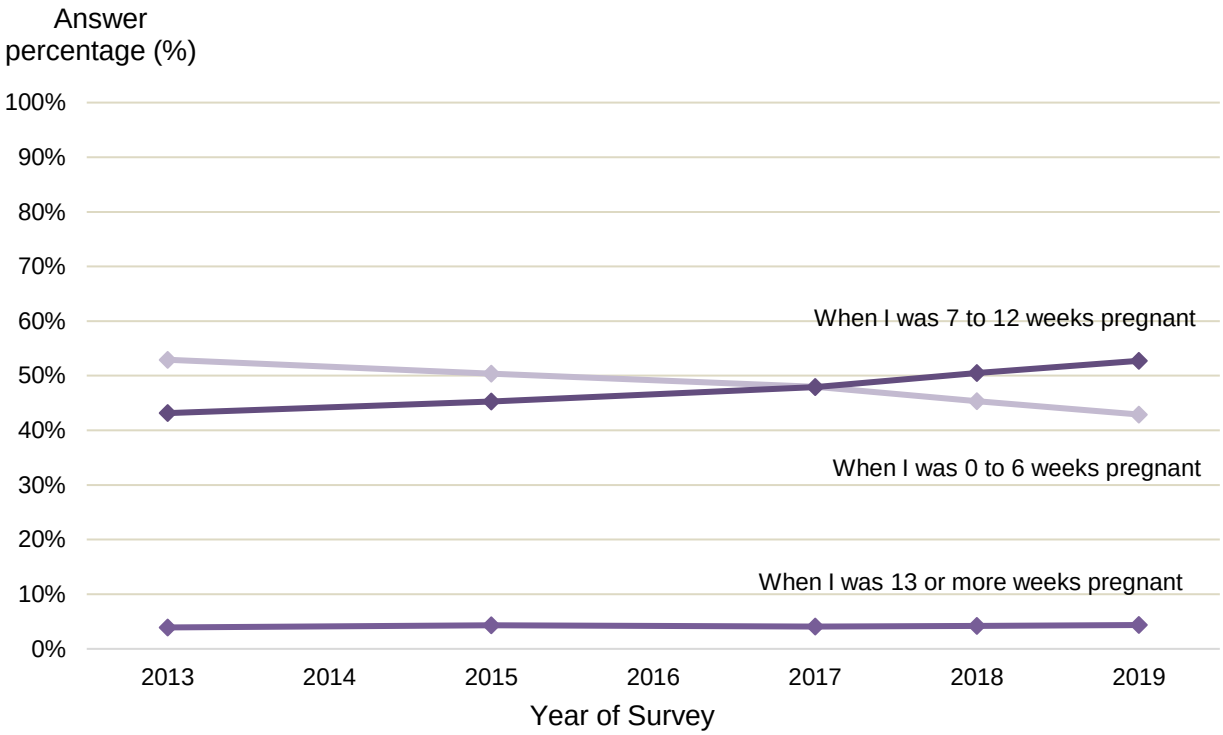
Women who had been pregnant before (multiparous) were more likely to consult a midwife at first. In 2019, 58% of them went first to a midwife, 37% went to a GP and 4% went to another health professional. The proportions of those referring to a GP (47%) or to a midwife (45%) were more similar for women in their first pregnancy (primiparous).

Maternity Matters encourages early access to maternity services as a way to improve outcomes for women and babies, by enabling earlier assessment of their health and for care planning to begin earlier.

Results show that the time before a woman first sees a health professional has increased over the years. Since 2018, there have been more women saying they were 7 to 12 weeks pregnant when they first saw a health professional about their pregnancy, than those saying they were 0 to 6 weeks pregnant. The proportion of women saying they were 7 to 12 weeks pregnant increased by 10 percentage points between 2013 and 2019 (from 43% to 53%). There has been a corresponding decrease in the proportion who said this was when they were 0 to 6 weeks pregnant (from 53% in 2013 to 43% in 2019).

[h] Bases for the charts are presented weighted

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) 2019 (16,776)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

The Royal College of Obstetricians and Gynaecologists states as part of its Framework for Maternity Service Standards that 'there must be a variety of routes and mechanisms for all women to access antenatal care in a setting of her choice, ideally before 10 weeks gestation'.

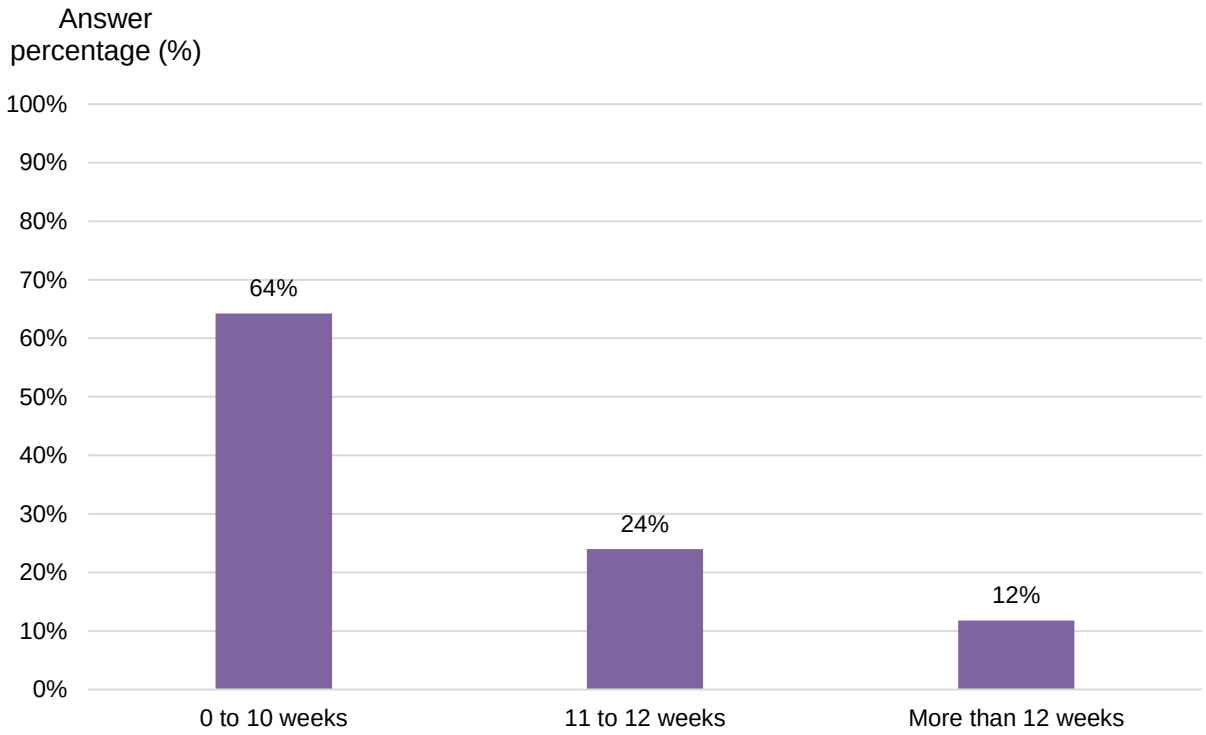
The initial contact with the system when women first present as pregnant is usually followed by a 'booking appointment' where women are given their pregnancy notes and provided with the information they need. This includes advice on diet, nutritional supplements, exercise, lifestyle and the baby's development, as well as screening for health issues affecting both mother and baby. NICE recommends that women should be supported to access maternity services and that the booking appointment should be by 10 weeks. Data from NHS Digital shows that around 57% of women have a booking appointment within their first 10 weeks of pregnancy.[i]

In 2019, our survey showed that 64% of women said they were 10 weeks pregnant or less when they had their first booking appointment. Another 24% had their booking appointment when they were 11 to 12 weeks pregnant and 12% were more than 12 weeks pregnant.

Due to the method of computation, the results from the survey and those from NHS digital mentioned above are not directly comparable.[j]

[i] Based on data published on 31 October 2019. Data range 1 July 2019 to 31 July 2019.
[j] The base used to compute the survey percentages for this question excludes missing responses while they are included in the NHS digital data.

B3: Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given access to your pregnancy notes)? (2019)



Number of respondents: 15,829
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Choice

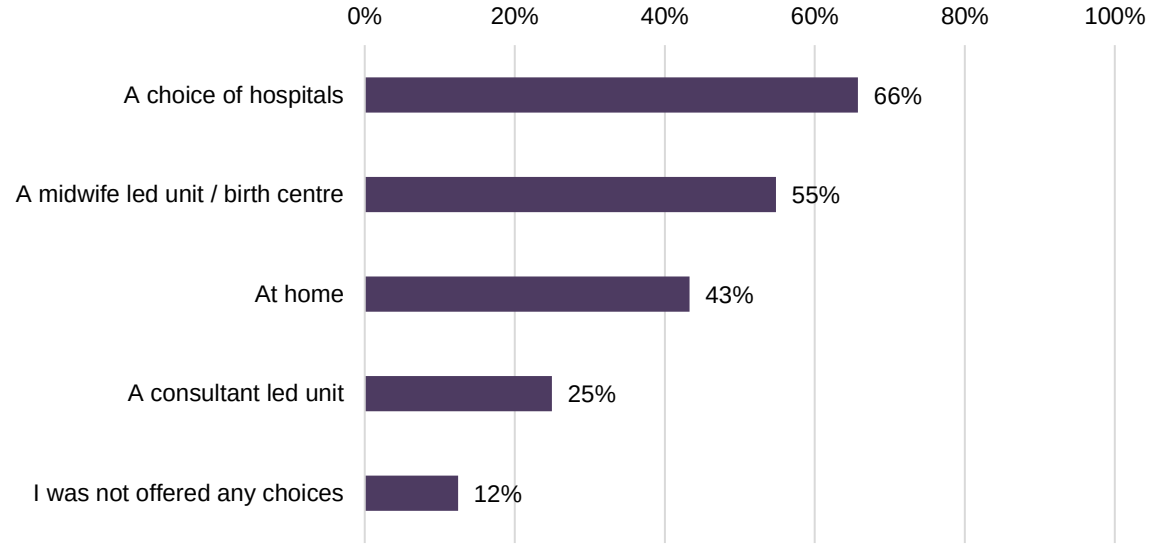
All recent national maternity policy has promoted women's choice of place of birth. Women's choice and personalised care is also one of the priorities of the Maternity Transformation Programme.

NICE guidelines encourage women with uncomplicated pregnancies to consider giving birth outside of hospital settings such as in midwifery units or at home (the latter particularly for women who had previous pregnancies).[24] They state that while the outcomes for babies are considered to be the same in any settings, births in midwifery units and at home are associated with lower rates of intervention and higher rates of spontaneous vaginal delivery than those in obstetric units.

However, *Better Births* discusses evidence showing that not all women are made aware of these options. In addition, a National Audit Office report[25] from 2013 describes how women's choices are limited by service provision, which is not equally distributed throughout the country. Recent research also found that women's choices might be limited by their understanding of the difference between settings.[26]

Results show that in 2019, 12% of women said they were **not** offered any choices about where to have their baby. The choice most commonly mentioned was 'a choice of hospitals' (66%) followed by 'a midwife led unit / birth centre' (55%). Forty-three percent of women answered 'at home' and a quarter (25%) answered 'a consultant-led unit'.

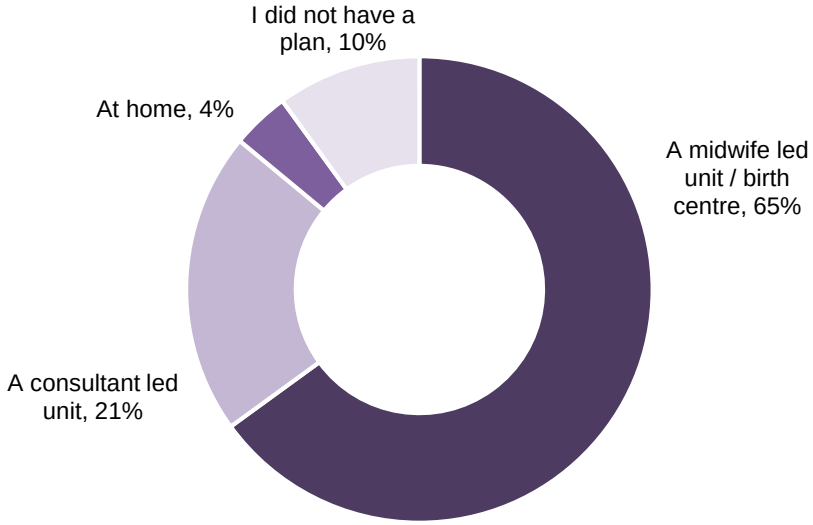
B4: Were you offered any of the following choices about where to have your baby?



Number of respondents: 14,763
Answered by all.
Respondents who stated that they didn't know / couldn't remember or had no choice due to medical reasons have been excluded.
Multiple response question: percentages may sum to more than 100.

In 2019, 65% of respondents said that before their baby was born, they planned to have their baby in a midwife-led unit/birth centre. However, 10% of women indicated that they did not have a plan for where they would give birth.

B5: Before your baby was born, where did you plan to have your baby?



Number of respondents: 16,430
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded

Looking at the actual reported place of birth, 77% of women who were planning to give birth in a midwife-led unit/birth centre went on to do so. Most (89%) of those who were planning to give birth in a consultant led unit went on to do so. However, less than half (44%) of those planning to give birth at home achieved this.

B5. Before your baby was born, where did you plan to have your baby? By C6. Where did you have your baby?

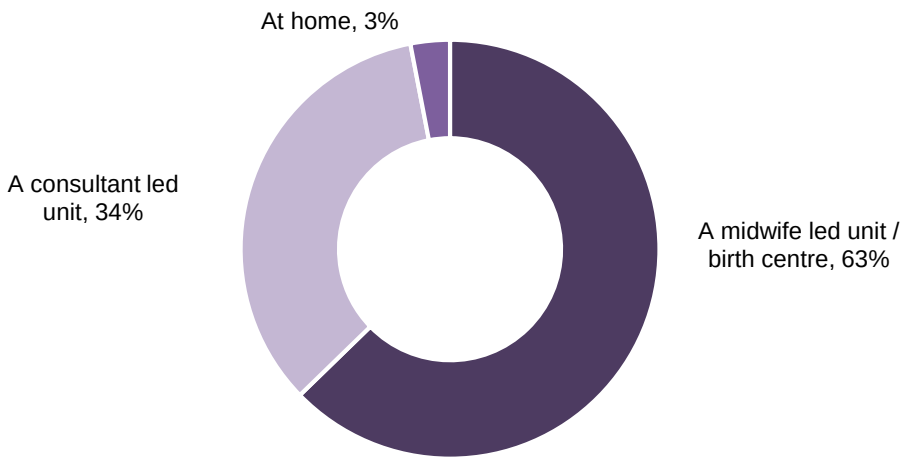
		B5 Before your baby was born, where did you plan to have your baby?			
		A midwife led unit / birth centre	A consultant led unit	At home	I did not have a plan
C6 Where did you have your baby?	A midwife led unit / birth centre	77%	10%	31%	68%
	A consultant led unit	22%	89%	25%	31%
	At home	1%	1%	44%	1%
	Total	9,414	2,232	626	1,180

For analysis purposes this data has been weighted by the weight applied to question C6 for the whole population

There were differences for home delivery according to whether women delivered their first baby or had previously had children. About three in 10 (29%) first time mothers who were planning to give birth at home did so, compared with over half (51%) of those who had given birth previously.

Overall, the most common places of birth were midwife-led units/birth centres with 63% of women actually giving birth in these settings. It was followed by consultant-led units (34% of women) and home (3%).

C6: Where did you have your baby?



Number of respondents: 13,939
Answered by those who had a labour or did not have a planned caesarean.
Respondents who stated that they didn't know / couldn't remember have been excluded

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*".

Getting enough information from health professionals to decide where to give birth is likely to play a role in a women's choice of place of birth. NICE guidance states that pregnant women should be offered information based on current available evidence, together with support to enable them to make informed decisions about their care. It also underlines that women's decisions should be respected, even when it is contrary to the views of the healthcare professional.

