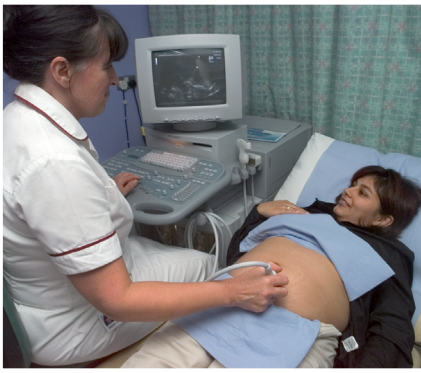
Recorded delivery: a national survey of women's experience of maternity care 2006



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National Perinatal Epidemiology Unit

Recorded delivery: a national survey of women's experience of maternity care 2006

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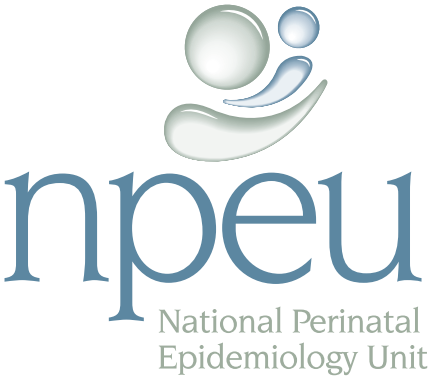

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Contents

Executive summary

As maternity services change over time it is important to document the views of women with recent experience of maternity care, at national and local level. The last national survey of recent mothers was carried out in 1995[1] and the publication in 2004 of the National Service Framework for Children, Young People and Maternity Services (NSF) made it timely to undertake another national survey. Maternity services are evolving, with a range of innovations planned and being introduced. The information from this study will provide a benchmark of current practice and a baseline for measuring change over the period that the NSF is implemented. The study will inform policy in maternity care, support the implementation of the NSF and provide a point of comparison for the local audits of user views and experiences in individual trusts.[2 3]

The main survey on which this report was based used similar methods to those employed in 1995: a random sample of 4800 women were selected by the Office for National Statistics, using birth registration for births in one week in March 2006. Women whose babies had died and mothers less than sixteen years of age were excluded. The usable response rate for the postal survey was 63% and 13% of respondents came from Black and Minority Ethnic groups.

Key findings:
The care provided during pregnancy

- A high proportion of women (86%) accessed healthcare at less than twelve weeks' gestation, and this proportion is greater than in 1995 (82%). Earlier access to the health services allows women to receive information and make earlier decisions about antenatal screening, e.g. Down's syndrome screening.
- A minority of women (13%) directly accessed midwives for their first contact with the maternity services, which is similar to the 12% reported in 1995. Recommendations in the 'NSF' suggest that women should be able to directly access their midwife for their first contact with the maternity services.
- The number of antenatal appointments women had was lower (median 10 compared with 12 in 1995), in line with recommendations in the NICE Antenatal Care Guideline[4], although there is little apparent difference between women having their first baby and women having their subsequent babies.
- About half of all women (49%) are cared for in the antenatal period by midwives exclusively.
- A proportion of women (14%) were not or do not recall being offered screening tests for Down's syndrome, even though the National Screening Committee recommendations are that all women should be offered screening tests.
- Almost all women (99%) had one or more ultrasound scans during pregnancy in 1995 and 2006, however, the use of ultrasound in pregnancy has increased (median number of scans in the antenatal period was 3 per woman, compared with 2 in 1995).
- A substantial proportion of women (21%) were admitted to hospital for one or more overnight stays during the antenatal period (excluding inductions).
- Most first-time mothers reported being offered NHS antenatal classes (89%), though only two-thirds actually attended these classes. Offer (59%) and uptake (20%) were lower for women having their second or subsequent babies.

The care provided during labour and birth

- Almost all women (97%) gave birth in a hospital or a birth centre.
- Very small numbers of women were transferred between birth settings while in labour (3.5%).

1 Audit Commission. First Class Delivery: Improving Maternity Services in England and Wales. London: Audit Commission, 1997.
2 Department of Health, Supporting Local Delivery. London: DH Publications, 2004.
3 Healthcare Commission. Healthcare Commission programme of local surveys of maternity care. Available at: URL:http://www.healthcarecommission.org.uk/nationalfindings/surveys.cfm/. Accessed Dec 1, 2006.
4 National Institute for Clinical Excellence. Antenatal Care: routine care for the healthy pregnant woman. London: NICE, 2003.

- Just over 3% of women gave birth to their baby at home. Three-quarters of these women did so having planned to give birth at home, the remainder being accidental home births.
- Most women who planned to give birth at home and did so, put forward the view that home was more relaxing and comfortable (78%) and they wanted freedom to do things as they wished (61%) and some also expressed a desire to avoid unnecessary technology (46%).
- For two-thirds of women labour started naturally (68%), compared with 65% in 1995.
- The majority of women used some form of pain relief in labour. The overall rate for epidural anaesthesia in 2006 (28%) differs little from that in 1995 (27%). The proportion of women having pethidine was lower (33%, compared with 42% in 1995)
- The use of continuous electronic fetal monitoring in labour was lower (41%) than in 1995 (53%), with greater use of different types of intermittent monitoring.
- Fewer women had a non-instrumental vaginal birth in 2006 (65%) compared with 71% in 1995.
- The episiotomy rate (24%) for women having vaginal births was lower than in 1995 (28%). The rates were lower for women having their first and subsequent babies.
- More babies were born by caesarean section in 2006 (23%), compared with 17% in 1995.
- For the majority of women (62%) a midwife was responsible for delivering their baby. Doctors were more likely to be involved for first-time mothers (49%) compared with women who had previously given birth (25%).
- Although maternity services are striving to provide one-to-one care in labour, it is clear that the majority of women were left alone for periods of time during the labour (56%) and shortly after the birth (64%). For the majority of women left alone, this was not worrisome. However, approximately 18% of those who were left alone during labour were worried by this. The proportion of women worried by being left alone shortly after the birth (7%) was substantially lower.

The care provided during the postnatal period

- The length of postnatal stay in hospital was shorter than in 1995. A total of 63% of women had stays of less than three days in 2006 compared with 52% in 1995. Following a non-instrumental vaginal birth, the median length of stay for first time mothers was two days and for second or subsequent time mothers, it was one day. For women who had a caesarean section, the median duration of stay was four days.
- Approximately 10% of babies born to women in this sample were admitted to a neonatal unit, more than a third of which were preterm (39%) and low birthweight (less than 2500 g) (35%).
- Almost all women (98%) were visited at home by a midwife after birth.
- In the postnatal period nearly a quarter of all women (23%) had their final contact with their midwife 16-28 days after the birth and 7% had their final contact with the midwife after this time. This has changed substantially since 1995.
- The majority of women (76%) recalled discussing infant feeding during their pregnancy with their midwives and two-thirds stated that during pregnancy they had intended to exclusively breastfeed their baby. However, although most women put the baby to the breast in the first few days after birth (80%), by three months of age only 26% were exclusively breastfeeding, with an additional 17% using breast and formula feeding.

Options for care

- Options for where antenatal checks took place and about which health professional would carry these out were limited, with only 27% and 19% of women feeling they had a choice.
- Most women felt they had a choice about screening tests in pregnancy: blood tests (82%); screening for Down's syndrome (87%); a dating scan (75%) and an anomaly scan (76%).
- Choice in relation to place of birth was limited for some women. More than a third (39%) indicated that at the start of pregnancy they only had the option of going to one hospital. However, a similar proportion (38%)

indicated that at this stage home birth had been a possible option, which is greater than that reported for 1995 (18%).

- Nearly one in five women (19%) felt that they were not able to move around and choose the position which made them most comfortable during labour. Women who had previously given birth were more likely to feel they had choice in this respect.
- Almost all women had a companion or partner with them as much as they wished during labour and birth (94%).
- Most women thought their postnatal stay was of the right length (69%), some would have liked a longer stay in hospital (13%) and others a shorter stay (15%). Women who had previously had a baby were more likely to say their length of stay was about right.
- More than three-quarters of women were satisfied with the frequency with which midwives visited them at home for postnatal care.

Communication and interaction

- During their booking appointment almost all the women felt that staff communicated well with them and that they were treated with respect and kindness (95-98%).
- Perceptions of the interpersonal aspect of care from health professionals during pregnancy and birth were generally positive. However, some women reported that one or more midwives and doctors did not talk to them in a way that they could understand during their pregnancy (13% and 14% respectively).
- Similar proportions of women felt that they were not treated with respect by one or more midwives (14%) or doctors (11%) providing antenatal care.
- A similar pattern of response about care during labour and birth was found, though fewer women felt they were not spoken to in a way that they could understand by one or more midwives (9%) or doctors (9%) or treated with respect by one or more midwives (11%) or doctors (7%).
- Differences between the perceptions of medical and midwifery staff during labour and birth was minimal, with approximately 80% of women responding positively about both groups.
- Similar proportions of women respondents in 2006 and 1995 agreed with a statement about midwives talking to them in a way they could understand (96% and 93%), though the view of doctors had changed, with 93% now being seen as talking in a way women could understand compared with 66% in 1995.
- More than four out of five women (83%) selected the term 'supportive' to describe the staff who looked after them during labour and birth. A similarly high proportion selected the term 'kind' (79%). The terms 'sensitive' and 'warm' were selected less often (56% and 60%), but by over half the women in the study.
- The more negative descriptors of care were chosen less often by women to describe care during labour and birth, with 'rushed' being the most common (16%), followed by 'bossy' (12%). Much smaller numbers perceived staff as 'off-hand' (6%), 'inconsiderate' (5%) or 'unhelpful' (6%).
- Two-thirds of women were wholly positive about the interpersonal aspect of postnatal care in hospital. However, 16% indicated that one or more members of staff did not communicate with them effectively and 22% that they were not treated with respect by one or more members of staff.
- Women generally felt that the hospital staff treated them as an individual during their postnatal stay (53% always and 36% sometimes), though one in ten indicated that this was not their experience.