In 2019, 61% of women said they 'definitely' received enough information from either a midwife or doctor to help them decide where to have their baby. Twelve per cent said they did not receive enough information.

Information provided during antenatal care also includes information regarding how to feed the baby. This is discussed separately in the section on feeding.

Communication

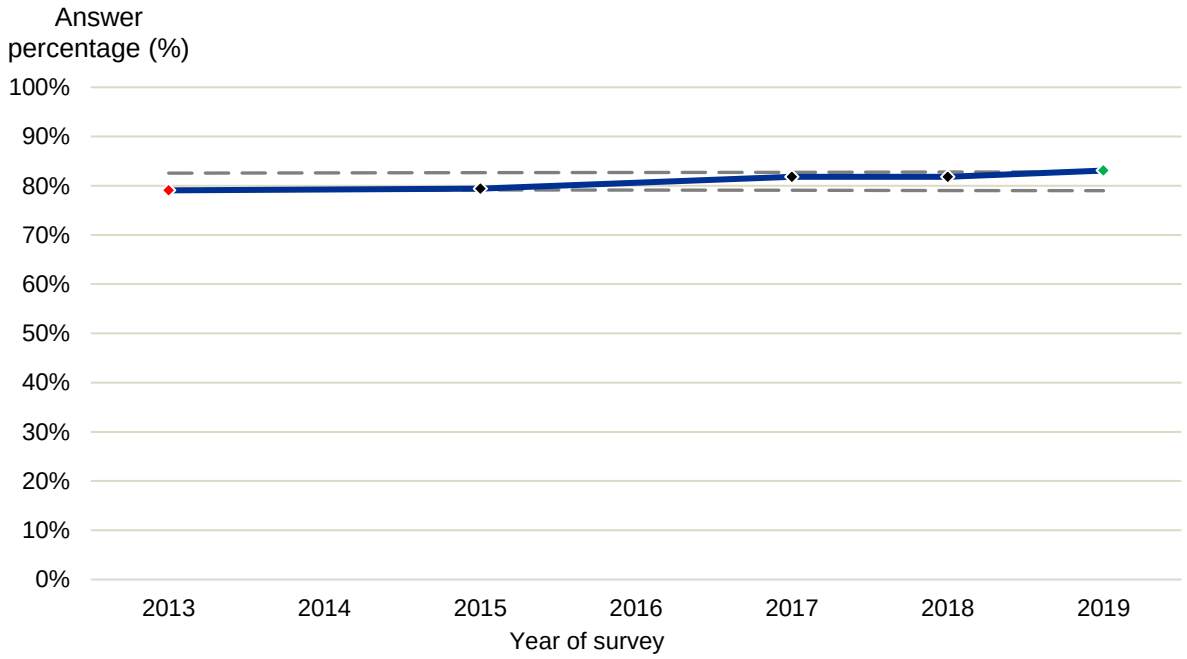
Effective communication is essential to help deliver the vision of personalised care set out in *Better Births*. NICE clinical guidelines on antenatal care for uncomplicated pregnancies recommend that, at each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, and should provide pregnant women with an opportunity to discuss issues and ask questions.

We asked women about their interactions with midwives during their antenatal check-ups. A majority of women (79%) said they were 'always' given enough time to

ask questions or discuss their pregnancy, an increase from 77% in 2018. The proportion of those saying they were not given enough time decreased from 4% in 2018 to 3% in 2019.

Improvements are also visible over time in terms of women saying midwives 'always' listened to them during their antenatal check-ups. There was a small but significant change from 82% to 83% between 2018 and 2019. Over the longer period, the line went from below control limits in 2013 to above in 2019 indicating a positive trend.

B10: During your antenatal check-ups, did your midwives listen to you? – Yes, always



Number of respondents: 2013 (22,537), 2015 (19,604), 2017 (18,317), 2018 (17,493), 2019 (17,067)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded

Most women (89%) said that they were 'always' spoken to in a way they could understand while receiving antenatal care, and this figure has not changed significantly over time. Ten per cent were 'sometimes' spoken to in a way they understood.

Involvement and support

Involving women in their care is essential to providing the personalised, women-centred care described in *Better Births*. This 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".*

Most women (82%) said that they were 'always' involved in decisions around their antenatal care. Only 2% said they did not feel involved.

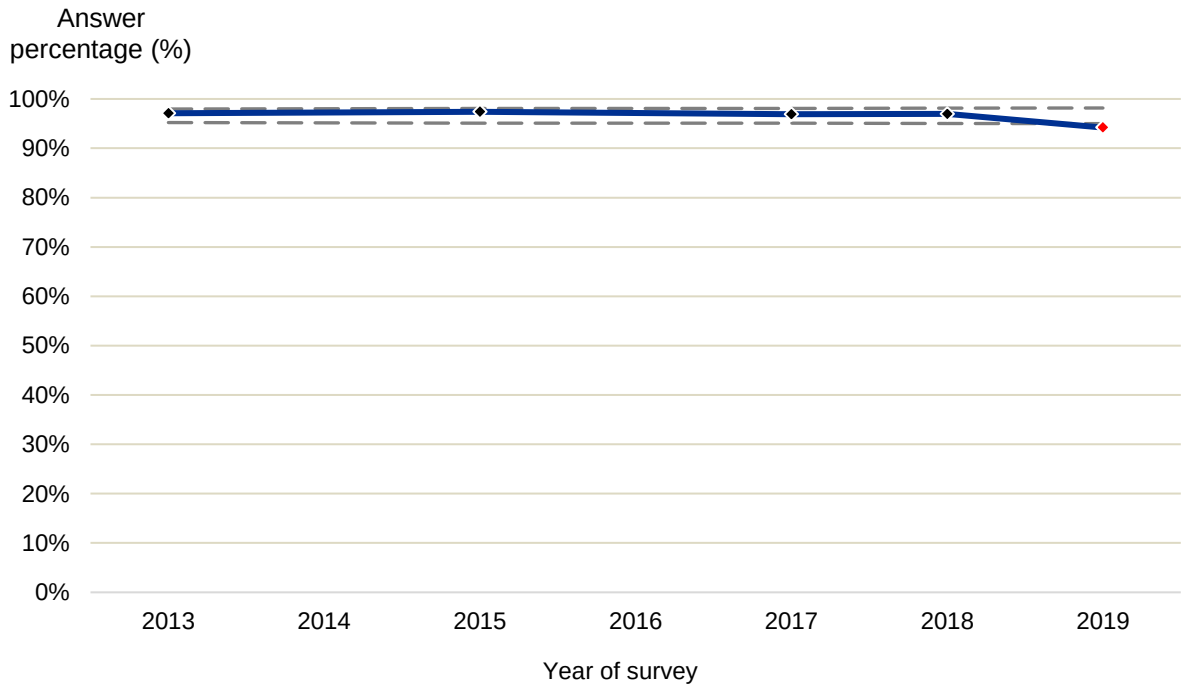
NICE clinical guidance on Intrapartum care for healthy women and babies recommends that healthcare professionals offer consistent and clear explanations at each antenatal appointment and provide pregnant women with an opportunity to discuss issues and ask questions.

Just over half (52%) of women said that midwives ‘always’ appeared to be aware of their medical history during their antenatal check-ups. This is higher than in 2018 when 50% of women said so. However, in 2019 there were still 36% of women saying this was ‘sometimes’ the case and 12% saying that it was not the case.

During their antenatal care, NICE recommends that women should also be given information on how to contact their midwifery care team and what to do in an emergency. The guidance does not specify through which communication channel these contacts should take place.

This year saw a decrease in the number of women saying they had a telephone number for a member of the midwifery team from 97% in 2018 to 94% in 2019. This decrease was significant over the longer period and crossed the lower control limit.

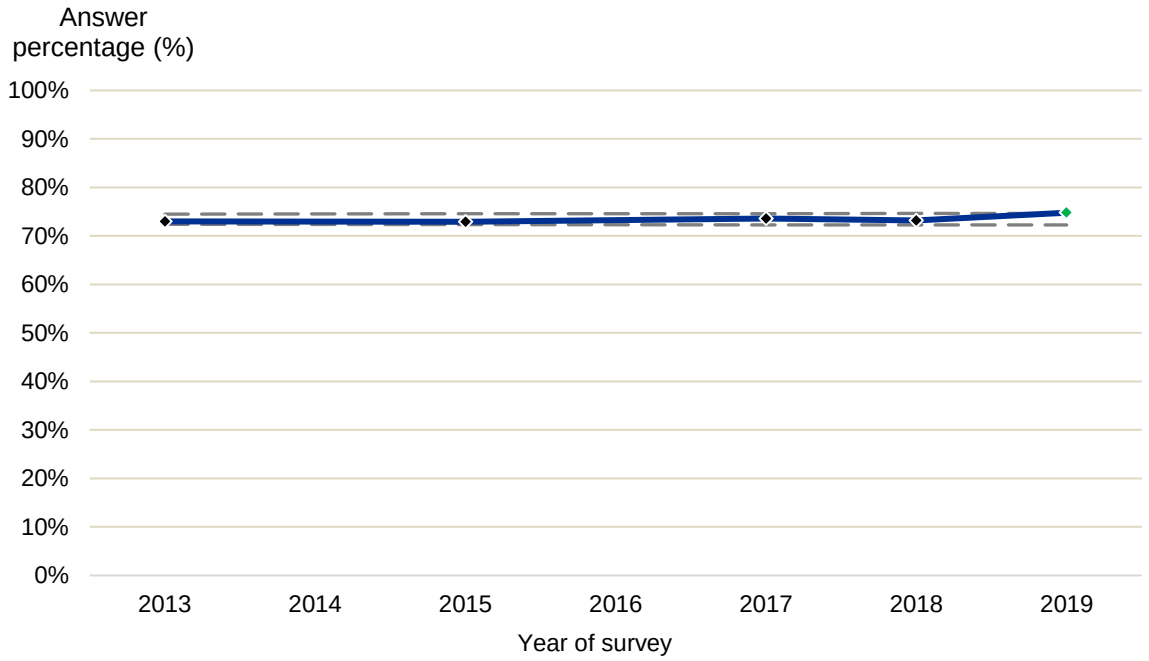
B14: During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact? - Yes



Number of respondents: 2013 (22,476), 2015 (19,560), 2017 (18,265), 2018 (17,426), 2019 (16,844)
Answered by all.
Respondents who stated that they didn’t know / couldn’t remember have been excluded

Of those who tried to contact a midwife during their pregnancy, three-quarters (75%) ‘always’ got the help that they needed. This is a significant increase from 73% last year and it shows an increasing trend over the longer period.

B15: During your pregnancy, if you contacted a midwifery team, were you given the help you needed? – Yes, always



Number of respondents: 2013 (17,953), 2015 (15,665), 2017 (14,997), 2018 (14,263), 2019 (14,207)
Answered by all.
Respondents who stated that they did not contact a midwife have been excluded

The proportion of those who contacted a midwife but did not feel that they were given the help they needed decreased to 3%. In addition, 3% said they were unable to contact a midwife when needed.

Antenatal classes

Two new questions were introduced in the survey this year regarding antenatal classes. NICE guidelines state that pregnant women should be offered opportunities to attend participant-led antenatal classes, including breastfeeding workshops. The classes provided by the NHS are free and organised by the trust. The provision of such classes and the number of classes is left at the discretion of the trust. Antenatal classes provide future mothers and their partners/companions information on how to look after and feed their baby, how to stay healthy during the pregnancy and how to make a birth plan.[27]

Less than a third (30%) of women said that they were offered any antenatal classes or courses provided by the NHS and chose to attend them. A similar proportion of women said they were not offered such classes (29%). A higher proportion (41%) said they were offered such classes but choose not to attend.

Of those who were offered and attended antenatal classes, 59% stated that they ‘definitely’ found these classes useful and 37% stated they found these useful to ‘some extent’. Five per cent said that they did not find them useful. These results should be interpreted with caution as the number of respondents was very low for some trusts, which meant their results had to be suppressed.

2. Perinatal mental health

Mental health issues during pregnancy are not uncommon but are perhaps less known to the wider public as pregnancy is often seen as a happy and exciting time for mothers. The charity Mind notes that this might be an additional deterrent for women experiencing mental health issues during pregnancy to disclose it to their health professionals.[28]

NICE notes that although response to treatment for mental health problems is good, these problems frequently go unrecognised and untreated in pregnancy and the postnatal period and affect women, babies and their family for many years.[29]

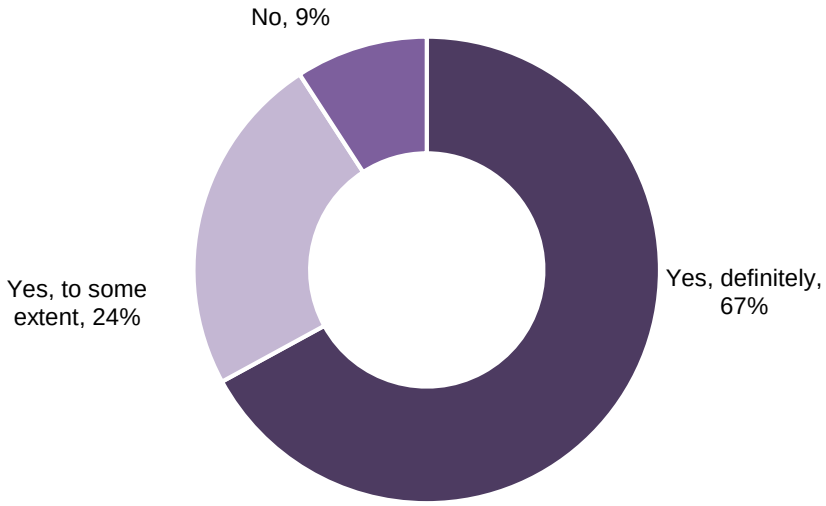
For women with pre-existing mental health problems, additional support, monitoring their symptoms and adjusting their treatment might be necessary during pregnancy. For pregnant women or new mothers experiencing it for the first time, prompting might be needed from health professionals to monitor the onset of symptoms and provide support. Combating poor mental health of pregnant women is significant to preventing maternal death.[12]

Results from the survey show that out of the 15% of women who said they had one or more long-term conditions, 42% said they had a mental health condition.

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.

In 2019, more than two-thirds of women (67%) said that they ‘definitely’ had been asked about their mental health during their antenatal check-ups. About a quarter of women (24%) said they had been asked this ‘to some extent’.

B11: During your antenatal check-ups, did your midwife ask you about your mental health?



Number of respondents: 16,606
Answered by all.
Respondents who stated that they didn’t know / couldn’t remember have been excluded

The risk of experiencing mental health issues is also present after the birth and health professionals should therefore make sure to identify and support women experiencing it.

During the postnatal period, when they were visited at home or seen in a clinic by a midwife after the birth, 95% said they had been asked about their mental health. The remaining 5% said they had not been asked.

Even if health professionals are enquiring about the mental health of women following birth, results from the survey seem to show that information on mental health at the postnatal stage could be improved.

In 2019, 63% of women said they ‘definitely’ were given information about any changes they might experience to their mental health after having their baby. However, one out of four (25%) indicated that they only received this information ‘to some extent’ and about one out of eight (12%) said they did not receive this information. As mental health problems during pregnancy and after the birth are sometimes not recognised by the wider public, women experiencing mental health difficulties might not necessarily identify them as such. A description of the symptoms might help them to do so and encourage them to disclose them to their health professional.

Most respondents (80%) were told who to go to for advice about changes to mental health after birth, though one in five respondents (20%) were not.

By 6 to 8 weeks after the birth, women should have a postnatal check with a GP to check their own recovery. Some GP practices do not routinely offer them, leaving the

initiative to make a specific appointment to the mother and sometimes these check-ups are coupled with the baby's check. During this check, women should be asked about their own mental health and wellbeing.[30]

Results from the survey[k] show that it is not always the case, with 30% of women saying the GP did **not** spend enough time talking to them about their own mental health while another 30% said the GP did so 'to some extent'. The remaining 40% said that the GP 'definitely' spent enough time.

Barriers to effectively identify women experiencing mental health problems during these check-ups might exist as women are asked many other questions (such as physical recovery and birth control) in the same appointment. Recent research suggests that some women might feel that the check is rushed or that when they wanted to discuss a mental health problem, they did not feel able to do so.[31]

[k] Please note that some women might not have had their postnatal check-up yet at the time of the survey, therefore, results should be treated with caution.

3. 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.[32] Some studies have shown that being admitted to hospital too early can cause certain complications, such as increased risk of caesarean section, and health professionals recommend that women stay at home until contractions become frequent.[33] Therefore, it is important to provide advice and reassurance to women in early labour about how long they can stay at home.

The proportion of respondents saying that at the start of their labour, they felt they were given appropriate advice and support when contacting a midwife or the hospital has increased since last year. In 2019, 88% of respondents said so compared to 86% in 2018. However, this remained within control-limits over the longer period.

Guidance on care throughout labour recommends that communication between the woman, midwives and other health professionals should be established from the beginning of labour. It includes encouraging the woman to adapt the environment of the room to meet their individual needs.[34]

Sixty-three per cent of women said that staff 'definitely' helped them create a more comfortable atmosphere in the way they wanted, while 28% said they did that 'to some extent'. Nine per cent of women said that they did not. Factors such as control over who can see or hear them, who can enter the room, temperature or lighting are among factors that can help create a more comfortable environment for women in labour.[35]

Women giving birth in a midwife-led unit/birth centre or at home were more likely to say that staff 'definitely' helped create a more comfortable atmosphere than those giving birth in a consultant led unit. Sixty-nine per cent of women giving birth in a midwife-led unit and 68% of women giving birth at home said so, compared to 53% of women giving birth in a consultant led unit.

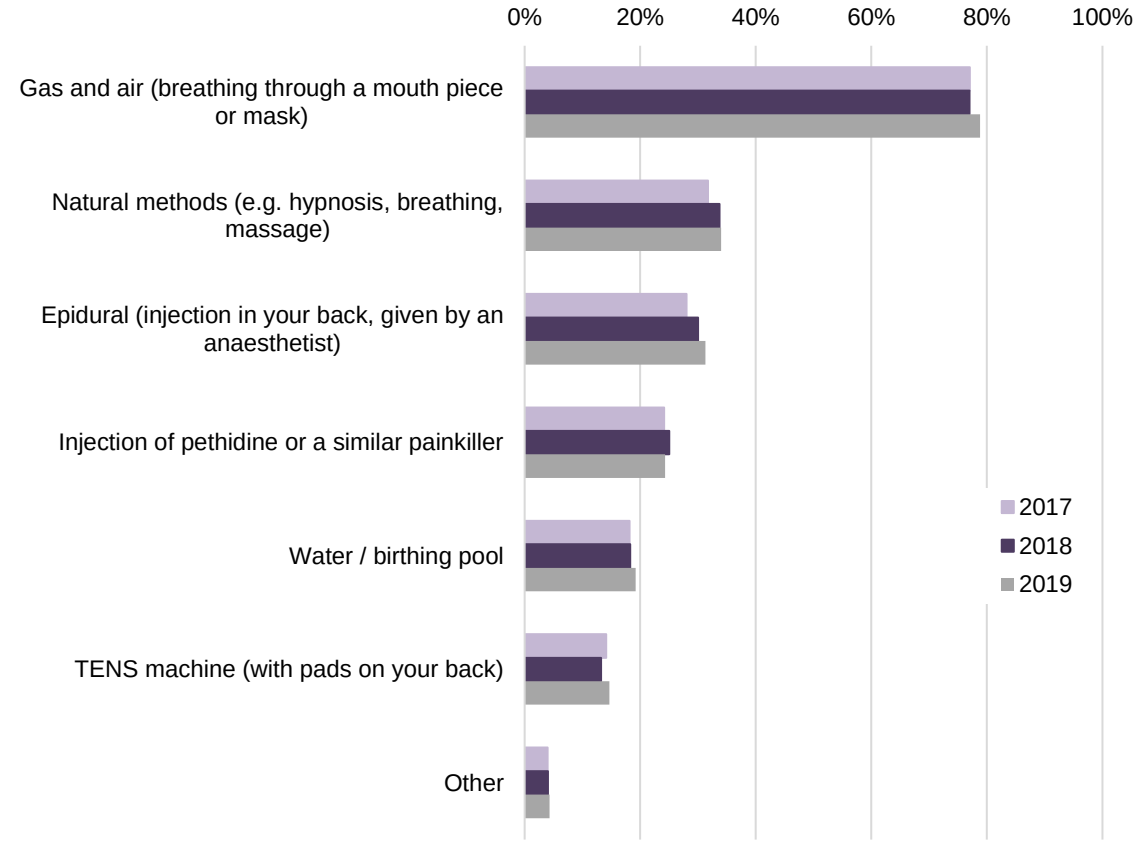
Delivery and choice

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 recommends that healthcare professionals give women information about the different options for pain relief, including how they work and any side effects.[36] Pregnant women are invited to choose pain relief options before labour, as part of their birth plan.[37] However, this can change when labour starts and during labour to adapt to the circumstances or to the mother's wishes.[34]

The most common method of pain relief used was gas and air. Its use increased from 77% in 2018 to 79% in 2019. Natural methods (such as hypnosis, breathing or massage) are the second most commonly cited method (used by 34% of women). Between 2018 and 2019 there have been increases in the proportion of women who said they used an epidural (30% in 2018 and 31% in 2019) and TENS machine (13% in 2018 and 15% in 2019). Women with uncomplicated pregnancies should be offered the option of being in water during labour, as a pain relief method. Nineteen per cent of women said they used a birthing pool.

C3. During your labour, what type of pain relief did you use?

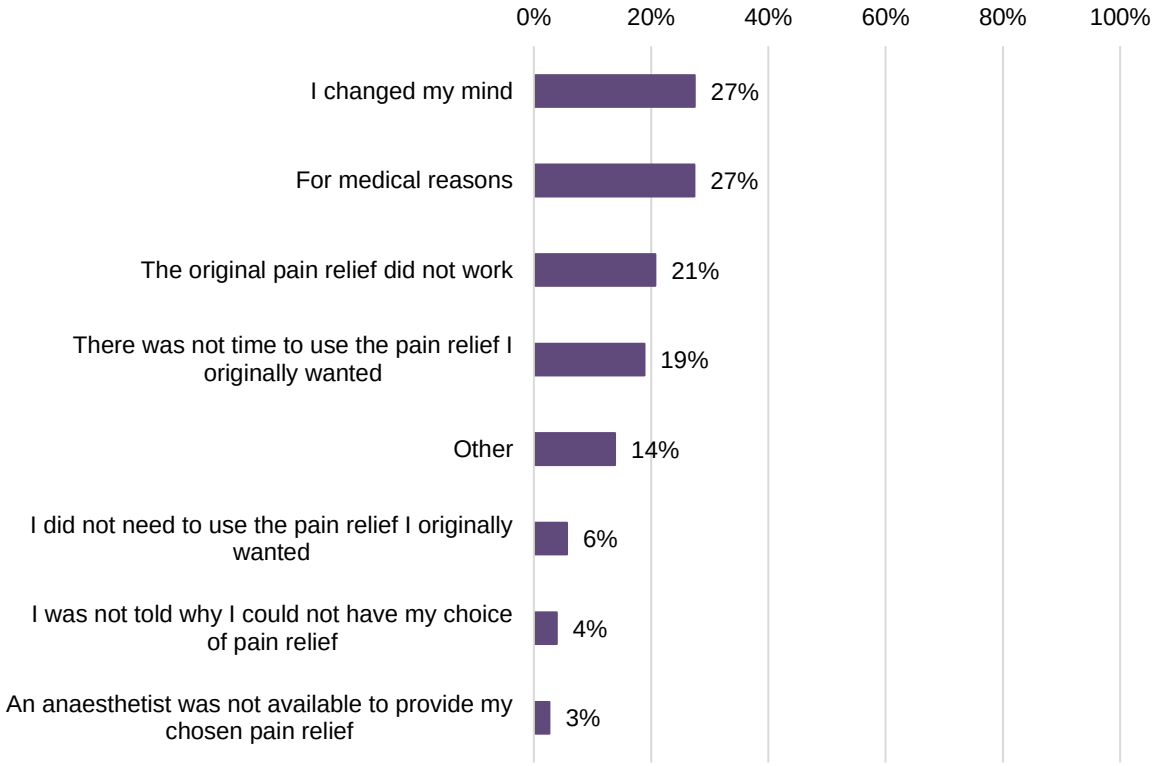


Number of respondents: 2017 (16,029) 2018 (14,821) 2019 (14,190)
Answered by those who had a labour or did not have a planned caesarean.
Multiple response question - percentages may not sum to 100.

The pain relief used changed during labour for 38% of women (compared to what was originally planned). Women who were giving birth for the first time were more likely than other women to change pain relief option (47% compared to 27% of other women).

The most common reasons for not using planned pain relief were medical reasons (27%) and changing their mind (27%). Followed by the planned pain relief not working (21%) or that there was no time to use the pain relief originally wanted (19%). Three percent of women said there was no anaesthetist available to provide the chosen pain relief and 4% said that they were not told why they could not have their choice of pain relief.

C5. Why did you not use the pain relief that you had originally wanted (before you went into labour)?



Number of respondents: 3,907
Answered by those who had a labour or did not have a planned caesarean, and whose pain relief changed from what they had originally wanted.
Multiple response question - percentages may not sum to 100.

Induced births

NICE recommends induction of labour (i.e. artificially starting labour) to prevent prolonged pregnancy or if there is a risk to the baby or the mother's health.[38] Inductions are usually planned in advance and women should be able to discuss the advantages and disadvantages with their doctors or midwives. For the first time in the maternity survey, we specifically asked about induction. Results show that 44% of women who responded had their labour induced.

Research indicates that induced labour may be more painful than spontaneous labour and women are more likely to need epidural analgesia and assisted delivery. It can therefore be more resource intensive and can place additional strain on labour wards compared with spontaneous labour; however, there are often very good reasons for induction.[39] Findings from research conducted in 2015 indicated that when women had to make a decision about whether to have an induction, information from health professionals was sparse and often difficult for women to relate to their own circumstances. This resulted in women's experience of induction differing from what they expected and negatively impacting on their experiences of care.[40]

The results show that women whose labour was induced were more likely to have an epidural than women who had a spontaneous birth (47% of women whose labour was induced compared with 19% of women who had a spontaneous birth). Similarly, 31% of women whose labour was induced had an injection of pethidine or a similar

painkiller compared to 20% of women who had a spontaneous labour. In contrast, only 7% of women whose labour was induced used water or a birthing pool, compared to 29% of those with spontaneous labour.

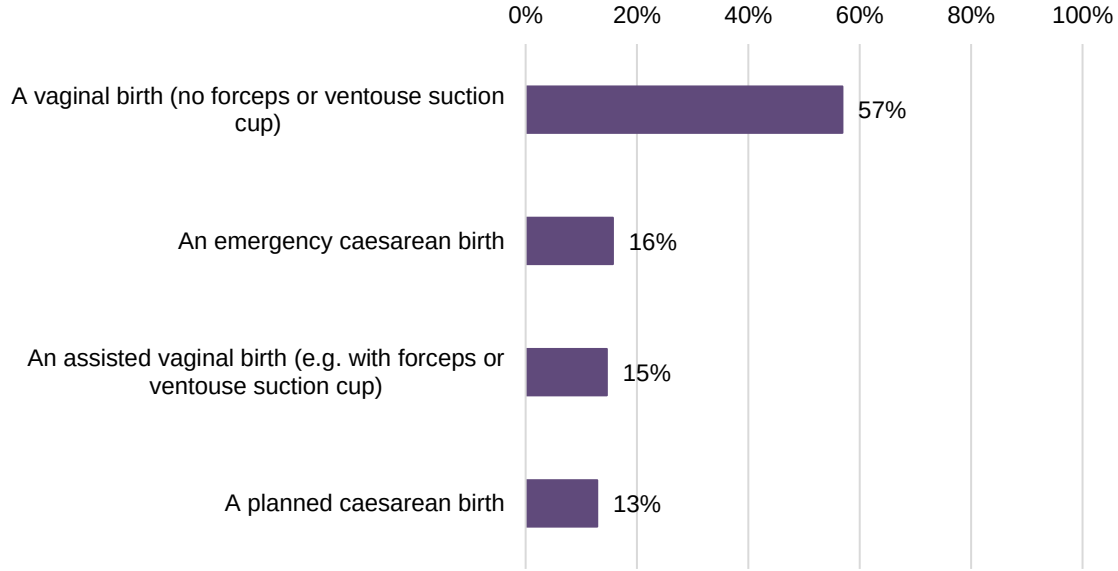
Twenty-two per cent of respondents whose labour was induced gave birth via emergency caesarean section compared to 11% of respondents who had a spontaneous labour. The proportion of those whose delivery was assisted is also higher for respondents whose labour was induced (21% of respondents whose labour was induced compared to 14% of respondents whose labour was not induced).

Nineteen per cent of women who had an induction said that they felt that if they had a concern during labour and the birth it was **not** taken seriously. This was higher than for other women (15%). Women whose labour was induced were also less likely to say that their partners were involved as much as they wanted when compared to other women (4% said a partner was not involved as much as they wanted compared to 3%) and that they 'completely' had the opportunity to ask questions about the labour after their baby was born (52% compared to 59% for other women).

Type of delivery

Fifty-seven per cent of women said that they had an unassisted vaginal birth, which is the most commonly reported type of delivery. The percentage of unassisted vaginal births is stable from last year, but has decreased from 62% in 2013. Since 2018, there was a small increase in the proportion of women saying they had a planned caesarean birth (from 12% in 2018 to 13% in 2019).

C8: What type of birth did you have?



Number of respondents: 16,895
Answered by all.

Most women said that they gave birth on a bed (82%). Eleven per cent said they gave birth in water/a birthing pool and 4% on the floor. These proportions are stable compared to 2018.

During labour, women are advised to keep moving as it helps to find a position that can reduce the pain.[37] NICE clinical guidance on Intrapartum care for healthy women and babies describes how women should be encouraged to move around and adopt whatever positions they find most comfortable throughout labour. While research shows that it is beneficial and may be more comfortable 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.[41]

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.[42] [43]

Most women who responded to the survey gave birth lying down, either with their legs in stirrups (37%, consistent with 2018 but up from 32% in 2013) or lying flat/ supported by pillows (23%, consistent with 2018 but down from 26% in 2013). The proportion of women saying they gave birth while standing, squatting or kneeling increased to 18% from 16% in 2018. However, this proportion has fluctuated over the years (from 15% in 2013 and 2015 to 17% in 2017).

As might be expected, a large proportion of women who had an assisted delivery gave birth lying with legs in stirrups (89%). However, almost a quarter (24%) of women who had an unassisted vaginal delivery said they gave birth lying with legs in stirrups.

C10. What position were you in when your baby was born? By C8. What type of birth did you have?

		C8 What type of birth did you have?	
		A vaginal birth (no forceps or ventouse suction cup)	An assisted vaginal birth (e.g. with forceps or ventouse suction cup)
C10 What position were you in when your baby was born?	Sitting / sitting supported by pillows	17%	4%
	On my side	6%	0%
	Standing, squatting or kneeling	22%	0%
	Lying flat / lying supported by pillows	27%	6%
	Lying with legs in stirrups	24%	89%
	Other	4%	1%
	Total	9,499	2,440

For analysis purposes these data have been weighted by the weight applied to question C10 for the whole population.

NICE recommends 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 improves breastfeeding initiation and continuation rates.[44,45] The World Health Organization recommends that skin-to-skin contact happens during the first hour after birth.[46] Results from the survey shows that most women (93%) said they had skin-to-skin contact following the birth.