Care from midwives

- Approximately one in five women had one midwife caring for them during labour and while giving birth (19%). Women who were having their first baby were more likely to be cared for by more midwives during their labour and birth, with over half having three or more midwives.

- The proportion of women who had previously met all or some of the midwives who saw them after the birth of their baby was quite high (78%). However, first time mothers were less likely to have previously met all the midwives they saw in the postnatal period.
- More than two-thirds of women always felt confident in the midwives they saw. However, first time mothers were less likely to say they always felt confident about their midwifery care. There was little change in this perception between 1995 and 2006.
- Some changes in continuity are evident when comparisons are made between 2006 and 1995 with slightly more women having three or more midwives visit them at home in 2006 (45% compared with 41%), and fewer having met all those who visited before (26% compared with 32%).

Information

- Almost all the study women felt they were given the information they needed at the booking (91%), but only three-quarters (74%) of the women having their first baby received 'The Pregnancy Book'.
- A total of 9% of women did not have the name and contact details of a midwife that they could get in touch with if they were worried during pregnancy and 4% did not have these details after their baby was born.
- Not all women reported being given explanations about the reasons for all blood tests (82%), or for the other screening procedures (90-93%). This means that between 1 in 5 and 1 in 10 did not feel they had received information about these procedures.
- For a total of 38% of respondents a health professional talked over with them what happened during the labour and birth. A further proportion of women (36%) did not have this discussion, but would have liked to have been able to do so.

The care environment

- Half of the women in the study were satisfied with the environment of labour and delivery and thought that no improvements were needed, whereas only about a quarter were satisfied with the postnatal environment.
- In relation to labour and delivery approximately one in ten women were critical of the cleanliness and hygiene (9%), temperature (12%), furnishings (10%) and decoration (11%).
- In relation to the postnatal ward environment women were critical about the lack of privacy (28%), space (22%), temperature (27%), cleanliness (19%) and background noise (23%).

Women's health and wellbeing

- During pregnancy 90% of women experienced 'minor' health problems. The most common were nausea, indigestion and back-ache, with more than 50% of women reporting each of these three problems. Less commonly, symptoms which also impact on daily life such as stress incontinence, haemorrhoids, constipation, were each reported by more than 20% of women.
- While many women reported suffering from one or more of these problems, nearly half (44%) did not seek help from a health professional.
- Depression during their pregnancy was reported by 10% of women and by 9% at one month after the birth.
- While pregnant many women had worries about labour and birth. More than half worried about the possibility of caesarean section or instrumental vaginal birth and about the length, pain and discomfort of labour itself. Approximately half focussed on the uncertainty associated with the onset and duration of labour and the possible need for induction.
- After birth women also suffered from a range of health problems most of which improved in the following months.
- Some women continue to have poor health in the months that follow birth, so that even several months later a proportion reported both physical and psychological problems that are likely to affect their emotional wellbeing:

11% severe tiredness, 6% stress incontinence, 11% difficulties with intercourse, and 5% sleep problems not associated with the baby.

Specific groups of women

Separate analyses were carried out focusing on the care and experience of different groups: all the self-identified Black and Minority Ethnic women (BME); the Black and Minority Ethnic women born outside the United Kingdom, women living in the most deprived areas (based on the Index of Multiple Deprivation[5]) and women who were single parents (Appendix D).

- Women in the four groups examined were more likely to recognise their pregnancy later, to first see a health professional later and to book later for antenatal care.
- Care in labour and delivery differed less from the experience of women in other groups, though the women in these groups were more likely to have longer postnatal stays and to be visited for longer at home.
- With regard to relationships with staff and communication there were differences in the way that care was perceived. Women from these groups were less likely to have felt that they were treated with respect and talked to in a way that they could understand by one or more members of staff during pregnancy, labour and birth and postnatal care.
- The analyses of the different groups also show some differences in care and perceptions of care, but many of the findings demonstrate the overlap between the groups and the way in which multiple disadvantage may affect access to care and how it is experienced.

Conclusion

The data provide a picture of current practice in maternity care linked to women's experience of that care. Some aspects of care have changed over the last decade and the population of women having babies in England has also changed over that time. The commonalities and diversity in the experience and views of different groups and individual women, that are reflected in the evidence presented, have the potential to inform policy-makers, commissioners, user groups and practitioners in supporting further change and development in this important area of healthcare. Those involved in providing care for women at this important time in women's lives are in a powerful position to make a difference to that care.

5 Office of the Deputy Prime Minister. The English Indices of Deprivation 2004 (revised). London: Office of the Deputy Prime Minister, 2004.

1. Introduction

Contemporary NHS maternity care aims for women 'to have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies' (Standard 11 of the NSF[6]). Underpinning this is the principle that the best care is defined by the health and social needs of the woman and her family. The national survey on which this report is based allowed us to hear the voices of mothers who gave birth in 2006 and to describe their experience.

Three policy documents have collectively mapped out the future aspirations for children's and pregnant women's health and health services over the next decade. These documents are 'Every Child Matters: Change for Children in Health Services', the 'National Service Framework for Children, Young People and Maternity Services'[7] (the NSF), and the public health white paper 'Choosing Health'[8]. In addition, existing policy documents such as 'Why Mothers Die. Report of the Confidential Enquiry into Maternal Deaths 2000-2002'[9], and the series of NICE guidelines starting with 'Antenatal Care: routine care for the healthy pregnant woman'[10] have provided an impetus for changes in maternity services. A number of broad themes emerge from these policy documents. These include making the user perspective central to service design, delivery and outcome evaluation, and supporting people in making better choices for their health and the health of their families.

Service provision, organisation and staffing are key inter-linked aspects of maternity care[11]. Changes in the organisation of services are occurring as a result of a number of drivers. These include the emphasis placed by the NSF on the effective organisation of maternity care within managed care networks; policy recommendations within the NSF to improve access, equity and quality of care; shortages of traditional staff groups and the changes necessary to implement the European Working Time Directive; changing skill mix and the development of new professional and support roles; centralisation of some services; the need to maintain a local service base; and the importance of users' views about the services provided.

1.1 Background

As services change over time it is critical to document the views of women with recent experience of maternity care, at national and local level. The last national survey of recent mothers was conducted in 1995 as part of a maternity audit[12 13] and with the publication of the National Service Framework it is timely to have undertaken another national survey. In the context of evolving maternity services, the information from this study will provide a benchmark of current practice and a baseline for measuring change over the period that the NSF is implemented. It will inform policy in maternity care and support the implementation of change[14]. The report and the survey data it contains will also provide a point of comparison for local audits of user views and experiences in individual trusts, such as the local user surveys carried out in all trusts in England in 2007 as part of the Healthcare Commission programme[15].

Obtaining information about women's views and experiences in the context of their clinical care is important for several reasons:

- All health care is about more than the technical aspects of treatment. Good care meets the needs of people as individuals, including their needs for encouragement, information and reassurance.

6 Department of Health. Maternity Standard, National Service Framework for Children, Young People and Maternity Services. London: DH Publications, 2004.

7 Department of Health. National Service Framework for Children, Young People and Maternity Services. London: DH Publications, 2004.

8 Department of Health. Choosing health: making healthier choices easier. London: DH Publications, 2004.

9 Department of Health. Why Mothers Die: The Confidential Enquiries into Maternal Deaths in the United Kingdom 2000-2002. London: RCOG Press, 2004.

10 National Institute for Clinical Excellence. Antenatal Care: routine care for the healthy pregnant woman. London: NICE, 2003.

11 Department of Health. Maternity and Neonatal Workforce Group Report to DH Children's Taskforce. London: DH Publications, 2003.

12 Audit Commission. First Class Delivery: Improving Maternity Services in England and Wales. London: Audit Commission, 1997.

13 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

14 Department of Health. Supporting Local Delivery. London: DH Publications, 2004.

15 Healthcare Commission. Healthcare Commission programme of local surveys of maternity care. Available at: URL: http://www.healthcarecommission.org.uk/nationalfindings/nationalthemedreports/maternityservices.cfm#maternity /. Accessed Dec 1, 2006.

- Women's reactions to their care around the time of birth can affect the way they care for themselves and their baby and influence the contact they go on to have with care-givers. Whether women feel they have had a 'good' or 'bad' experience is partly affected by the clinical events they experience, but the explanations and support they get from staff can also be important to them for a long time. When things go well, women may feel more confident with their new baby and happier to ask for help and advice from care-givers. When things go badly, women may dwell on their experiences and may be very anxious about another pregnancy.
- Some aspects of care can be assessed only by asking women directly. For example, if a trust aims to provide women with information about local maternity services, then it is important to ask whether women actually received this information. Women need to be the ones to say whether they got enough information, whether they were able to understand what was said to them, whether they were treated kindly, and whether the food and other facilities were good. Women are also best able to say whether they knew the care-givers who looked after them at different stages.

1.2 The research questions

The research questions the survey aimed to address are:

1. From the perspective of women needing maternity care, what is current clinical practice in England, including the service provision and organisation that underpin care?
2. What are the key areas of concern for women receiving maternity care in England?
3. Have women's experiences and perceptions of care changed over the last ten years and in what ways?

These questions were addressed with reference to a number of overarching topics within maternity care including access, information, communication and choice.

2. Research methods, sample and response

The 2006 survey of recent mothers used a similar cross-sectional design and postal survey method to that employed in the 1995 Audit Commission study and covered many of the same topics. The questionnaire focused on the care received and women's views about that care (Appendix A). It was developed by the project team to cover the core aspects of maternity care and to reflect issues of current interest, with input from the project management and stakeholder groups (Appendices B and C). Questions about clinical aspects of care were included, as previously, to provide a background to women's experiences, to enable effective interpretation and because national statistics about maternity care do not cover all relevant topics[16].

The random samples of women selected for the pilot and main studies were identified by staff at the Office for National Statistics (ONS), using live birth registrations for births within two specific weeks: 2-8 January (pilot) and 4-10 March 2006 (main). The same method of sampling was used as had been employed in 1995, to enable direct comparison. Random samples of 400 women for the pilot survey and 4800 women for the main survey who were aged 16 years and over who had their baby in a one week period in England were selected. The sampling was stratified on the basis of births in different geographical areas (Government Office Regions, GORs). No sub-groups were over-sampled. The questionnaires were mailed out at 3 months after the birth. In the week prior to mailing for each sample, checks on infant deaths were made by ONS and any women whose baby had died were excluded and replacements selected. The survey and reminders were mailed to women by ONS and returned to NPEU.

Descriptive statistics, including means, medians and proportions were calculated. Proportions were compared using Chi-squared tests and means compared using t-tests and p values of less than 5% were reported as statistically significant. Data are presented for all the respondents and separately for women who had given birth previously (multiparous) and those for whom this was a first birth (primiparous). Some women (116) did not provide information about parity and the tables show different totals for primiparous women, multiparous women and all women. Data on the different phases of maternity care are described and on specific aspects of care, and comparisons made with those collected in the 1995 survey[17].

ONS provided simple aggregate statistics of the women who did not respond, including their age, marital status, country of birth, Index of Multiple Deprivation categorisation[18] (based on grouping into quintiles), socio-economic classification (available on 10% of the sample), to enable comparison of the responders and non-responders.

The usable response rate for the pilot survey was 60% and 63% for the main survey. This compares with 67% for the 1995 survey. The data show some evidence of response bias, with higher proportions of responders being married, born in the UK, living in areas of lower deprivation and having the highest socio-economic classification. Non-responders were more likely to have registered the birth of their baby jointly while living at a different address from their partner or registered their baby alone, to have been born outside the UK, to live in areas of most deprivation and to be classified as 'occupation not stated or inadequately described'.

Among the respondents 4% of women indicated that they had a long-standing physical or mental health problem and for two-thirds (67%) this affected their day to day activities. A total of 3% of respondents indicated that they needed help in understanding English and they were more likely to be Black and Minority Ethnic women.

Comparison with the most recent national statistics for women giving birth in England and Wales[19] shows that the survey sample is older, with higher proportions of women aged 30-39 years, and that fewer survey respondents were born outside the UK.

Comparison with the 1995 survey shows that the more recent sample of mothers is older, with higher proportions of women aged 35 years or older, and more ethnically diverse, with 13% of responders from BME groups compared with 8% in 1995. This reflects the more general demographic changes in the population over this time period[20].

Full details of the research methodology, the sample and response rates are presented in Appendix D.

16 The Information Centre. NHS Maternity Statistics, England: 2004-05. London: The Information Centre, 2006.

17 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

18 Office of the Deputy Prime Minister. The English Indices of Deprivation 2004 (revised). London: Office of the Deputy Prime Minister, 2004.

19 Office for National Statistics. 2006 Birth statistics: Review of the Registrar General on births and patterns of family building in England and Wales, 2005. Series FM1 no.34. London: Office for National Statistics, 2006.

20 Nazroo J, editor. Health and social research in multi-ethnic societies. London: Routledge, 2006.

3. The care provided during pregnancy

The findings reported in this section focus on women's access to care, the locations for care, the health professionals involved, antenatal checks, antenatal screening, hospital admissions and access to antenatal education. Differences in the care provided for first time mothers and women who have previously given birth are described and some comparisons made with women's antenatal care in 1995.

3.1 Access to antenatal care

Recent changes in patterns of care and a gradually changing configuration of maternity services may have affected women's access to care in pregnancy[21]. In addition, the NICE Antenatal Care Guidelines recommend that women access services early to benefit from antenatal screening. Data are presented in relation to access early in pregnancy and then booking and screening.

Table 3.1 *Timing of early contact and booking in weeks gestation by parity*

	Primiparous women			Multiparous women			All women		
	mean (median) gestation		n	mean (median) gestation		n	mean (median) gestation		n
First realised pregnant	5.8	(5)	1159	5.6	(5)	1665	5.7	(5)	2938
First saw health professional *	7.4	(6)	1147	8.1	(8)	1657	7.8	(7)	2918
Booking appointment	10.9	(10)	1122	11.1	(11)	1629	11.0	(10)	2861

* Significant difference by parity

Four out of five women realised they were pregnant within the first 6 weeks (80%), with smaller proportions taking longer to become aware of their pregnancy (16% at 7-11 weeks and 4% at 12 or more weeks). Little difference in this timing was evident between women who were having their first baby and women who had previously given birth (Figure 3.1).

While women were aware of their pregnancy, not all women contacted a health professional about their pregnancy care immediately. Less than half (43%) had made their first contact with a health professional about their pregnancy by the time they were 6 weeks pregnant, a similar proportion (44%) did so at 7-11 weeks and 14% of women at 12 weeks or more of pregnancy. In this respect there was a clear difference between primiparous and multiparous women (Figure 3.2).

Some change over time is evident in when women first saw a health professional about their care in pregnancy with 86% of women doing so before 12 weeks gestation in 2006 compared with 82% in 1995 (median 7 weeks compared with 8 weeks). Despite the improvement which this suggests, informed decision-making about first trimester antenatal screening is problematic for the proportion of women who first contact a health professional after this time about their pregnancy.

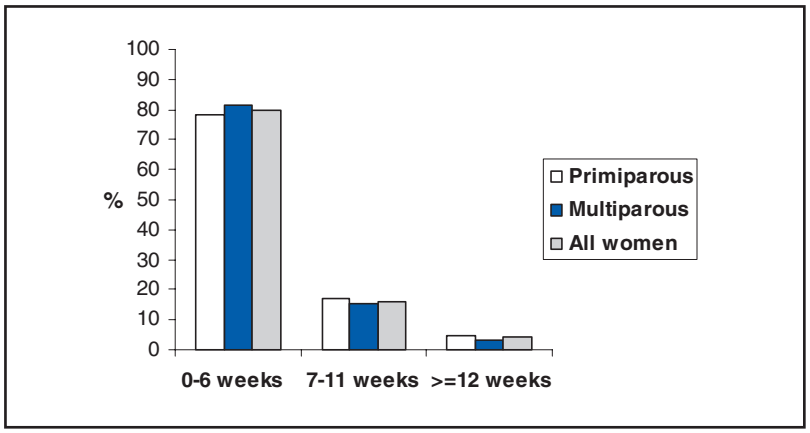

Figure 3.1 *Proportions of women who first realised they were pregnant at different times during their pregnancy*

21 Department of Health. National Service Framework for Children, Young People and Maternity Services. London: DH Publications, 2004.

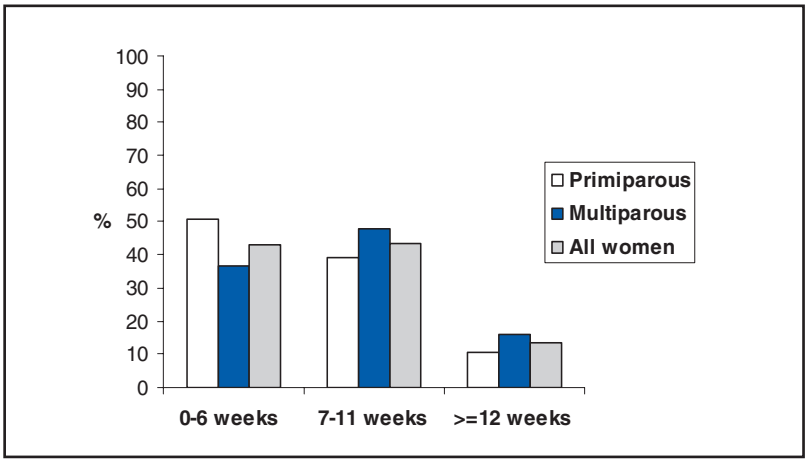

Figure 3.2 *Proportions of women first seeing a health professional about their pregnancy care at different times*

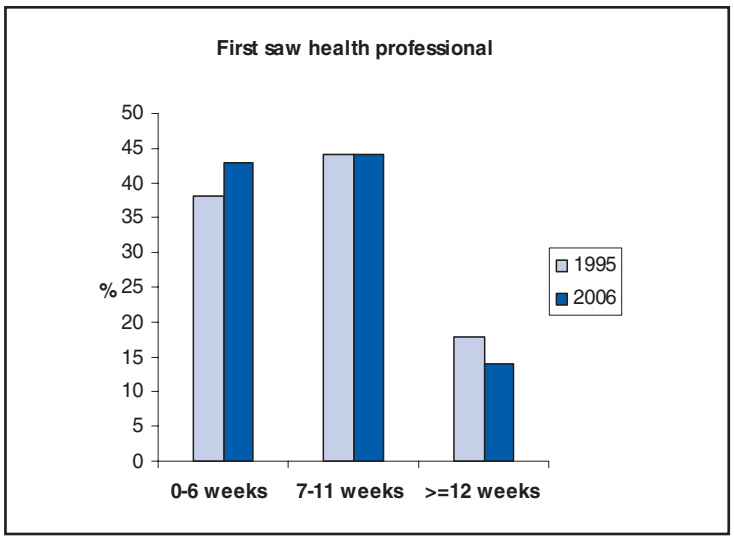

Figure 3.3 *Proportions of women first seeing a health professional at different stages in their pregnancy in 1995 and 2006*

Table 3.2 *Health professional first seen about pregnancy care*

Health professional first seen %	Primiparous women n=1160	Multiparous women n=1675	All women n=2923
General Practitioner (GP) or family doctor	86.0	79.3	82.5
Midwife	7.0	16.9	12.7
Hospital doctor	2.1	1.8	1.8
IVF clinic / specialist	2.4	0.5	1.2
Family planning clinic	0.5	0.4	0.4
Practice nurse	0.8	0.5	0.7
Other e.g. diabetes nurse, health care assistant	1.2	0.5	0.8

The first health professional most commonly seen by the large majority of women who realised they might be pregnant was their General Practitioner or family doctor (83%) (Table 3.2). Midwives were accessed less often in the first instance (13%), though this was more likely among women who had previously given birth (17% compared with 7%).