Involvement and responsiveness

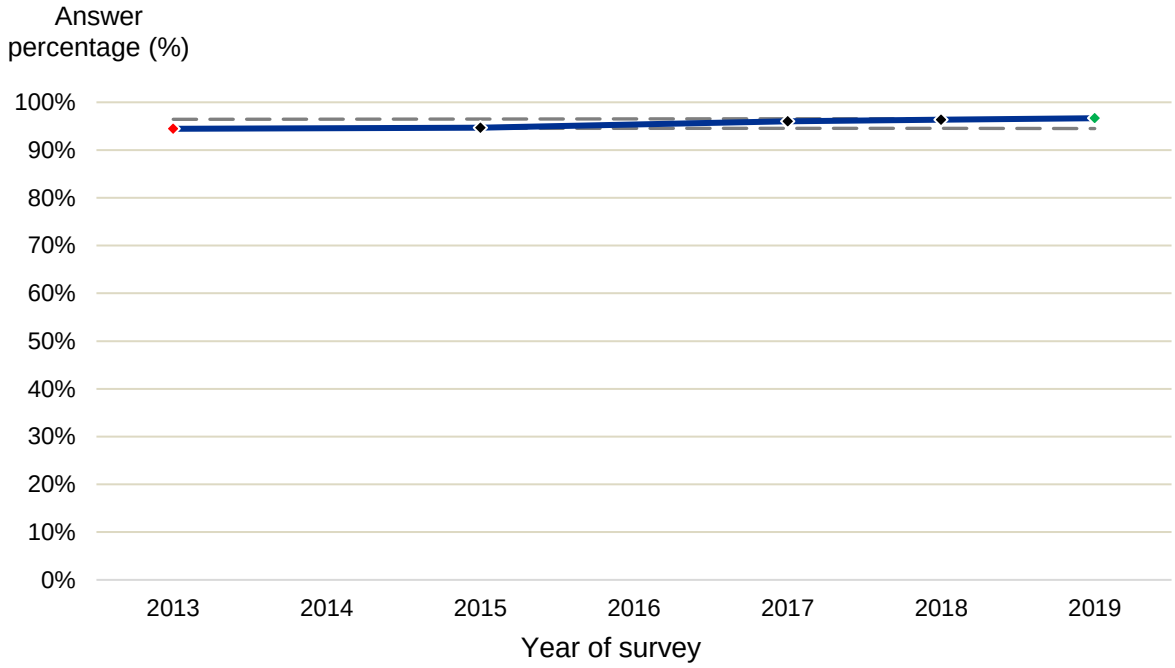
All current national policy emphasises the importance of women feeling involved in their care. NICE clinical guidance on Intrapartum care for healthy women and babies notes the importance of ensuring that women feel in control and involved in what is happening to them. They should be involved in discussions and make informed decisions about their care, including decisions about their birth plan options for managing the stages of labour, and discussions around any tests or interventions.

More than three quarters (78%) of women said that they were 'always' involved in decisions about their care during labour and birth. Eighteen per cent of women said they were 'sometimes' involved, with 4% saying they were not involved in these decisions.

Women should also 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.[47] However, *Better Births* highlighted that some partners felt excluded and that their role was not recognised, and recommended that healthcare staff help to involve partners where appropriate.

In 2019, 97% of women said that their partner or someone else close to them was involved as much as they wanted, up from 94% in 2013. The results went from below to above control limits, showing a trend of improvement between 2013 and 2019.

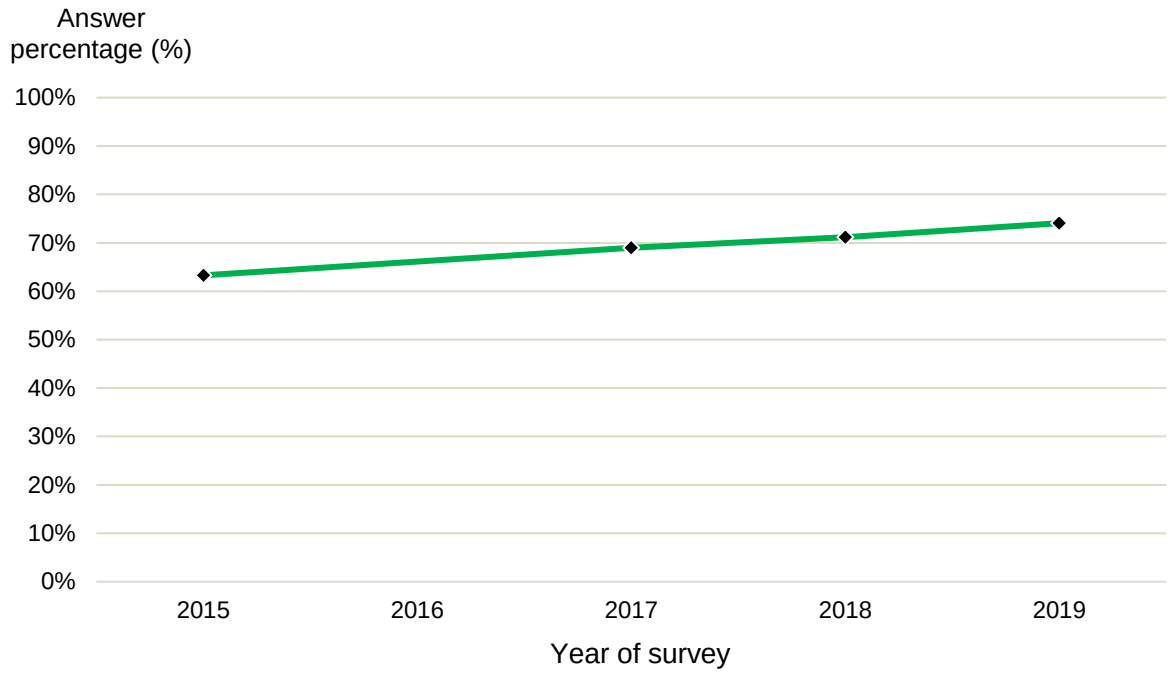
C12. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? - Yes



Number of respondents: 2013 (22,062) 2015 (19,159) 2017 (17,980) 2018 (16,986) 2019 (16,628)
Answered by all.
Respondents who stated that they did not have a partner / companion with them, did not want their partner / companion to be involved, or that their partner / companion did not want to / could not be involved have been excluded.

After the birth, during postnatal care in hospital, 74% of women that their partner or someone else close to them was able to stay with them as much as they wanted compared with 63% in 2015. The proportion of respondents who said they were restricted by visiting hours, decreased from 30% in 2015, to 24% in 2017, 22% in 2018 and 18% in 2019.

D7. 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? - Yes

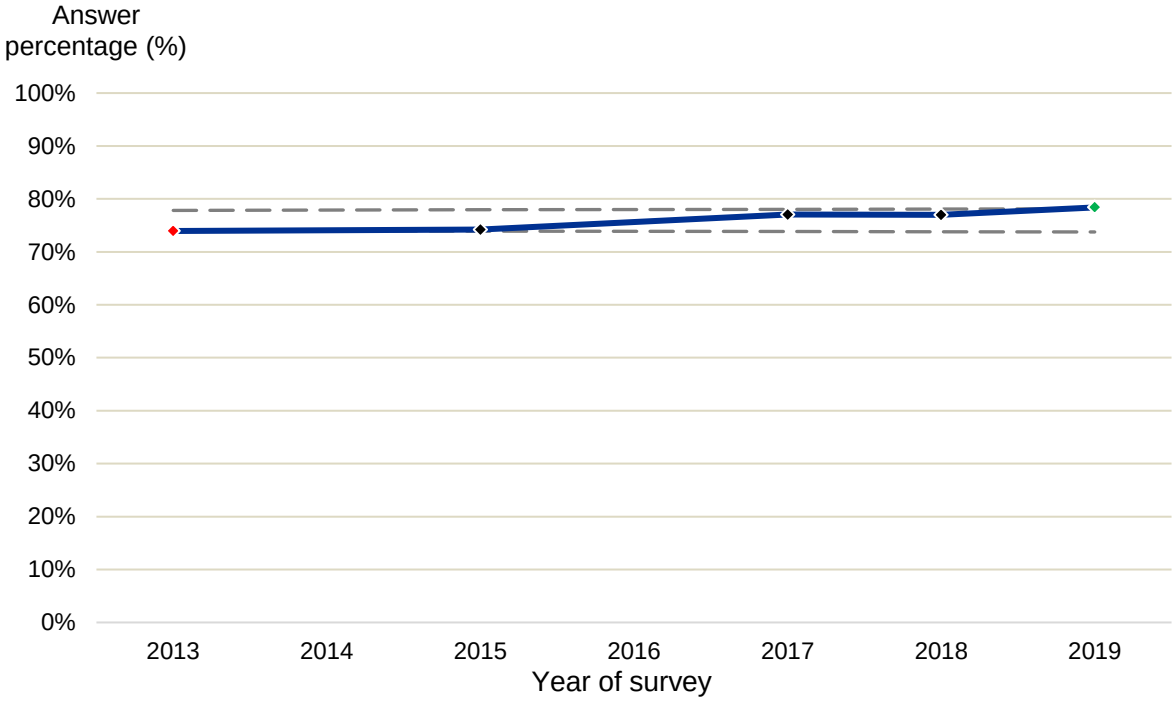


Number of respondents: 2015 (18,355) 2017 (17,129) 2018 (16,147) 2019 (15,880)
Answered by those who stayed in hospital after the birth.
Respondents who stated that their partner / companion was not able to stay for another reason, or that they did not have a partner / companion with them have been excluded.

All current national policy and guidance states that one-to-one midwifery care should be provided to women in established labour. A Cochrane review looking at continuous support during labour suggests that this can improve outcomes for both mother and baby, for example, increased spontaneous vaginal birth, shorter duration of labour, decreased caesarean births, and a decreased need for an assisted vaginal birth.[48]

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. This has improved over time, with the line representing those saying that it did not happen to them ‘at all’ going from below control limits in 2013 to above control limits in 2019. The proportion of women saying they were left alone while they were worried during the later stages of labour (just before the birth) decreased significantly from 8% in 2018 to 6% in 2019.

C15. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? – No, not at all



Number of respondents: 2013 (22,403) 2015 (19,521) 2017 (18,042) 2018 (16,956) 2019 (16,736) Answered by all.

Nine per cent of respondents said that a member of staff was with them all the time during the labour and birth, and 72% said they 'always' were able to get a member of staff to help them when they needed it. Sixteen per cent said that they 'sometimes' could and 3% said they could not.

NICE advises midwives to show the woman and her birth companion(s) how to summon help and reassure her that she may do so whenever and as often as she needs to at the beginning of labour. When leaving the room, midwives should let them know when they will return.

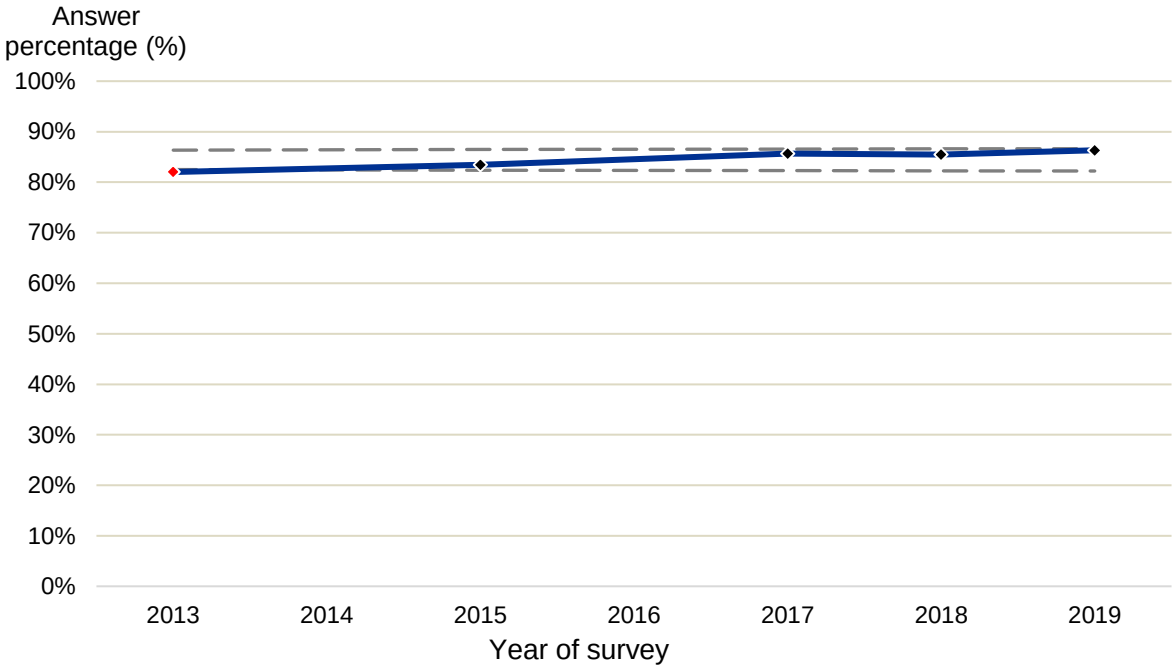
Communication and interactions

Better Births says that women's experiences of maternity services are linked to the quality of the care that staff provide. 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. As labour and birth can last for a long time, there might be handovers of care between different health professionals (for example because of a work shift) requiring them to introduce themselves to the woman in labour.

The proportion of women saying that 'all of the staff introduced themselves' increased over time, from below control limits in 2013 (82%) to within control limits in 2019 (86%). The change is also significant from 2018 (85%). One per cent said 'very few' or 'none' of the staff introduced themselves.

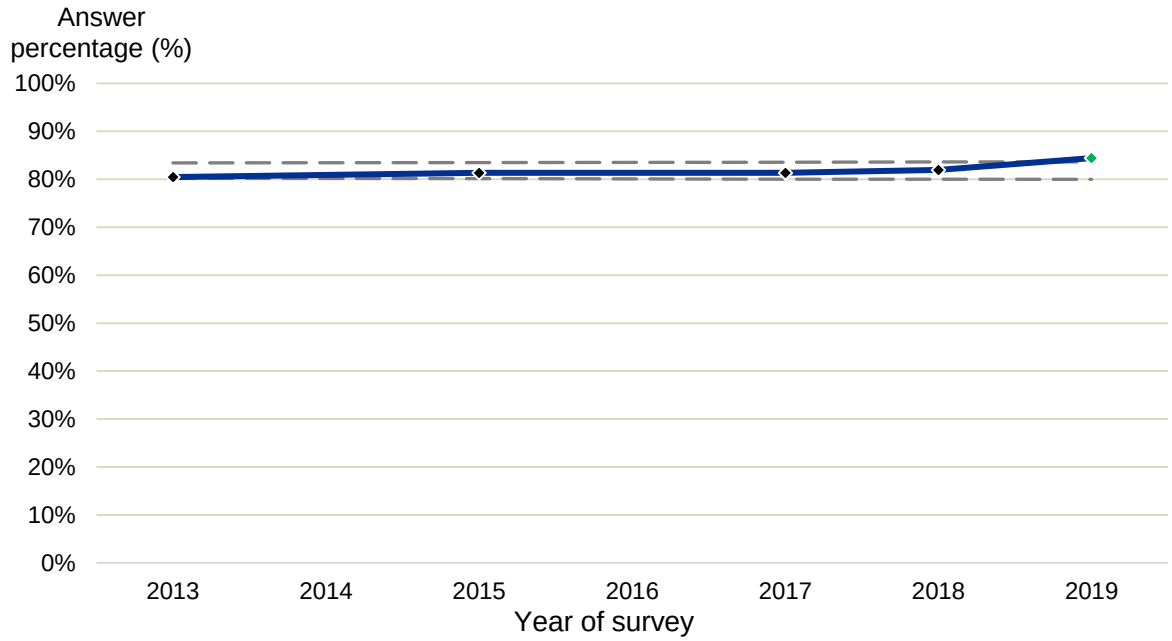
C13. Did the staff treating and examining you introduced themselves? – Yes, all of the staff introduced themselves



Number of respondents: 2013 (22,119) 2015 (19,258) 2017 (17,965) 2018 (17,089) 2019 (16,745)
Answered by all.
Respondents who stated that they did not know / could not remember have been excluded.

Results show that how well staff respond to women's concerns has improved over time. The proportion of those saying that they did feel that their concerns were taken seriously increased from 80% in 2013 to 84% in 2019 while crossing control limits. It increased by two percentage points between 2018 and 2019.

C16. If you raised a concern during labour and birth, did you feel that it was taken seriously? - Yes



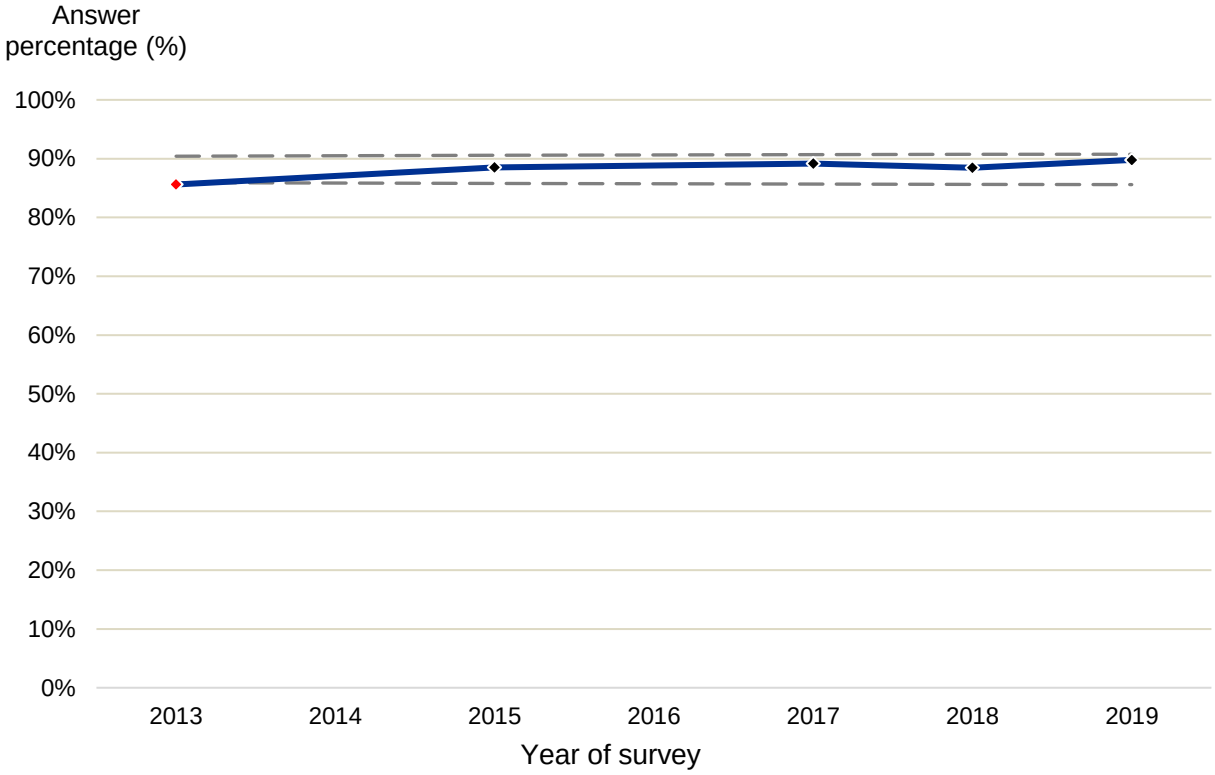
Number of respondents: 2013 (13,660) 2015 (12,358) 2017 (11,233) 2018 (10,709) 2019 (10,633)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Despite these improvements, about one in six women (16%) said that they felt that when they raised a concern during labour and birth, it was not taken seriously, a proportion decreasing from 18% last year.

NICE guidance on Intrapartum care for healthy women and babies advises that all healthcare professionals should make sure that in all birth settings there is a culture of respect for each woman as an individual. Recognising they are undergoing a significant and emotionally intense life experience, and ensuring that women feel in control, are listened to and cared for with compassion. Informed consent must also be sought.

A majority of women (90%) said that, during labour and birth, they were 'always' spoken to in a way they understood. This is an increase of two percentage points compared to 2018 (88%) and longer trend improvement is visible since 2013 when it was below control limits (at 86%). The proportion of those who said it happened 'sometimes' decreased from 10% in 2018 to 9% in 2019.

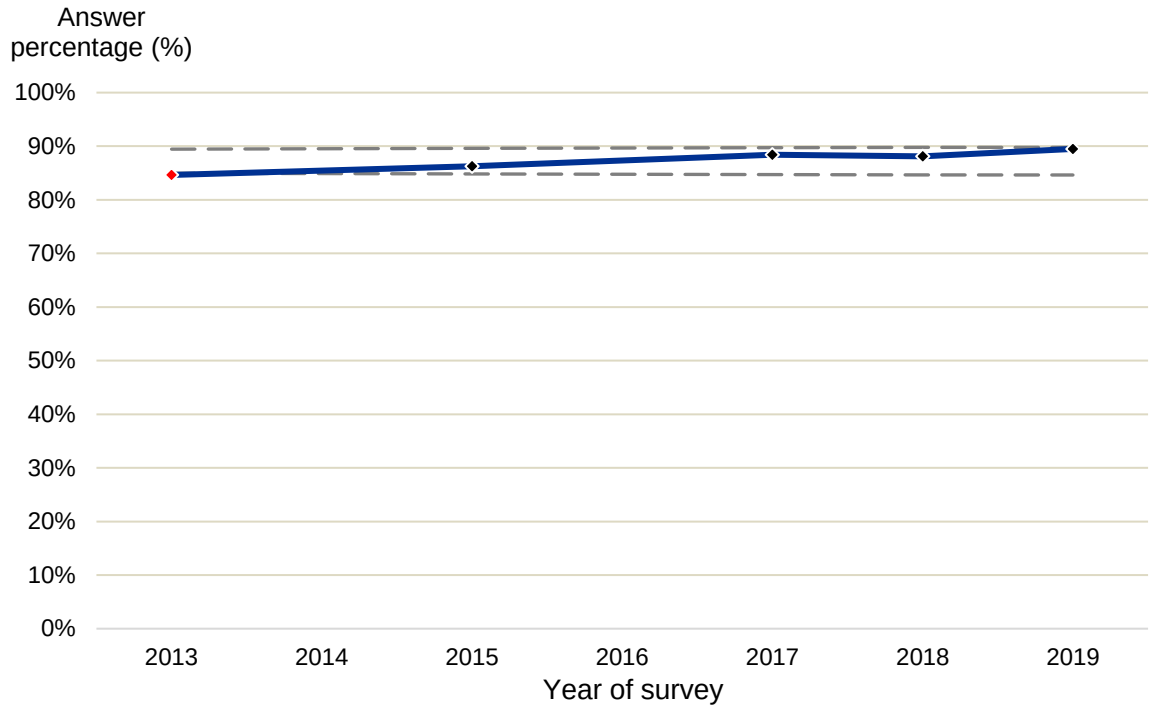
C18. Thinking about your care during labour and birth, were you spoken to in a way you could understand? – Yes, always



Number of respondents: 2013 (22,353) 2015 (19,485) 2017 (18,139) 2018 (17,318) 2019 (16,914)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Women reporting that they had been treated with respect and dignity also improved. In 2019, 89% of respondents said that they had ‘always’ been treated with respect and dignity compared with 88% in 2018. This is a significant improvement from 85% in 2013 when it was below control limits. Similarly, the proportion of those saying they had ‘sometimes’ been treated with respect and dignity and the proportion of those saying they had **not** been decreased (respectively 9% and 2% in 2019).

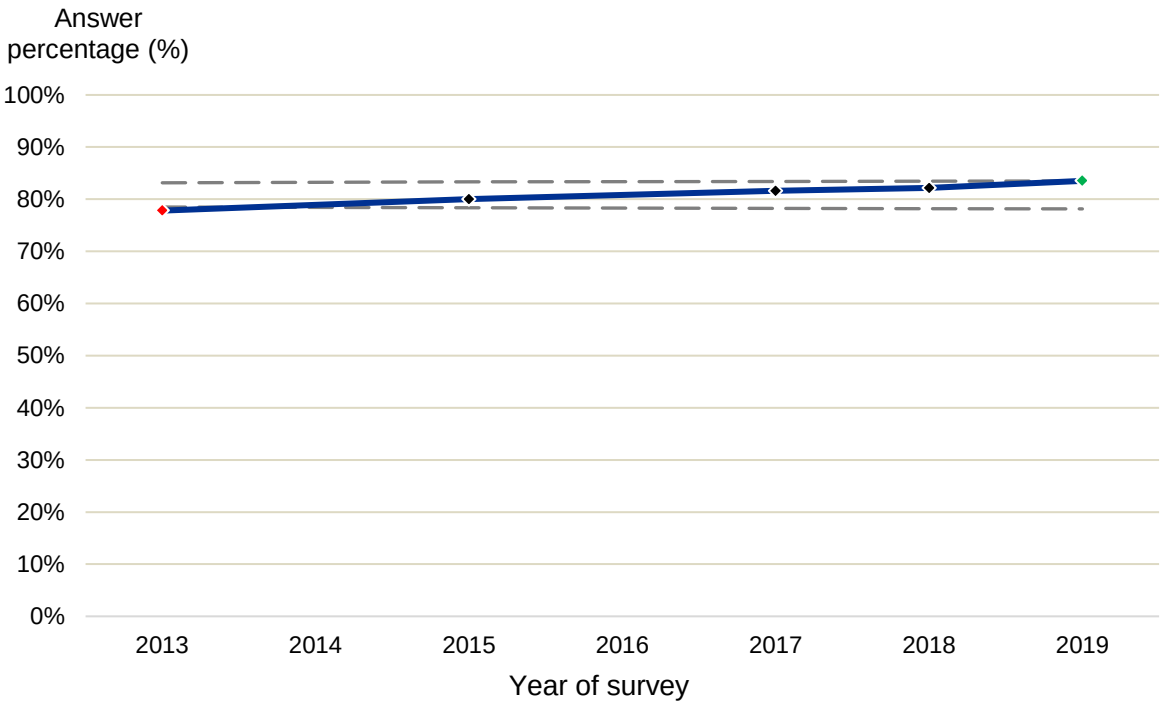
C20. Thinking about your care during labour and birth, were you treated with respect and dignity? – Yes, always



Number of respondents: 2013 (22,392) 2015 (19,495) 2017 (18,158) 2018 (17,339) 2019 (16,930)
Answered by all.
Respondents who stated that they didn’t know / couldn’t remember have been excluded.

The proportion of women saying they ‘definitely’ had confidence and trust in the staff caring for them during their labour and birth has increased significantly from 78% in 2013 to 84% in 2019. There was also a significant year-on-year decrease in the proportion of those saying that they had confidence and trust ‘to some extent’ (from 15% in 2018 to 14% in 2019) and those saying they did not have confidence and trust (from 3% in 2018 to 2% in 2019).

C21. Did you have confidence and trust in the staff caring for you during your labour and birth? – Yes, definitely



Number of respondents: 2013 (22,463) 2015 (19,533) 2017 (18,194) 2018 (17,410) 2019 (16,936)
Answered by all.
Respondents who stated that they don’t know / couldn’t remember have been excluded.

4. Postnatal care in hospital

The following section presents the survey results regarding the care received in hospital after the birth. Women who gave birth at home and did not go to hospital were asked not to answer these questions.

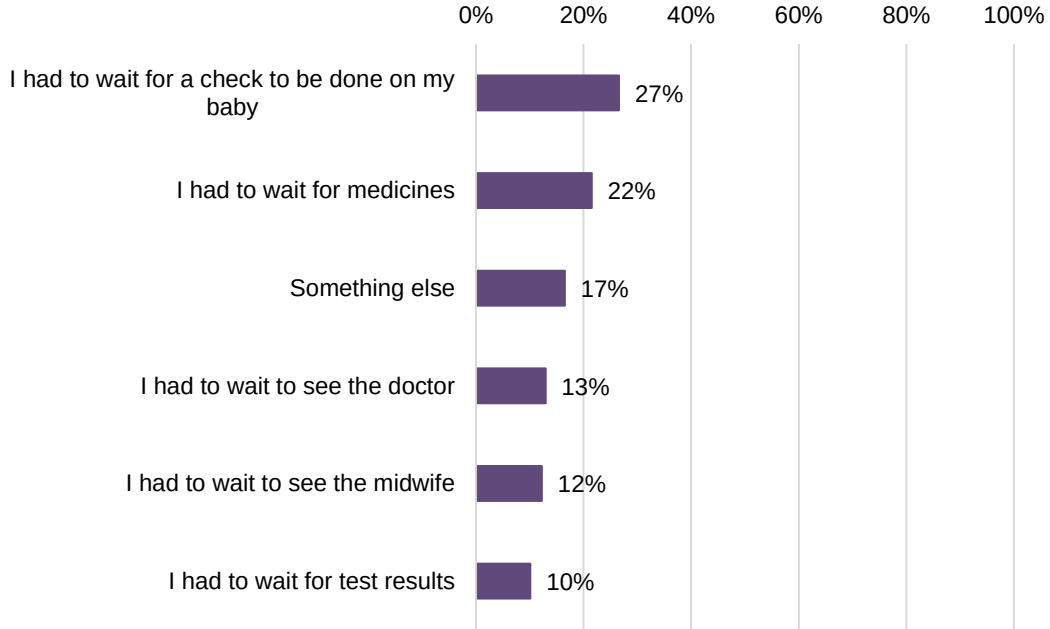
Length of stay and discharge

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.[49] 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 (74%) who responded to the survey left hospital within two days of the birth. Between 2018 and 2019, there was a slight but significant increase in the proportion of women saying they stayed more than 12 hours but less than 24 hours (from 20% to 22%).

Forty-four per cent of women said that on the day they left hospital their discharge had been delayed. This represents a decrease from 45% in 2018. Looking at the main reasons for delay in discharge, the most common is 'I had to wait for a check to be done on my baby' (selected by 27% of women whose discharge from hospital was delayed).

D3. What was the main reason for the delay?



Number of respondents: 2019 (6,310)
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 personalised care should continue through postnatal care, with women having choice and involvement in decision making. Women should be able to talk about their experiences and ask questions.

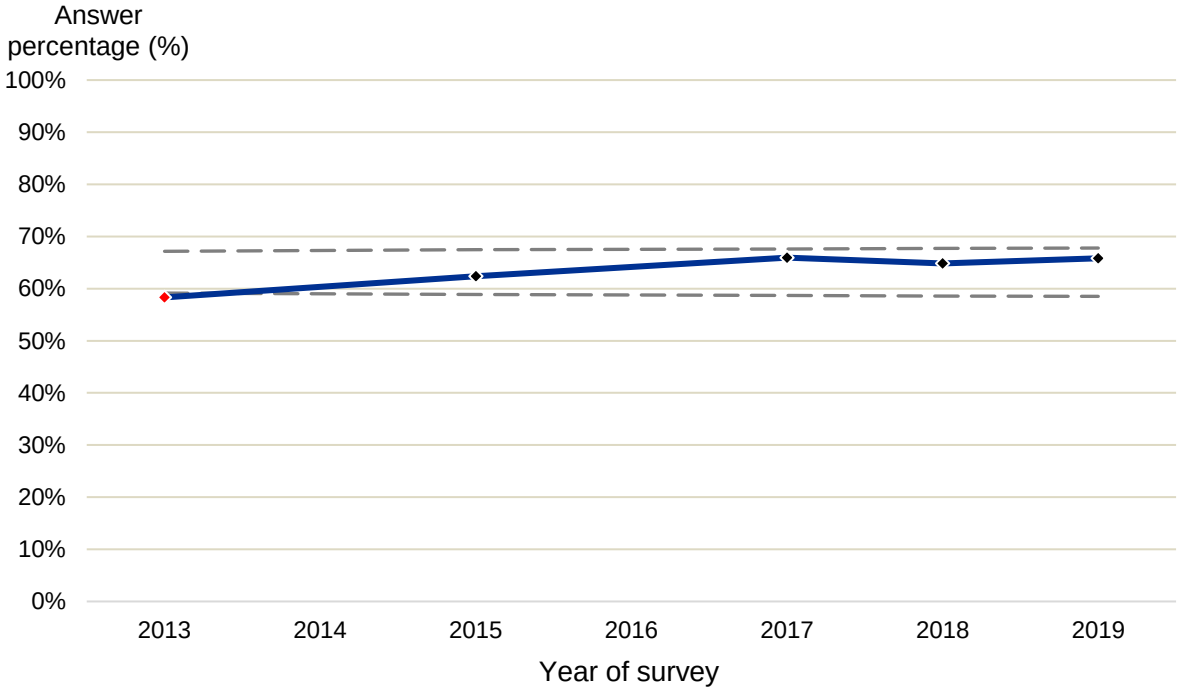
The survey asked questions about whether women received the care and information they needed while in hospital after the birth. Results show that women's experience of postnatal care might not be as positive as their experience of antenatal care and labour and birth.