Most, but not all women found it easy to access a health professional about their pregnancy care and while 91% of those first contacting a GP did so as soon as they wished, a slightly smaller proportion were able to contact their midwife as soon as they wanted (85%) (Table 3.3). First time mothers were slightly more likely to say they had been unable to do so (82%) than women who had previously given birth (86%).

Table 3.3 *Number of women seeing different health professionals first about their pregnancy and the proportion of those who saw them as soon as they wished*

Health professional seen	Primiparous women		Multiparous women		All women	
	%	n	%	n	%	n
General Practitioner (GP) or family doctor	91.2	992	90.9	1322	90.9	2411
Midwife	81.5	81	86.3	278	85.1	370
Hospital doctor	95.5	22	89.7	29	90.6	53
IVF clinic / specialist	100.0	24	100.0	8	100.0	34
Family planning clinic	100.0	5	100.0	7	100.0	13
Practice nurse	100.0	9	88.9	9	94.7	19
Other	84.6	13	100.0	9	91.3	23

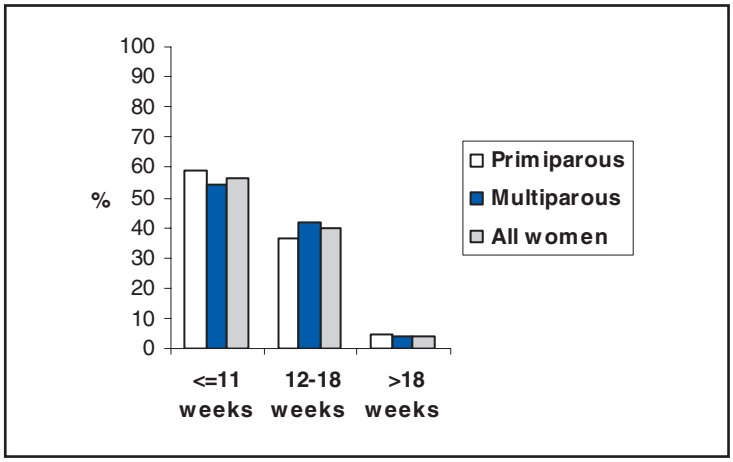

Figure 3.4 *Proportions of women who had their booking appointment at different times during pregnancy*

More than half of the women in the study had made a 'booking' appointment (the appointment when they were given their pregnancy notes) before 12 weeks gestation (56%) and almost all by 18 weeks gestation (96%) (Figure 3.4). Women who had previously had a baby were more likely to be later in booking, though not markedly so.

3.2 Antenatal checks

A 'check-up' is a contact with a midwife or doctor to check on the progress of a woman's pregnancy. This usually includes having her blood pressure and urine checked and does not include other hospital or clinic appointments such as going for an ultrasound scan or a blood test.

Table 3.4 *Number and proportion of women having any antenatal check-ups and the mean and median number of check-ups*

	Primiparous women		Multiparous women		All women	
Had antenatal check-ups % (n)	98.8	(1148)	99.4	(1661)	99.0	(2918)
Number of check-ups* mean (median)	10.9	(10)	10.2	(9)	10.5	(10)

* Significant difference by parity

Almost all women had antenatal checks in pregnancy (99%), with an average overall of 10.5 (median 10) checks and little difference between women who had previously had babies and those who had not (Table 3.4). A comparison with the 1995 data shows that for a similar sample of women there has been a change in this aspect of care, with fewer antenatal checks now being carried out. The NICE Antenatal Care Guidelines[22] recommend that women are

22 National Institute for Clinical Excellence. Routine postnatal care of women and their babies. London: NICE, 2006.

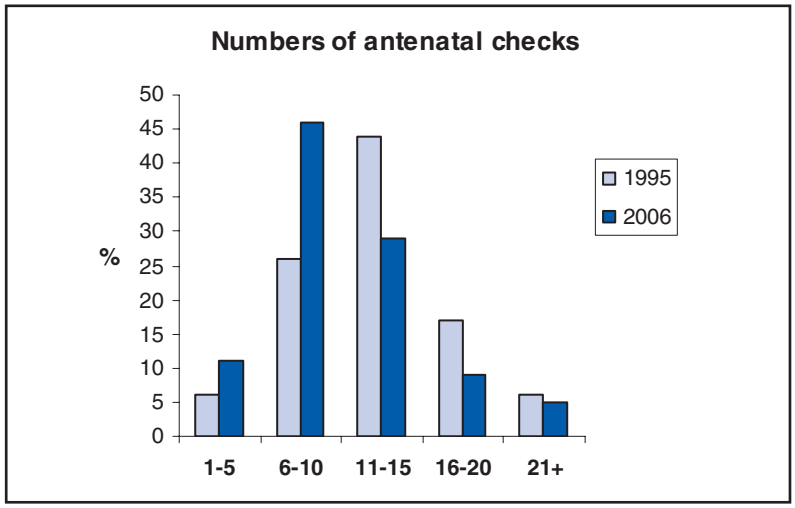

Figure 3.5 *Proportions of women having different numbers of antenatal checks in 1995 and 2006*

offered a minimum of 10 antenatal appointments if it is the first pregnancy and 7 antenatal appointments if it is a second or subsequent pregnancy. In 2006 53% of primiparous women had ten or fewer appointments and 29% of multiparous women had 7 or fewer checks.

Antenatal checks are carried out in a variety of locations, with many women experiencing more than one of these. Most women were seen in their local clinic or surgery, nearly three-quarters in a hospital clinic and over a third at home on one or more occasions. Little difference was evident in this aspect of care for women who had previously given birth and those who were first time mothers (Table 3.5).

Table 3.5 *Proportion and number of women having at least one antenatal check-up in various locations*

Location for antenatal check-ups	Primiparous women % (n)		Multiparous women % (n)		All women % (n)	
Hospital clinic	72.6	(846)	74.4	(1247)	73.5	(2176)
GP surgery or local clinic	88.1	(1026)	89.2	(1498)	88.6	(2622)
At home	40.9	(476)	41.0	(687)	40.8	(1207)
Other	2.0	(23)	1.6	(27)	1.8	(52)

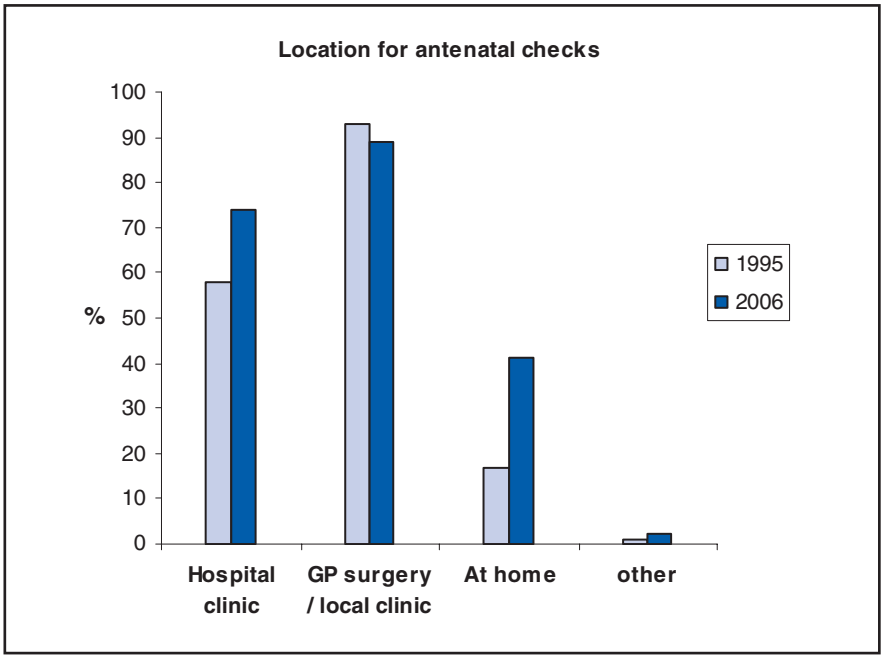

Figure 3.6 *Proportions of women having antenatal checks in different locations in 1995 and 2006*

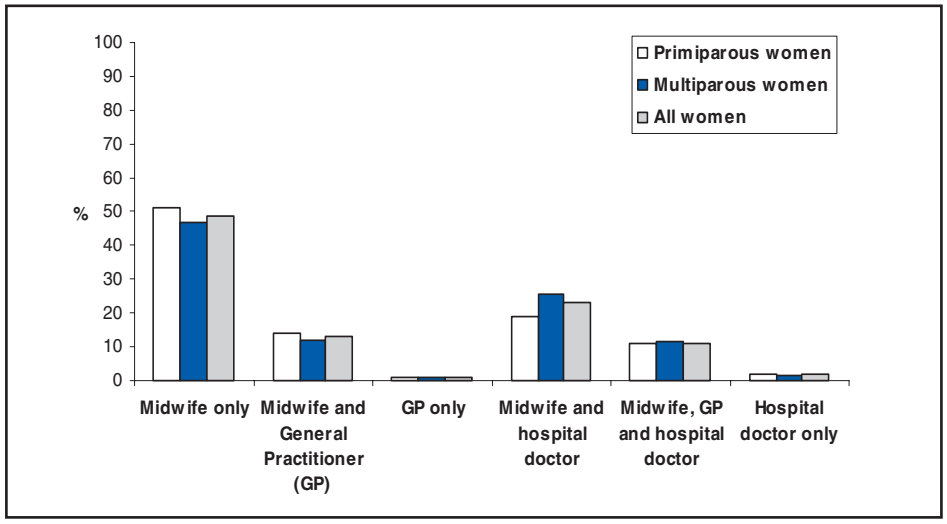

Figure 3.7 *Proportions of women having antenatal care provided by different health professionals (Significant difference by parity)*

A comparison with the responses to the same question that was asked in 1995 shows some changes: while more women had one or more checks in a hospital clinic (74% compared with 58%), a larger proportion had checks at home in 2006 (41% compared with 17%).