Although women were generally positive about communication during labour and birth, it does not seem to be the case post birth. When asked if, after their baby was born, they had the opportunity to ask questions about their labour and the birth, 56% of women said 'yes, completely'. More than a quarter (26%) said they did 'to some extent' and 18% said they did not.

Availability of staff in hospital, outside of the acute setting of the labour ward might be at stake with less than two thirds (62%) of women saying they were always able to get a member of staff to help them when they needed attention in hospital after the birth. This is much lower than the 81% reporting always being able to get help from a member of staff when they needed it during labour or that a member of staff was with them at all times during labour. In hospital after the birth, 31% of women said they 'sometimes' got a member of staff to help them when they needed it and 6% said they **did not**.

The proportion of women saying they were ‘always’ given the information or explanations they needed in hospital after the birth has improved over time. This moved from below control limits in 2013 (58%) to within control limits in 2019 (66%). The proportion of women saying they did not receive the information or explanations they needed decreased by two percentage points since last year (from 9% in 2018 to 7% in 2019) and almost halved since 2013 (12%).

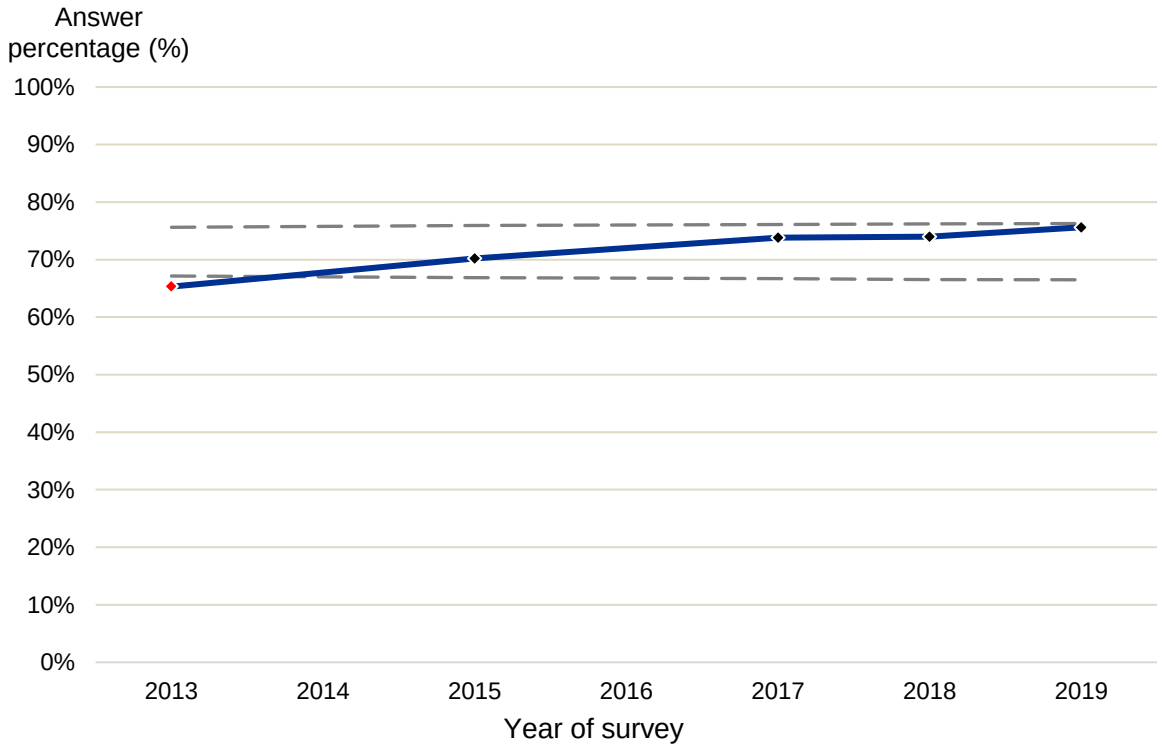
D5. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? – Yes, always



Number of respondents: 2013 (22,056) 2015 (19,199) 2017 (17,906) 2018 (17,045) 2019 (16,490)
Answered by those who stayed in hospital after the birth.
Respondents who stated that they didn’t know / couldn’t remember have been excluded.

The proportion of women who said that they were ‘always’ treated with kindness and understanding while in hospital after the birth has continued to improve, increasing from 65% in 2013 (below control limits) to 76% in 2019 (within control limits). There was a corresponding decrease in those saying they ‘sometimes’ had been (from 28% in 2013 to 21% in 2019) and those saying they had not been treated with kindness and understanding (from 6% in 2013 to 3% in 2019).

D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? – Yes, always



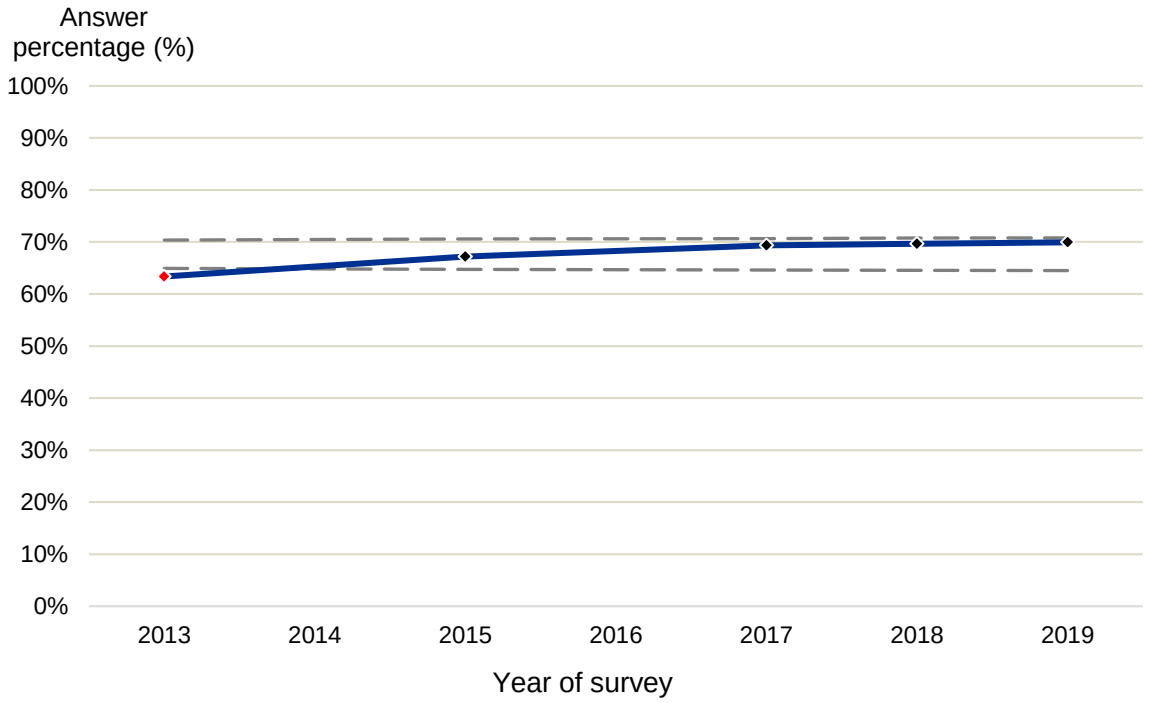
Number of respondents: 2013 (22,113) 2015 (19,249) 2017 (17,979) 2018 (16,985) 2019 (16,595)
Answered by those who stayed in hospital after the birth.
Respondents who stated that they didn’t know / couldn’t remember have been excluded.

Cleanliness

Cleanliness is essential to good infection control. The Code of Practice on the prevention and control of infections 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.[50] 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 the results are stable compared to the last two years, this has improved since 2013 when 63% of women then said that the hospital room or ward was 'very clean'.

D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in? – Very clean



Number of respondents: 2013 (22,062) 2015 (19,192) 2017 (17,915) 2018 (17,017) 2019 (16,552)
Answered by those who stayed in hospital after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded.

5. Infant feeding

National policy and guidelines promote breastfeeding and the associated benefits. 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. Women are encouraged to actively consider the way they want to feed their baby while pregnant.

NICE clinical guidelines on antenatal care for uncomplicated pregnancies recommends that midwives should discuss breastfeeding as early as the booking appointment and keep providing support and advice during the whole antenatal period. In addition, pregnant women should be offered opportunities during the pregnancy to attend breastfeeding workshops.

Just under three-fifths of women (57%) said that during their pregnancy midwives 'definitely' provided relevant information about feeding their baby. Twenty-nine per cent said they did 'to some extent' and 14% that they did not.

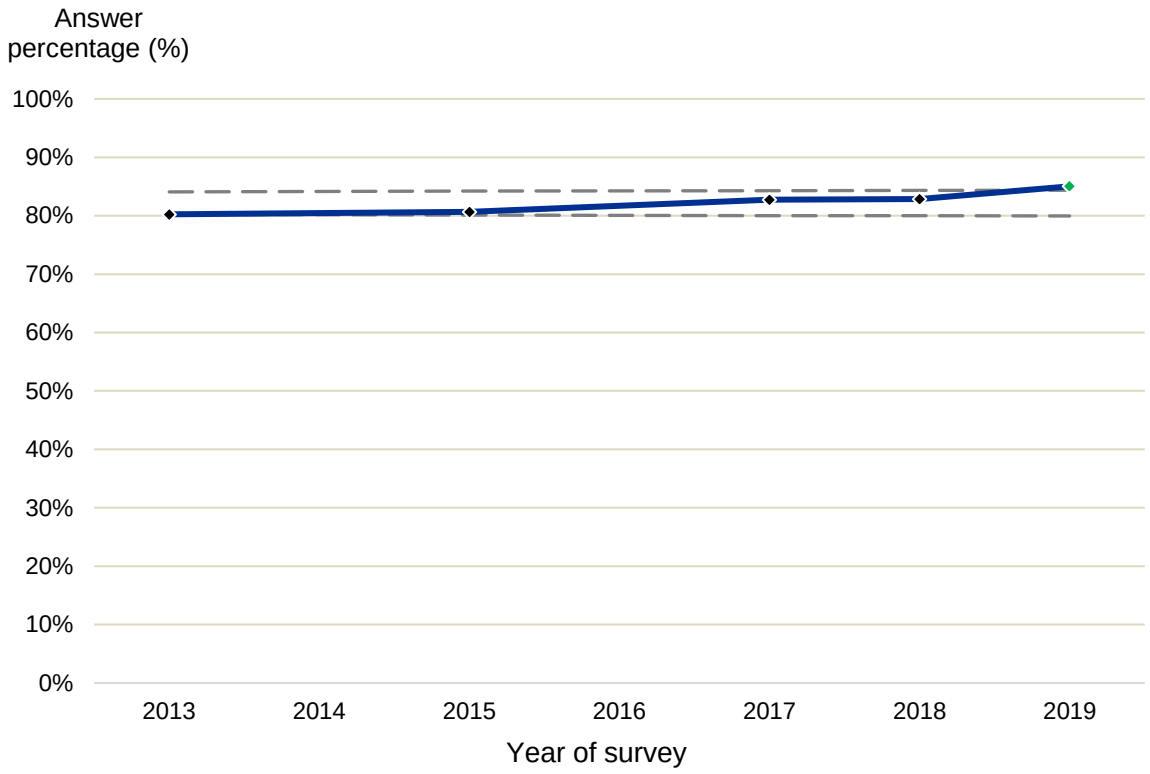
The first few hours and days after birth are critical for midwives providing new mothers with the care and support they need to breastfeed successfully.[51] Guidance from the Royal College of Midwives describes how midwives have a valuable role in providing support and advice to new mothers to encourage breast-feeding such as by helping them to find a new position and adopting an 'enabling' approach.[44] To support this the World Health Organization (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 their baby with breast milk only and 23% with both breast and formula (bottle) milk. There was a slight but significant decrease in the proportion of those saying they used formula (bottle) milk only (from 20% in 2018 to 19% in 2019).

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.[52]

Improvements are visible over time in this domain. In 2019, 85% of respondents said that their decisions about how they wanted to feed their baby were ‘always’ respected by midwives, an increase from 83% in 2018. This crosses the upper limit of the control chart indicating an upward trend over time.

E2. Were your decisions about how you wanted to feed your baby respected by midwives? – Yes, always



Number of respondents: 2013 (22,355) 2015 (19,408) 2017 (18,138) 2018 (17,376) 2019 (16,972)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Twelve per cent of respondents said their decisions regarding how to feed their baby were ‘sometimes’ respected and 3% said their decisions had not been respected.

Women who said their decisions were ‘always’ respected by midwives were more likely to have fed their baby with breast milk (or expressed breast milk) only during the first few days after the birth.

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?

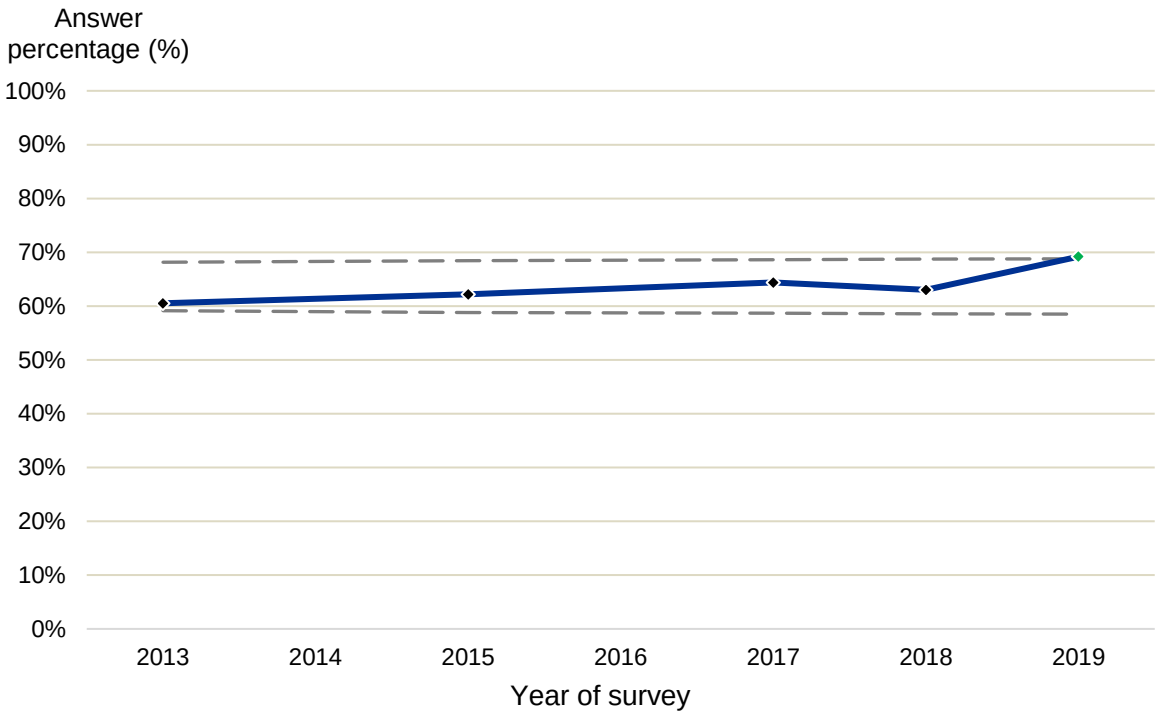
		E2 Were your decisions about how you wanted to feed your baby respected by midwives?		
		Yes, always	Yes, sometimes	No
E1 In the first few days after the birth how was your baby fed?	Breast milk (or expressed breast milk) only	63%	34%	28%
	Both breast and formula (bottle) milk	19%	44%	47%
	Formula (bottle) milk only	18%	22%	26%
	Total	14,379	2,031	484

For analysis purposes these data have been weighted by the weight applied to question E1 for the whole population.