Approximately half the women in the study (49%) had midwifery only care for their pregnancy, with a further proportion (13%) having shared care provided by a midwife and a GP. Hospital doctors were involved in the care of just over a third of women (36%) and GP only care was provided for 1% of the respondents.

The changing technology associated with communications has meant that the way in which health professionals can communicate with women during their pregnancy has become more diverse. Thus in this study women were asked about communicating by mobile phone or telephone and text-messaging for other than simply making appointments. Nearly half the women responding (46%) used a mobile phone or telephone and a small proportion (3%) used text-messaging.

Table 3.6 *Other contact with midwife or doctor during antenatal period*

Other contact with midwife or doctor during antenatal period %	Primiparous women n=1154	Multiparous women n=1657	All women n=2921
Yes, by telephone	44.2	47.4	45.9
Yes, by text-message	3.2	2.5	2.8
No neither of these	55.4	52.0	53.4

3.3 Antenatal screening

Almost all women had blood tests in pregnancy (99%). Antenatal screening for Down's syndrome should be offered to all women[23 24]; however, only 86% of women in the study reported that they had been offered screening for Down's syndrome and overall 62% were screened.

Table 3.7 *Women having tests during pregnancy*

	Primiparous women % (n)		Multiparous women % (n)		All women % (n)	
Had blood tests during pregnancy	99.4	(1156)	99.4	(1665)	99.4	(2934)
Offered screening tests for Down's syndrome	87.8	(1017)	85.3	(1421)	86.1	(2529)
Had screening tests for Down's syndrome*	64.9	(751)	60.4	(1005)	62.4	(1831)
Blood test only	40.5		34.8		37.2	
Nuchal scan only	12.0		12.0		12.1	
Nuchal scan and blood test	12.4		13.6		13.1	

* Significant difference by parity

23 National Institute for Clinical Excellence. Routine postnatal care of women and their babies. London: NICE, 2006.

24 National Library for Health. National Screening Committee policy – Down's Syndrome screening. Available at: URL:http://www.library.nhs.uk/screening/viewResource.aspx?catID=2007&resID=35689/. Accessed Nov 27, 2006.

Almost all women had one or more ultrasound scans during their pregnancy (99%), A smaller proportion had a dating scan (86%), though almost all (97%) had a '20 week' or 'anomaly' scan. No differences were evident in relation to parity. The proportion of women not having a scan at all differed little when comparing 1995 and 2006 (0.2% and 0.5% respectively).

Table 3.8 *Women having scans during pregnancy*

Scans during pregnancy	Primiparous women % (n)		Multiparous women % (n)		All women % (n)	
Had ultrasound scan	99.7	(1157)	99.2	(1659)	99.5	(2929)
Had a dating scan (8-14 weeks)	86.1	(998)	86.0	(1430)	86.3	(2530)
Had a '20 week', 'anomaly' or 'mid-trimester' scan	96.9	(1124)	96.5	(1611)	96.6	(2845)

Table 3.9 *Timing of first scan and mean number of scans*

Mean (median) range	Primiparous women			Multiparous women			All women		
Timing of first scan (weeks gestation)	11.8	(12)	1-38	12.1	(12)	2-40	11.9	(12)	1-40
Total number of scans	3.4	(3)	1-30	3.4	(3)	1-20	3.4	(3)	1-30

The timing of the first scan ranged widely, though the mean and median gestation at which this was carried out was 12 weeks. This is slightly lower than the 14 weeks average reported from the 1995 sample. While women have scans for a range of reasons, the first scan was probably a dating scan for most women, though it may have been

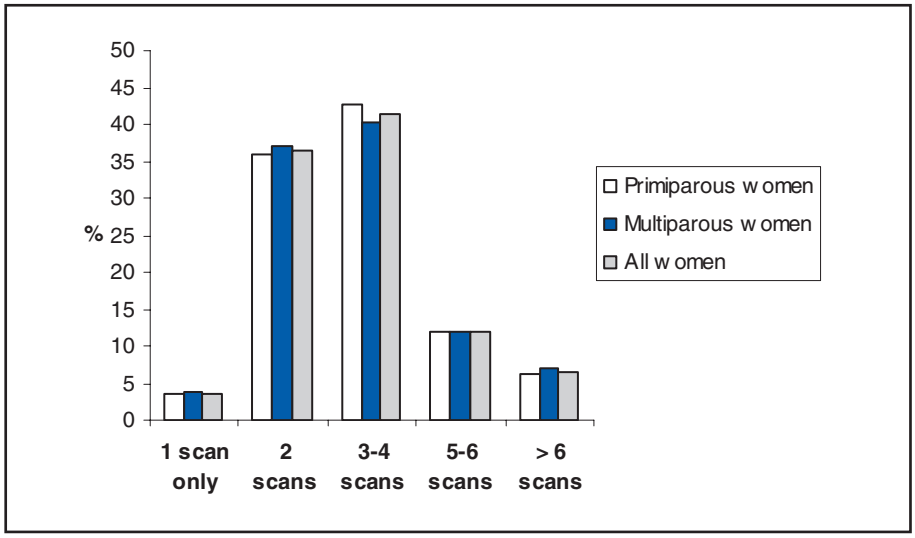

Figure 3.8 *Proportions of women having different numbers of scans during pregnancy*

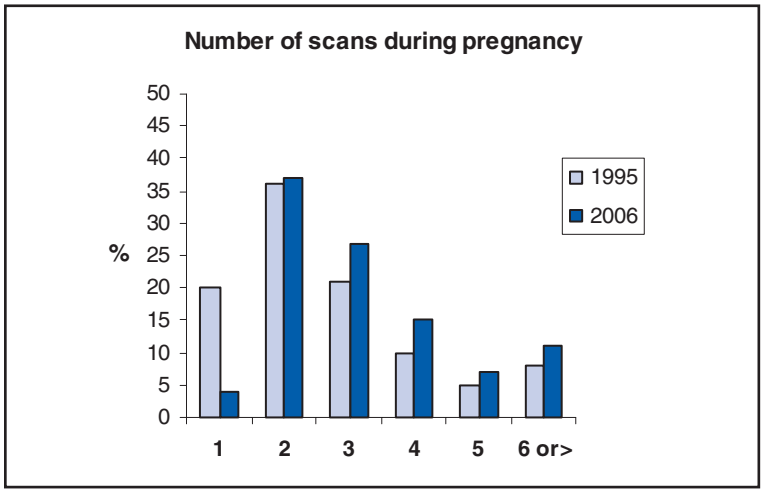

Figure 3.9 *Proportions of women having different numbers of ultrasound scans during pregnancy in 1995 and 2006*

used for Down's screening and for some women following treatment for infertility. While a proportion of women (18%) had five or more scans during their pregnancy, most women had less than this, with a mean of 3.4 (median 3). No significant difference was found in relation to parity. A total of 66% of women had a scan at 12 weeks or less compared with 24% in 1995.

The number of ultrasound scans that individual women had during pregnancy in 2006 was greater than that reported for 1995 (Figure 3.9).

3.4 Hospital admissions during pregnancy

Women's antenatal inpatient experiences are an aspect of care that is rarely emphasised or documented. The survey asked several questions about antenatal admissions and overnight stays including the frequency, duration and reasons for admission.

Table 3.10 *Hospital admissions during pregnancy excluding those associated with induction of labour*

	Primiparous women	Multiparous women	All women
Women having overnight stays* % (n)	23.6 (273)	19.1 (320)	21.1 (623)
Number of overnight stays			
mean (median) range	2.0 (1.0) 1-8	2.1 (1.0) 1-9	2.1 (1.0) 1-9

* Significant difference by parity

One in five women had at least one night in hospital in the course of their recent pregnancy and this excluded admissions associated with induction of labour. A slightly greater proportion of women who had not yet had a baby stayed overnight (24%) compared with women who had previously given birth (19%). Those admitted antenatally were on average likely to have more than one stay during this period. The total number of nights on average was 4.2 (median 2, range 1-78) with some women needing hospital inpatient antenatal care over a much longer period than others. The reasons for admission were wide ranging and included hyperemesis (repeated vomiting), infection, high blood pressure and pre-eclampsia, bleeds, premature rupture of membranes, concern about fetal movement and growth and maternal health problems such as cholestasis (problem with liver metabolism). Some women were also admitted to pregnancy day units.

3.5 Access to antenatal education

The antenatal period is a key time for women to learn more about pregnancy, childbirth and about caring for a newborn.