Women were also asked whether they felt that midwives and other health professionals took their personal circumstances into account when giving advice about feeding their baby. Sixty-nine per cent of women said they ‘always’ did. However, one in five women (20%) said that they did ‘sometimes’, 7% said they did not and another 4% said they did not receive any advice.

Nonetheless, there were improvements over time in terms of support given by health professionals about infant feeding. In 2019, 69% of women said they were ‘always’ given active support and encouragement about feeding their baby – this crossed the upper control limit indicating a significant change over the longer period. Twenty-three per cent of women said they did ‘sometimes’ and 8% said they did not.

E4. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? – Yes, always



Number of respondents: 2013 (21,084) 2015 (18,440) 2017 (17,195) 2018 (16,463) 2019 (16,199)
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.

Evidence shows that though a high proportion of women start breastfeeding, very few continue for the six-month period recommended by the World Health Organization (WHO). For example, the Infant Feeding Survey (2010) reported that while 81% of mothers breast-feed at birth, this dropped over time to 69% at one week, 55% at six weeks and to 34% at six months.[53] It is therefore important that women continue to receive support in the early weeks after leaving hospital.

We asked women whether, in the six weeks after the birth, they received help and advice from a midwife or health visitor about feeding their baby. Sixty-two per cent of women said that they ‘definitely’ did, a proportion stable from last year. The proportion of those saying they did **not,** increased slightly from 9% in 2018 to 10% in 2019, while the proportion of those saying ‘to some extent’ decreased from 29% to 27%.

Similar to last year, over half of women said that if they needed support or advice about feeding their baby during evenings, nights or weekends they could ‘always’ get this (53%). The remainder of women said they could not get this (24%) or that they could get it ‘sometimes’ (23%).

6. Postnatal care at home

When going home after the birth, women and their babies still need to receive special care from maternity services. During the 6 to 8 weeks following the birth, they should continue to benefit from individualised care that includes monitoring of maternal health (including physical and mental health), infant feeding and maintaining infant health.

NICE notes that although the postnatal period is uncomplicated for most women and babies, care during this period needs to address any variation from expected recovery after birth.[54] The guidance recommends that postnatal care should include providing appropriate advice and support and assessing the health and needs of both the mother and baby.

Better Births calls for more support for women at home after the birth. It recommends that personalised care should continue at home with health professionals providing comprehensive support to new mothers and their babies.

Most women will be discharged from midwifery care to a health visitor approximately 10 days after birth, 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. As a result, some questions in this section of the questionnaire ask about care from midwives as well as other health professionals.

Organisation of postnatal care outside of the hospital

Good postnatal care should enable women to take part in the decision about where it takes place. NICE guidance describes how appointments can take place in the woman or baby's home or another setting such as a GP practice or children's centre.

Results from the survey show that less than half of women who responded (48%) said that they were given a choice about where their postnatal care would take place, an increase from 42% in 2018. Although not directly comparable, this can be put in perspective with the results to the question on choice of place of birth (see antenatal care section). It could indicate that women were offered more choice in terms of place of birth than in terms of place of postnatal care.

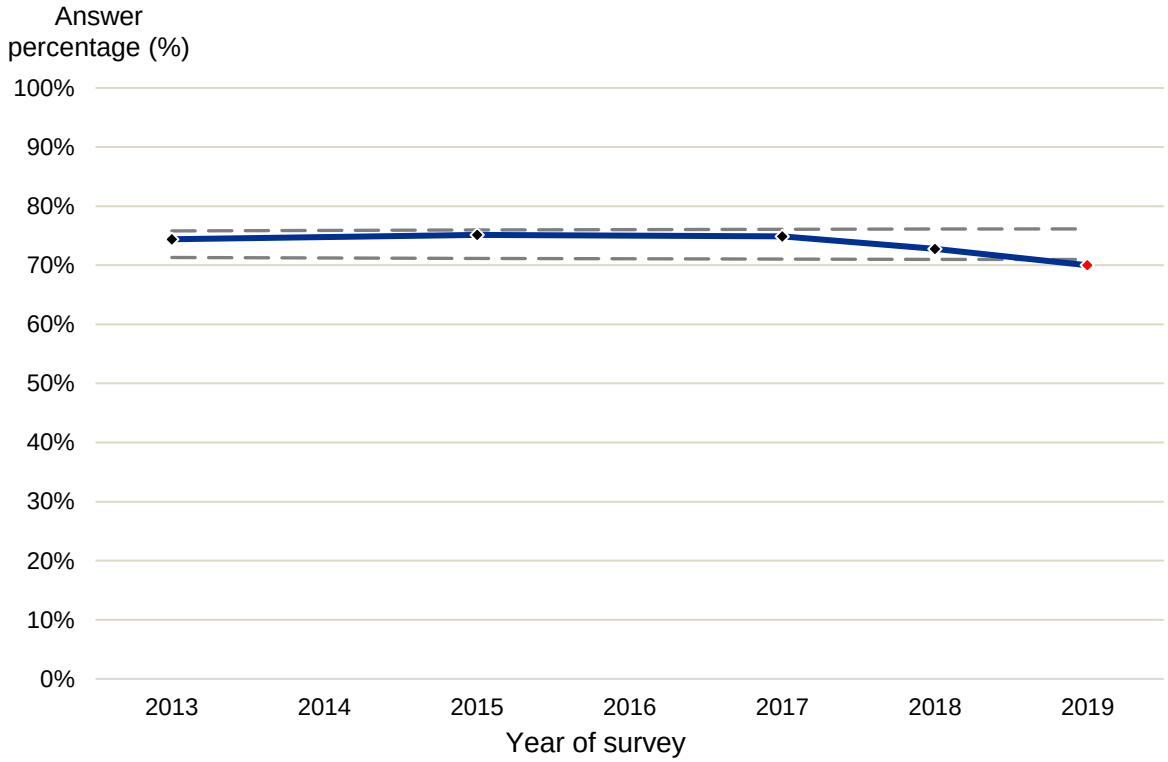
Unchanged since last year, the majority of women (96%) were visited at home by a midwife, though 2% said they had to ask for this. The proportion who received a visit without needing to request it has decreased over time from 95% in 2013 to 93% in 2018 and 2019.

NICE recommends that women and their babies should receive a 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.

A quarter (25%) of women said they would have liked to see a midwife more often after going home. This is an increase compared to 23% in 2018 and is mirrored by a decrease of the proportion of women saying they saw a midwife as much as they wanted (from 73% in 2018 to 70%). This decrease is significant over the longer

period with the proportion of those saying they saw a midwife as much as they wanted crossing the lower control limit.

F6. Would you have liked to have seen a midwife… - I saw a midwife as much as I wanted



Number of respondents: 2013 (22,159) 2015 (19,240) 2017 (17,966) 2018 (17,121) 2019 (16,702)
Answered by those who saw a midwife after the birth

Personalised care

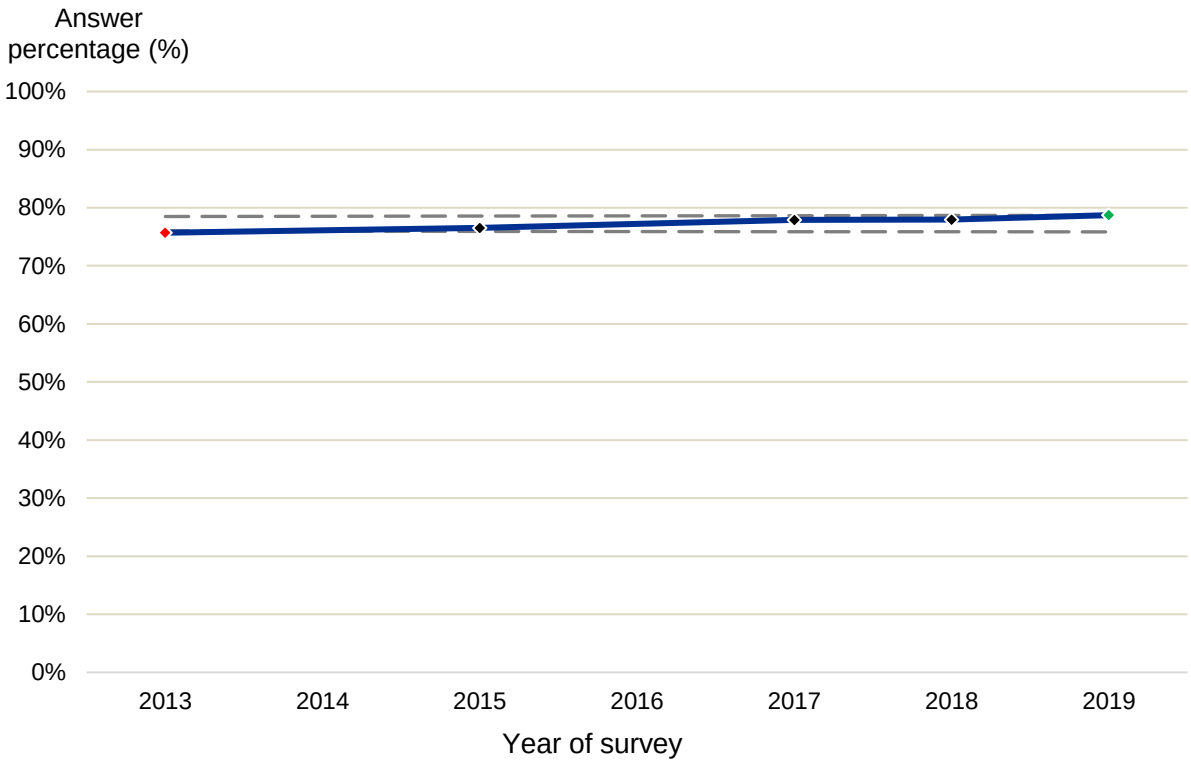
Healthcare professionals need to pay attention to women's personal circumstances in care provided after the birth to ensure that it is responsive and personalised to each woman and their baby.

Midwives and midwifery teams should ensure they are aware of the medical history of the woman and their baby as this can have an impact on the way they recover from the birth. In addition, this can help women to build trust in the midwife.

Seventy-seven per cent of women said that the midwife or midwifery team they saw appeared to be aware of their and their baby's medical history. While we reported a slight decrease in 2018 (76%), this is now back to the level of 2017, indicating that no trend of improvement is visible since 2013.

The proportion of women saying they ‘always’ felt listened to by their midwife and midwifery team has improved slightly since 2013. In 2019, 79% of women said so, compared with 76% in 2013.

F8. Did you feel that the midwife or midwifery team that you saw always listened to you? – Yes, always



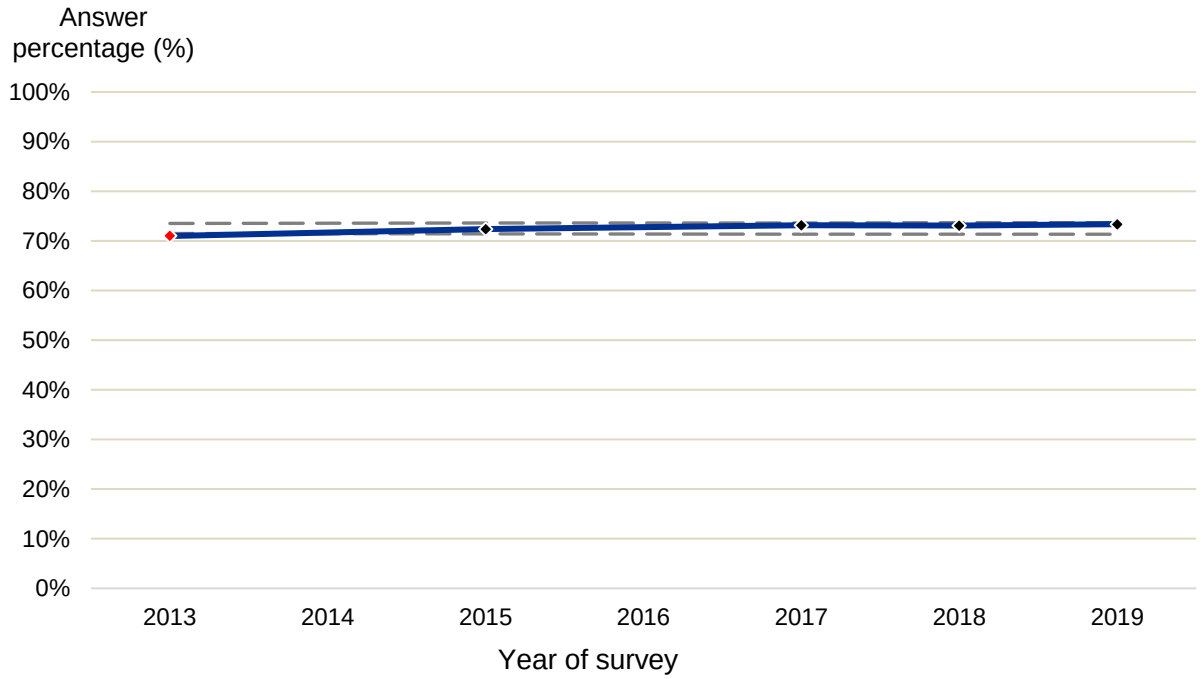
Number of respondents: 2013 (22,197) 2015 (19,285) 2017 (17,988) 2018 (17,167) 2019 (16,730)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn’t know / couldn’t remember have been excluded

Despite these improvements, 18% of women still indicated that they felt that midwives only listened to them ‘sometimes’, and 3% said they felt that midwives did not listen to them.

More than three-quarters of women (78%) said the midwife or midwifery team ‘always’ took their personal circumstances into account when giving them advice. This leaves 19% of women saying they ‘sometimes’ did and 3% saying they did not.

Between 2013 and 2017, there was a slight improvement in the proportion of women saying they 'definitely' had confidence in their midwife or midwifery team after going home, which moved the line above the lower control limit. Since then, there has been no meaningful change in results with just under three-quarters of women (73%) saying they 'definitely' had confidence and trust in the midwives they saw.

F10. Did you have confidence and trust in the midwife or midwifery team you saw after going home? – Yes, definitely



Number of respondents: 2013 (22,123) 2015 (19,177) 2017 (17,904) 2018 (17,037) 2019 (16,707)
Answered by those who saw a midwife after the birth.
Respondents who stated that they didn't know / couldn't remember have been excluded

Availability and 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. This is slightly higher than the proportion of women saying they had a telephone number to contact a midwife or midwifery team during antenatal care (94%).

Of the women who contacted a midwife or midwifery team during their postnatal care, 79% 'always' got the help they needed, 17% 'sometimes' did and 4% did not.

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. Just over half of women (54%) said they were 'definitely' given information about their own physical recovery after the birth. Ten per cent said they did not and 36% said they were given information to 'some extent'.

Similarly, women said that attention to their own physical health during their postnatal check-up with a GP could be improved. Less than half of women (42%) said the GP 'definitely' spent enough time talking to them about their own physical

health. Significant proportions of women said they did so to ‘some extent’ (30%) and said they did not (29%). These results are similar to those regarding whether the GP spent enough time talking to them about their mental health.