Table 3.11 *Offer and attendance at classes for antenatal education*

Antenatal education	Primiparous women % (n)		Multiparous women % (n)		All women % (n)	
Offered classes at hospital or local clinic*	88.5	(1025)	58.8	(979)	71.5	(2101)
Attendance* ****						
Attended hospital classes	33.2	(380)	9.6	(153)	19.3	(571)
Attended classes in local clinic	33.2	(380)	10.8	(172)	20.0	(591)
Paid for classes	8.9	(102)	3.1	(49)	5.5	(164)
Did not attend classes	32.9	(376)	79.5	(1271)	56.8	(1682)
Husband/partner went to classes*	77.0	(636)	43.9	(205)	65.9	(906)

* Significant difference by parity
** Respondents could tick more than one option

A total of 89% of first time mothers reported that they had been offered antenatal classes as part of NHS care and the comparable figure for women who had previously given birth was 59%. A third of first time mothers did not attend antenatal education classes (33%) and over three-quarters of the women who had previously given birth (80%) did not do so. A small proportion of women (6%) paid for antenatal classes.

However, of those who did attend classes in a hospital or at a local clinic, two-thirds (66%) were accompanied by their husband or partner and a small proportion attended with another relative or friend. First time mothers were more likely to have a partner attend classes with them and to pay for classes. This aspect of antenatal care is explored in the sub-group analyses in Section 8.

3.6 Summary of care in pregnancy

The data present a current picture of care in pregnancy and provide evidence of changes that are in line with recommendations, for example, earlier first contact with a health professional about pregnancy care, fewer antenatal checks and earlier ultrasound scans. Basic data were presented on care in pregnancy, offer and uptake of screening for Down's syndrome, antenatal education and hospital admissions. Differences between primiparous and multiparous women are shown in many aspects of antenatal care: first time mothers were more likely to see a health professional sooner about their care, more likely to see their GP, have more antenatal checks, have screening tests for Down's syndrome, to have overnight stays in hospital, to be offered and to attend antenatal classes. Some of the points made reflect the different experience and knowledge of both groups of pregnant women.

4. The care provided during labour and birth

The findings reported in this section focus on the place of birth, interventions in labour (including induction, monitoring and pain relief), transfer, type of birth, women experiencing vaginal birth, women having caesarean section (CS), care in labour and women having a home birth. Differences in the care provided for first time mothers and women who have previously given birth are described and some comparisons made with women's labour and delivery care in 1995.

4.1 Place of birth

Women's options in relation to the place of birth at the start of pregnancy are presented in Section 6. In relation to actual place of birth, almost all the women in the study gave birth to their baby in hospital or in a birth centre (97%). However, there was a significant difference between those for whom this was their first baby and women who had previously given birth, with the latter being significantly more likely to have their baby in a birth centre or at home (7.3%) although the overall proportion remains small. The proportion who gave birth at home was very small (3%) and data concerning their experience are presented separately in Section 4.8.

Table 4.1 *Place of birth for study sample*

Place of birth * %	Primiparous women n= 1161	Multiparous women n=1673	All women n=2948
In hospital	97.6	92.6	94.7
In a birth centre separate from hospital	1.4	2.3	1.9
At home	1.0	5.0	3.3
Other	0.0	0.1	0.0

* Significant difference by parity

4.2 Interventions in labour

Data were collected on a number of interventions commonly used in labour: induction of labour and augmentation, fetal monitoring and the administration of pain relief.

For two-thirds of women (68%), labour started naturally, which is slightly higher than the figure of 65% for the women in the 1995 survey. For the remainder, a range of methods were used to induce labour. Women who had not previously given birth were more likely to have their labour initiated with a vaginal gel or pessary (21% compared with 15% of multiparous women). For a proportion of women (44%), though labour may have started naturally or been induced, further intervention to augment labour was required and again this was significantly more common for women having their first baby (52% compared with 37%).

Table 4.2 *Proportions of women whose labour started in different ways*

Initiation of labour* %	Primiparous women n=1059	Multiparous women n=1439	All women n=2960
Started naturally	65.5	69.7	67.7
Given a vaginal gel or pessary	21.2	14.9	17.9
Had one or more membrane sweeps	8.0	9.3	8.7
Waters broken (amniotomy)	2.6	4.4	3.8
Given a drip	2.6	1.6	2.0

* Significant difference by parity

Similar reasons were given for being induced by primiparous and multiparous women and were dominated by the birth being overdue, and concerns about the mother and baby's health.

Most women used some form of pain relief in labour (93%) and many used more than one method (Figure 4.1). The use of different types of pain relief in labour differed significantly according to parity, with first time mothers being more likely to have pethidine or epidural anaesthesia or both of these, than women who had previously given birth. Women who had previously given birth were more likely to use gas and air and natural methods of pain relief that included breathing exercises and massage.

Table 4.3 *Proportions of women giving different reasons for induction of labour*

Reasons for induction of labour %	Primiparous women n=323	Multiparous women n=373	All women n=731
Baby overdue*	61.3	58.2	59.1
Labour did not establish	12.1	12.1	12.4
Concern about baby's health	27.9	26.5	27.1
Concern about mother's health	23.5	23.6	23.7
Other e.g. multiple birth, choice	1.9	1.9	1.8
Don't know	1.5	0.0	1.1

* Significant difference by parity. Respondents could tick more than one option

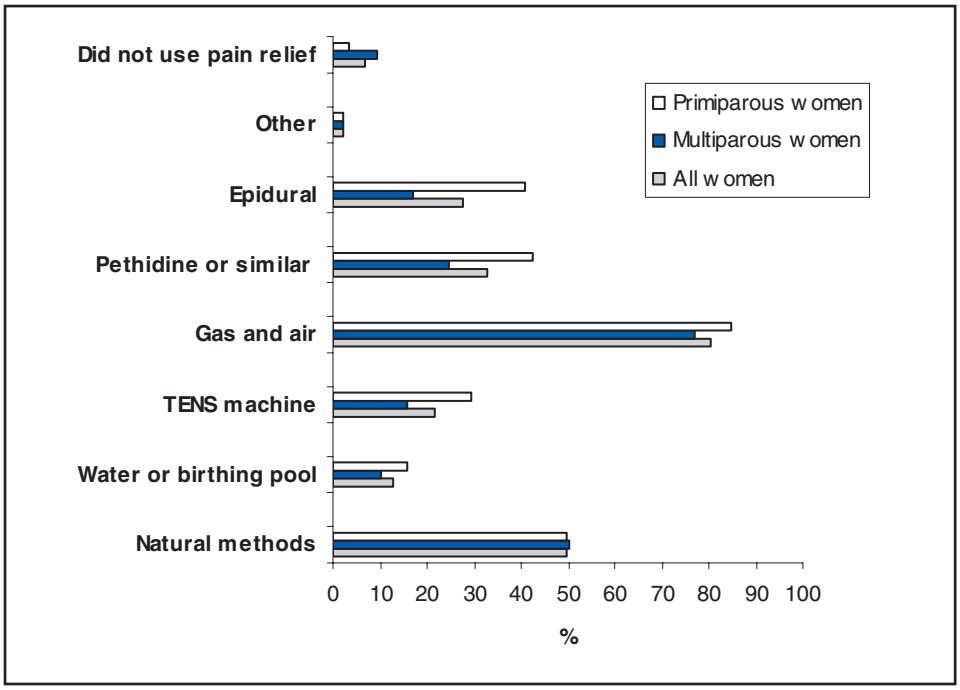

Figure 4.1 *Methods of pain relief used by women in labour (Respondents could tick more than one option)*

The overall rate for epidural anaesthesia for pain relief in labour was 28%. There was little difference in the use of epidurals, with a comparable figure of 27% for 1995. Similar proportions of women also received both pethidine and an epidural as had been reported for 1995 (10%). In contrast the use of pethidine was substantially lower for the respondents in the most recent survey (33% compared with 42% in 1995).

Table 4.4 *Combinations of pain relief used by women in labour*

Pain relief in labour* %	Primiparous women n=1052	Multiparous women n=1426	All women n=2580
Natural methods or no pain relief only	3.4	9.8	7.0
Gas and air with or without natural methods only	29.0	53.2	42.4
Epidural or similar only (with or without gas and air)	23.9	11.7	17.3
Pethidine or similar only (with or without gas and air)	26.2	19.5	22.4
Pethidine and epidural (with or without gas and air)	17.1	5.4	10.5
Other e.g. paracetamol	0.4	0.4	0.4

* Significant difference by parity

Women experienced different approaches to fetal monitoring in the course of their labour. Those having their first baby were more likely to be monitored and to have experienced more continuous forms of monitoring during their labour. However, an overall comparison of the proportions of women experiencing the different types of