In contrast, women had more positive experiences with receiving help and advice from health professionals about their baby’s health and progress. Seventy-one per cent of women said that they ‘definitely’ received this, a slight but significant increase from 70% in 2018. A quarter of women (25%) said they received this ‘to some extent’ and 4% said they did not receive this.

7. Continuity of care

Continuity models of care are associated with better outcomes for mother and baby. In line with *Better Births*, a key ambition of the Maternity Transformation Programme is for women to have a midwife, who is part of a small team of 4 to 6 midwives, who knows the women and family and can provide continuity throughout the pregnancy, birth and postnatally. This is to help women develop supportive relationships with their midwife and ensure that they are looked after by someone they know and trust.

NHS England has set an objective that by March 2021 most women should have the same person caring for them during pregnancy, birth and postnatally. Local Maternity Systems are responsible for drawing up plans to meet this objective.[55]

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 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".*

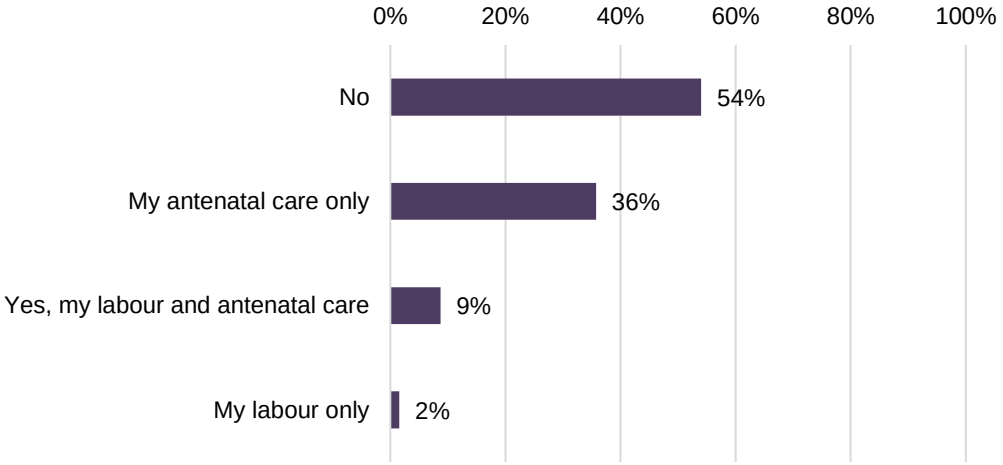
The survey did not directly ask women whether they had a named midwife, but asked women if they saw the same midwife every time for their antenatal check-ups. Questions specifically asked about the continuity of individual rather than care team, but it is important to note that continuity of carer models exist with varying focus on a single individual.[56]

Thirty-seven per cent of women said they saw the same midwife every time during their antenatal check-ups. This was higher than during postnatal care, where 28% of women said they saw the same midwife every time.

We also looked at continuity of carer between the different stages of the pathway. Fewer than one in six women (16%) said that any of the midwives who cared for them during labour had been involved in their antenatal care.

Only 9% of women said that at least one of the midwives who cared for them postnatally had also been involved in both their labour and antenatal care. More than half (54%) said that none of the midwives involved in their postnatal care had been involved in either their antenatal care or their labour. Thirty-six per cent said they had been involved in their antenatal care only and 2% said that they had been involved in their labour only.

F11. Had any midwives who cared for you postnatally also been involved in your labour and antenatal care?



Number of respondents: 16,241
Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded

8. Subgroup analysis summary

We looked at how different groups of women rated their experience 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: B7 for antenatal care and F5 for postnatal care), parity (whether women have had a previous baby or not), type of delivery (question C8), stirrups usage (question C10), ethnicity, religion, sexual orientation, long-term conditions and index of multiple deprivation.

This year, the analysis did not identify significant differences between groups except for one.[I] Women who did not want to disclose their religion had a poorer experience of information during labour.

Please see Appendix G for more details on the methodology used to compute the analysis.

[I] 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.

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 2019 questionnaire underwent significant changes. We removed nine questions, and added 11 new questions. Forty-one pre-existing questions were amended. The instructions on the front cover of the questionnaire were also re-worked.

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, 2017 and 2018.

The survey questionnaire underwent a major redevelopment ahead of the 2013 survey so results for 2019 are **only comparable** with 2013, 2015, 2017 and 2018.[m]

Survey method

As with most surveys in the NHS Patient Survey Programme, the maternity survey used a postal methodology. For those whose first language is not English, people could complete it over the phone via a translation service.

Sample members received their first survey pack containing a questionnaire, covering letter and a leaflet offering guidance on multi-language options for completing the questionnaire. This was followed by a reminder, then a final reminder containing another survey pack. The average time between mailings was two to three weeks, allowing time to check for infants that may have died or women who had opted-out from mailings.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between April 2019 and August 2019.

[m] Please note that some questions have been revised since 2013 and are therefore not comparable over time.

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 2019. Trusts with samples smaller than 300 were required to include women who gave birth during January 2019 also, starting with deliveries on 31 January and working back across the month until the sample size of 300 was achieved or 1 January was reached. 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. Five trusts were unable to take part as they did not have enough births in January and February combined:

- Bridgewater Community Healthcare NHS Foundation Trust
- James Paget University Hospital NHS Foundation Trust
- 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 2019 Maternity Survey:

1. a 'trust weight' (separate trust weight for each question), 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 126 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 is given to groups that had a lower propensity to respond.

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

The demographic questions discussed in the 'who took part' section of this report (G1-G9 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 2019 compared with the results for 2018.

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. The use of 'control charts' for this analysis shows whether change is in 'expected limits of variation'. Results outside these expected limits would suggest underlying behavioural or real change.

In other cases, even though there may be a visible change in the results between survey years, it is not significant. There are a number of reasons for this, such as:

- rounding figures up or down makes a difference appear larger than it actually is.
- generally speaking, the larger the sample size, the more likely that findings will be statistically significant, and we can be more confident in the result. In contrast, the fewer people that answer a question, there has to be a greater difference to be statistically significant.

The amount of variation also affects whether the difference is significant. 'Variation' means the differences in the way people respond to the question. If there is a lot of variance then differences are less likely to be statistically significant.

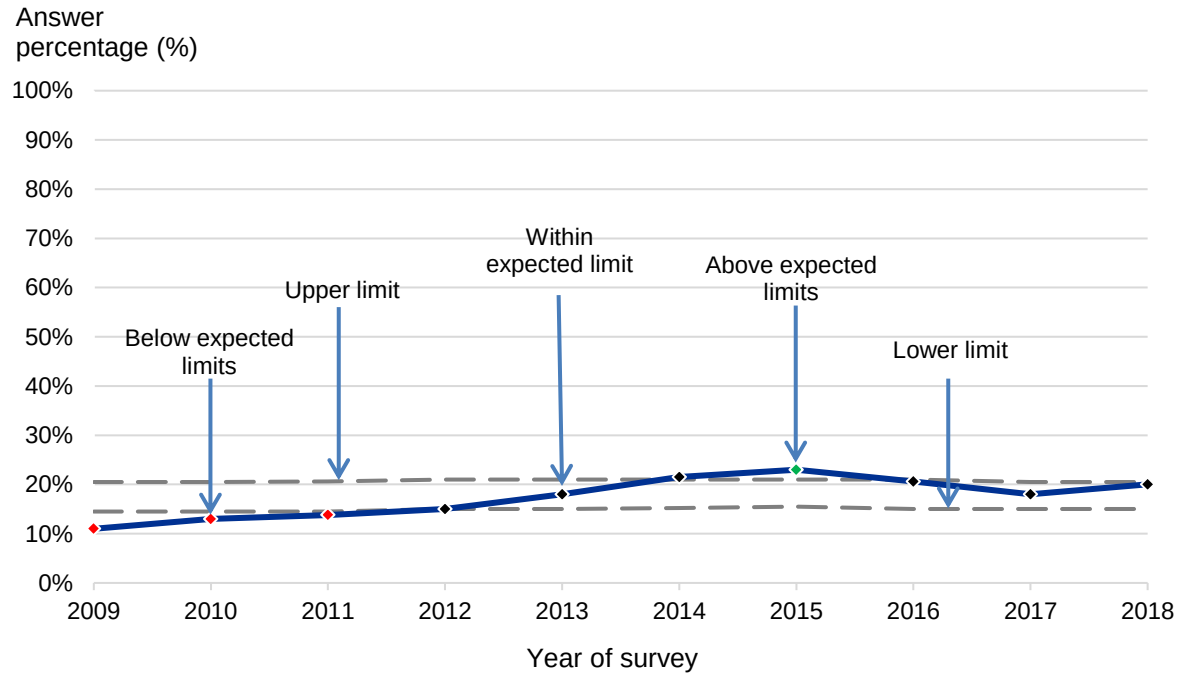
The quality and methodology report also contains relevant background information to help readers to understand the survey data, including response rates, sampling errors and data limitations.

Control charts

For each evaluative question, the control chart displays the percentage of respondents who reported the most positive experience of the service over the years. For example, for B10 'During your antenatal check-ups, did your midwives listen to you?', the answer considered to reflect the most positive experience is 'Yes, always', in comparison to the alternative responses 'Yes sometimes' and 'No'. In this case, the chart will only display the percentage of respondents who answered 'Yes, always'.

To allow readers to interpret patterns in the data with greater confidence, the control-chart also displays two lines setting expected limits. An assumption is made that there has been no 'real' or meaningful change unless the results go outside of these expected limits.[57] Therefore, it is possible to say that the experience of patients improved for a specific question only if the line plotting the percentage of most positive responses crosses the upper limit line. This suggests there is an underlying phenomenon at play or a real change in behaviour. Figure 2 below is an example of a control-chart that fluctuates from below expected limits in 2013 to above expected limits in 2019.

Figure 2: Control-chart example



All charts are available in the open data source files on the CQC website.

This method allows comparisons between a number of years of data and complements the significance test between the last two data points (2018 and 2019). The ability to see trends in survey results over multiple years provides users with greater confidence in interpreting patterns in the data as resulting from real change.

Data points appear in green when they are above the upper control-line and in red when they are below the lower control-line. Where control-chart results are not reported in the text of the report, this is because the change over time was not significant (the line of result does not cross the limit lines) or because not enough data points are available to produce reliable results.

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; 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'. Data from the Maternity services survey are used to populate domain 4.5 'Women's experience of maternity services'.

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 that can be used by providers, commissioners and people who use 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 and NHS Improvement publish 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.[n] 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 in 2014 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

National Childbirth Trust

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

[n] Results from the 2018 iteration have not yet been published.

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

Scotland

The Maternity Care survey carried out by the Scottish government is very similar to the NHS 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 main findings for the 2018 survey were that:

- nine in 10 women rated their antenatal care positively.
- just over nine in 10 women rated the care they received during their labour and birth positively.
- just over four in five women rated their postnatal hospital care positively.
- the vast majority of women whose baby had been admitted to a neonatal unit rated the care their baby had received positively.
- nine in 10 women rated the postnatal care they received at home and in the community positively.
- women were positive about person-centred behaviour in most areas of their care.

For more information please see:

https://www.gov.scot/publications/maternity-care-survey-2018-national-results/

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 enable them to trust the information given to them
- to have more information about the birthing options available, so that they can decide where to give birth, rather than 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/2017-maternity-care-survey

https://gov.wales/newsroom/health-and-social-services/2017/maternity/?lang=en

Northern Ireland

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

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.

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.

Republic of Ireland

The National Maternity Experience Survey will be conducted for the first time in the Republic of Ireland in 2020. It will sample women who gave birth between October and November 2019. The results from the survey will be published in Autumn 2020.

For more information, please see:

https://yourexperience.ie/maternity/about-the-survey/

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. The 2019 survey is currently in fieldwork.

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 respondents data that is in this report.

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

NHS England and NHS Improvement

In April 2019, NHS England and NHS Improvement merged, with both organisations continuing to use results from the NHS Patient Survey Programme to inform their activities.

Data from the maternity survey contributes to the NHS Oversight Framework which oversees performance of Clinical Commissioning Groups (CCGs), providers and sustainability and transformation partnerships. Two indicators - one regarding experience (125b) and one regarding choice (125c), measure performance of maternity services at CCG level and are computed using questions from the survey.

The Maternity Transformation Programme has recently developed a Maternity Services Dashboard gathering data from different sources, including Clinical

Improvement Metrics, Organisation profile information and National Maternity Indicators. The National Maternity Indicators use data from the Maternity survey.

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 and trust results** from previous maternity surveys that took place in 2007, 2010, 2013, 2015, 2017 and 2018 are available on the NHS survey website by selecting the year of reporting in the drop-down menu on the right-hand side. However, please note that the questionnaire went under a major redevelopment in 2013 meaning the England and trust level results for 2019 are only comparable with 2013, 2015, 2017 and 2018. 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 also available on the website.

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 2019. 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 comments, questions 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 methodology

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[o] 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 status** (derived from questions B7 for antenatal care and F5 for postnatal care): saw the same midwife for antenatal care and saw the same midwife for postnatal care (answered 'yes to both B7 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 B7 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 B7 or F5).
- **Parity:** whether women have had a previous baby 'multiparous' or not 'primiparous'
- **Type of delivery** (question C8): 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 C10): delivered without stirrups or delivered in stirrups
- **Ethnicity**: White, Multiple ethnic groups, 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

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

- **Sexual orientation:** Heterosexual / straight, Gay / lesbian, Bisexual, Other, I would prefer not to say
- **Long-term condition:** No breathing problem, Breathing problem, No blindness, Blindness, No cancer, Cancer, No dementia[p], Dementia, No deafness, Deafness, No diabetes, Diabetes, No heart problem, Heart problem, No joint problem, Joint problem, No kidney / liver disease, Kidney / liver disease, No learning disability, Learning disability, No mental health condition, Mental health condition, No neurological condition, Neurological condition, No other long-term condition, Other long-term condition.
- **Index of Multiple Deprivation decile:** decile one (most deprived) to decile 10 (least deprived)

The composite themes used to look at differences in experience are:

Choice

- B4: Were you offered any of the following choices about where to have your baby?
- F1: Were you given a choice about where your postnatal care would take place?

Respect for patient centred values, preferences and expressed needs

- B10: During your antenatal check-ups, did your midwives listen to you?
- D6: Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
- C20: Thinking about your care during labour and birth, were you treated with respect and dignity?
- E2: Were your decisions about how you wanted to feed your baby respected by midwives?
- F8: Did you feel that the midwife or midwifery team that you saw always listened to you?
- F9: Did the midwife or midwifery team that you saw take your personal circumstances into account when giving you advice?

Shared decision making – Antenatal

- B17: Thinking about your antenatal care, were you involved in decisions about your care?

Shared decision making – Labour and birth

- C19: Thinking about your care during labour and birth, were you involved in decisions about your care?

Involvement of family and friends

- C12: 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?

[p] Please note that the dementia / no dementia categories have been suppressed during the analysis due to low number of respondents

- D7: 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

- C21: Did you have confidence and trust in the staff caring for you during your labour and birth?

Confidence and trust – Postnatal

- F10: Did you have confidence and trust in the midwife or midwifery team you saw after going home?

Feeding support

- E3: Did you feel that midwives and other health professionals took your personal circumstances into account when giving 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?
- F16: 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?
- B9: During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Information, communication and education – Labour and birth

- C18: Thinking about your care during labour and birth, were you spoken to in a way you could understand?
- C22: After your baby was born, did you have the opportunity to ask questions about your labour and the birth?
- D5: Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Information, communication and education – Postnatal

- F15: Were you given information about your own physical recovery after the birth?
- F18: 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?

Availability of staff

- C15: Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- C17: During labour and birth, were you able to get a member of staff to help you when you needed it?
- D4: If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

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.

Charts are not presented this year as the analysis did not show significant changes in experience between groups apart from one. Women who did not want to disclose their religion had a poorer experience of information during labour.

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