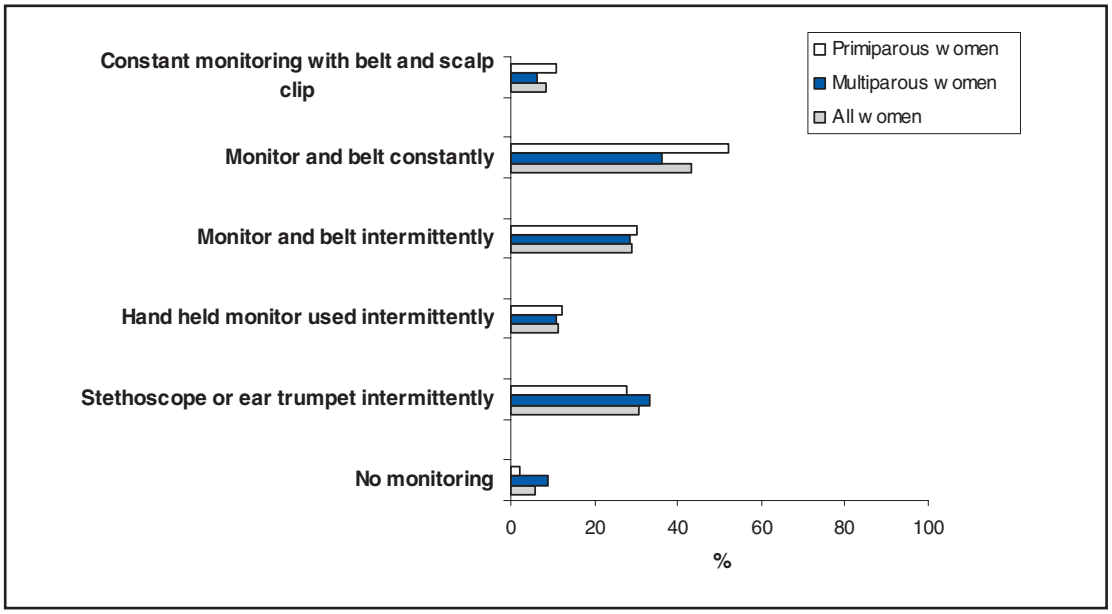

Figure 4.2 *Type of fetal monitoring experienced by women in labour (Respondents could tick more than one option)*

monitoring in 2006 compared with 1995 shows a reduction in the use of more continuous forms of monitoring and a relative increase in the intermittent use of a stethoscope or ear trumpet.

Constant monitoring with a belt and a scalp clip was half that reported for 1995 (9% compared with 18% in 1995) while use of a stethoscope or ear trumpet was twice as common (31% compared with 15% in 1995). Of the 154 women who were not monitored, almost all (91%) had short labours lasting eight hours or less.

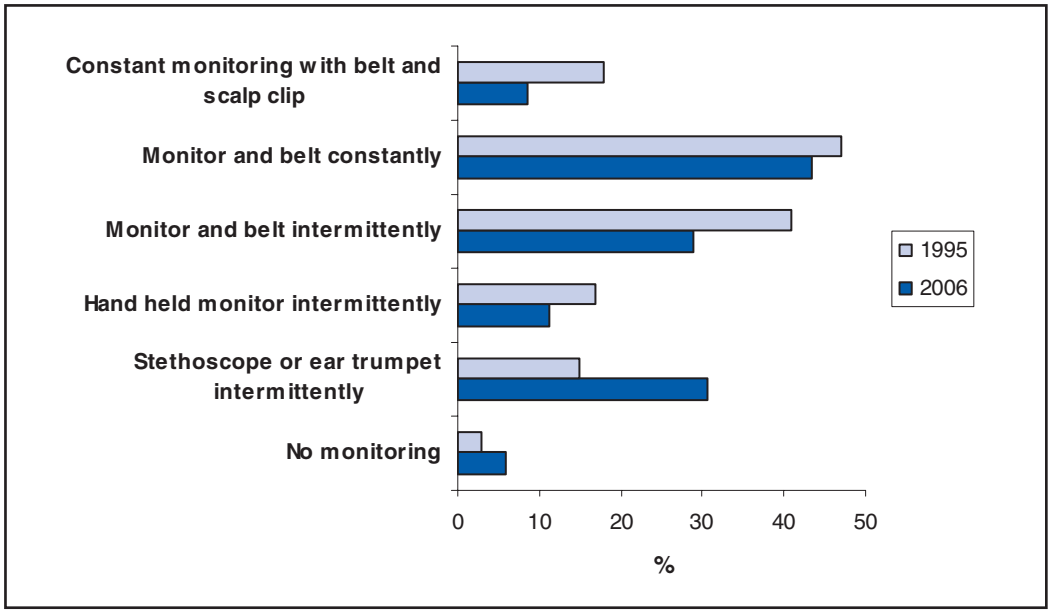

Figure 4.3 *A comparison of the types of fetal monitoring experienced by women in labour in 1995 and 2006 (Respondents could tick more than one option)*

4.3 Transfers in labour

What is known about women's experience of transfers is limited and in the evolving context of neonatal and perinatal networks it was appropriate to document this aspect of maternity care. Women in the study were therefore asked about being transferred during their labour. From the questions that were asked, it is straightforward to estimate the number of women experiencing different kinds of transfer as proportions of all women responding.

This shows that most women (79%) were not transferred at all. Some (17%) were transferred in labour within the hospital to which they had been admitted. These transfers may have been from alongside midwifery units to consultant units, from antenatal to labour wards or even to theatre. It is not possible to separate these out, due to the way services are organised and to the response options that women were given. Very small numbers of women were transferred between hospitals (0.5%), from separate birth centres or maternity units to hospitals (1.7%) or from home to hospital (1.3%). The reasons for transfer largely concerned the health of the woman and her baby and the need for more specialised medical care or facilities than were available at home or in the hospital or maternity unit to which she had initially been admitted.

Table 4.5 *Proportion of women experiencing transfer during labour*

Type of transfer %	All women n=2545
Not transferred	79.3
Transferred within hospital	17.2
From separate MW led unit (birth centre) to hospital	1.7
From home to hospital	1.3
From one hospital to another	0.5

It is also important to estimate the proportion of women who intended to give birth at home or in a separate birth centre, but were transferred to hospital during labour. Given the difficulties in asking women about their "intended" place for birth, the number of women intending to give birth at home and in a separate birth centre was derived from answers to other questions. Thus, we estimated that the number of women who intended to give birth at home was 108 (comprising the women who reported that they gave birth in hospital after transfer from home to hospital and the women who reported that they gave birth at home and planned to do this). 30.6% of these women were transferred from home to hospital during labour. Similarly, we estimated that the number of women intending to give birth in a birth centre separate from hospital was 95 (comprising the women who reported that they gave birth in hospital after transfer from a separate birth centre and the women who reported giving birth in a birth centre separate from hospital). 40% of these women were transferred to hospital during labour.

These proportions may be indicative of transfer rates to hospital from other settings for birth. It should be noted, however, that they are based on assumptions about intended place for birth based on women's answers to other questions. There is, therefore, considerable uncertainty in an area where the numbers involved are relatively small and these estimates of transfer rates should be interpreted quite cautiously.

4.4 Mode of delivery

Nearly two-thirds of the women in the study had a non-instrumental vaginal birth. However, the data show clear and significant differences between the mode of delivery for first time mothers and women who had previously given birth.

Table 4.6 *Mode of delivery for study sample*

Type of birth* %	Primiparous women n=1163	Multiparous women n=1670	All women n=2946
Non instrumental vaginal birth	53.0	73.4	64.6
Caesarean	25.4	20.7	22.8
Forceps	8.9	2.3	5.0
Ventouse	12.7	3.7	7.4

* Significant difference by parity

There also appears to have been a change over time. In 2006 65% of women had a non-instrumental vaginal birth compared with 71% in 1995. The comparable figures for caesarean section birth are 23% in 2006 and 17% in 1995. Also the use of forceps is slightly less (5% compared with 6%), while the use of ventouse has increased (7% compared with 5%).

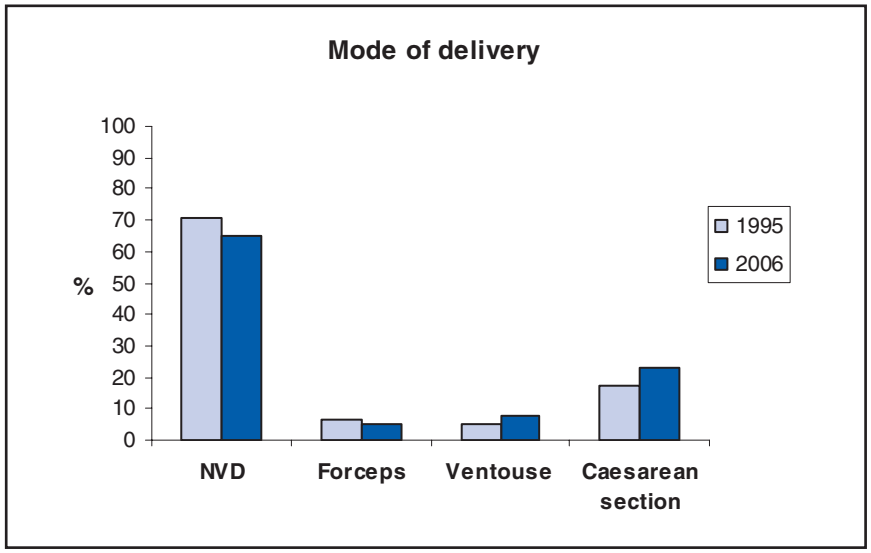

Figure 4.4 *A comparison of mode of delivery in 1995 and 2006*

4.5 Vaginal birth

Women were asked about where they gave birth and in what position. The answers to these questions may provide a marker for a more flexible attitude on the part of those providing maternity services. This issue in relation to choice is addressed in Section 6 and the data in terms of the perspective of care provided are presented below.

Most women in the study gave birth on a bed (89%), however, there was a significant difference by parity, with women who had previously given birth using more alternatives.

Table 4.7 *Location for women having a vaginal birth*

Location for birth * %	Primiparous women n=861	Multiparous women n=1321	All women n=2265
On a bed	93.4	85.2	88.5
On the floor	2.4	8.4	6.1
On a birthing stool/chair	0.2	0.3	0.3
In water/birthing pool	2.8	4.9	4.0
In theatre	1.2	0.2	0.6
Other e.g. car, toilet	0.0	0.9	0.6

* Significant difference by parity

An effect of parity was also evident in the responses from women concerning the position in which they gave birth, with women having their first baby being more likely to use horizontal rather than vertical positions. The same items were used in the 2006 question to women about the position in which they had given birth as had been asked in 1995. Women having a birth in 2006 were less likely than those having a baby in 1995 to give birth sitting or sitting supported (34% compared with 58%), were more likely to be lying (46% compared with 32%) and more likely to stand, squat or kneel (15% compared with 6%).

Table 4.8 *Position for women having a vaginal birth*

Position for birth* %	Primiparous women n=868	Multiparous women n=1325	All women n=2275
Sitting/supported by pillows	29.0	36.3	33.6
On side	3.3	7.4	5.6
Standing, squatting or kneeling	9.0	18.7	14.7
Lying	58.3	37.5	46.0
Other	0.4	0.1	0.2

*Significant difference by parity

24% of women reported having episiotomy (Table 4.9), with a significant difference by parity: 39% of first time mothers had this procedure in the course of their delivery compared with 13% of women who had previously given birth. This is lower than in 1995, for which the comparable overall figure was 28% (44% and 17% for primiparous and multiparous women respectively).

Table 4.9 *Women experiencing perineal damage and repair*

Episiotomy and tears for women who gave birth vaginally * %	Primiparous women n=847	Multiparous women n=1299	All women n=2225
Episiotomy	39.1	12.7	23.9
Had a third or fourth degree tear	9.2	2.2	5.0

* Significant difference by parity

Many women who gave birth vaginally did not have a tear or did not have a tear that required stitches (47%), though a small proportion did have a serious third or fourth degree tear to their perineum (5%). The experience of first time mothers and women who had previously given birth was significantly different in this respect. There was also an association with type of birth: 13% of women having non-instrumental vaginal birth had an episiotomy, compared with 91% of those having forceps and 74% ventouse. The questions women were asked about perineal damage and repair were slightly different in 2006 from those asked in 1995 and directly comparable data are not available. However, a study with data from 1987 and 2000, based on eight maternity units[25], shows that 27% of women had an intact perineum following vaginal birth in 1987 and 26% in 2000 and this compares with 28% for the respondents in this study.

If the definition of normal birth is one that excludes induction, the use of instruments, caesarean section, and general, spinal or epidural anaesthesia during delivery[26], the proportion of women giving birth in this category is 38%. A more limited definition which also excludes augmentation, the use of pethidine for pain relief and episiotomy, results in 13% of the study births being categorised in this way.

4.6 Caesarean section

Definitions and understanding of the terms 'elective' and 'emergency' caesarean section are variable, even amongst health professionals. Thus the question for women, in relation to caesarean section, referred to whether the caesarean was planned and whether it occurred before or after the onset of labour.

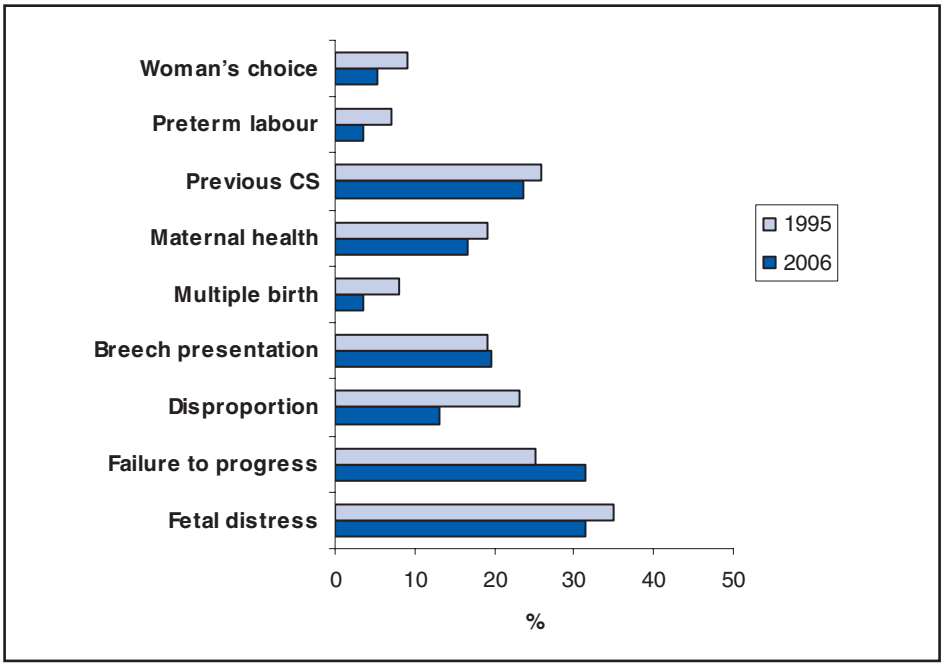

Figure 4.5 *The reasons for caesarean section in 1995 and 2006*

25 Green J, Baston H, Easton S, McCormick F. Greater Expectations? Summary Report. Mother and Infant Research Unit, University of Leeds, 2003.

26 The Information Centre. NHS Maternity Statistics, England: 2004-05. London: The Information Centre, 2006.

Of the 23% of caesarean section births that women in the study experienced, slightly more than half were carried out as a result of unforeseen problems in labour (54%), compared with 47% as a planned procedure. Women for whom this was a first birth were more likely to have a caesarean section as an emergency procedure.

Table 4.10 *Proportion and number of women experiencing different types of caesarean section*

Caesarean births* %	Primiparous women n= 293	Multiparous women n=340	All women n=664
Planned & before labour	22.9	57.0	40.5
Planned & in labour	3.4	8.2	6.0
Resulting from unforeseen problems in labour	73.7	34.7	53.5

* Significant difference by parity

Table 4.11 *Reasons given for caesarean section*

Reasons for caesarean section %	Primiparous women n=282	Multiparous women n=326	All women n=639
Fetal distress*	41.1	23.0	31.4
Failure to progress/ disproportion*	57.8	30.9	44.4
Breech presentation	19.9	19.0	19.6
Multiple birth	4.6	2.5	3.6
Maternal health	16.0	17.2	16.7
Previous caesarean section	N/A	45.7	23.6
Preterm labour	2.1	4.6	3.4
Woman's choice	3.5	6.7	5.2
Other reason	1.8	1.2	1.4
Don't know/Can't remember	0.0	0.0	0.0

* Significant difference by parity. Respondents could tick more than one option

The reasons for caesarean section relate to both pre-existing problems or experience in a previous birth and maternal or infant problems arising in the course of labour. Women were able to give more than one response to this question. The reasons that the women reported were dominated by fetal distress, failure to progress and cephalo-pelvic disproportion, and previous caesarean section. A small proportion of women indicated that this type of birth was their choice (5%), however, this includes those who also gave other responses most commonly relating to problems with fetal growth, previous difficult or traumatic births and to previous pregnancy losses. The proportion of the women who gave choice as the only reason for caesarean section was 1.6%. In 1995 the proportion of women who gave choice as one or more of the reasons for their caesarean section was 9% and less than 1% women indicated their choice was the sole reason for the caesarean section.

Of the 10% of women who had previously given birth by caesarean section, 65% (194 out of 299) had another caesarean, however, just over a third (35%) had a vaginal birth this time.

4.7 Care and support during labour and birth

Women were asked about who had delivered their baby. For the majority (62%) this was a midwife, for less than a third a doctor (32%) and for a further proportion of women (6%), their baby was delivered by a midwife and doctor together (Table 4.12). First time mothers and those having an assisted instrumental delivery were more likely to have their baby delivered by medical staff. Almost all women having a vaginal birth without forceps or ventouse were attended by midwives only (94%) with a minority also having medical staff (3%). Doctors were more involved with instrumental vaginal births and delivered 95% of babies born with the use of forceps and 94% of those born using ventouse, though midwives and doctors jointly worked together for 11% of births by forceps and 20% of births by ventouse.

The provision of support during labour is a key aspect of care in labour, much of which is provided by the health professionals involved in a woman's care. For almost all women, whether they had previously given birth or not, a partner or companion was present during labour and birth (94%). The need to feel supported by the health

professionals caring for you in labour is widely recognised and something women themselves have identified as important to them, as was shown by the open text responses to the 1995 survey[27 28].

Table 4.12 *Staff who delivered the baby*

Staff * %	Primiparous women n=1155	Multiparous women n=1664	All women n=2933
Midwife	50.2	69.8	61.5
Midwife & doctor	8.0	4.4	6.0
Doctor	41.4	24.5	31.6
Other	0.4	1.3	0.9

* Significant difference by parity

In this survey women were asked about being left alone during labour or shortly after the birth and about whether it worried them to be left alone at this time. More than half of the women said they and their partners had been left alone at some time in labour (56%) and shortly after the birth (64%), but much smaller proportions of these women reported that they were worried when this happened during their labour (18%) and in the period shortly after birth (7%).

Table 4.13 *Presence of partner or companion and staff with women during labour and shortly after birth*

Being left alone	Primiparous women % (n)		Multiparous women % (n)		All women % (n)	
Woman/partner left alone during labour	57.1	(658)	54.8	(906)	55.5	(1620)
Woman/partner left alone shortly after birth*	62.3	(718)	66.7	(1102)	64.4	(1878)
Woman/partner left alone during labour and worried	18.6	(174)	18.2	(241)	18.4	(430)
Woman/partner left alone shortly after birth and worried	8.4	(78)	6.5	(86)	7.3	(170)

* Significant difference by parity

The figure for labour is lower than reported for 1995 (68%) and the proportions of women who were worried were similar (18% during labour and 7% after birth).

For a small proportion of women (6%) their partner was not present during the labour and birth as much as they wished. This did not differ by parity. For those whose partner was not present as much as the women wished, the most common reported reason was because the staff did not allow it. Further information was not collected on this point.

Data on continuity of care during labour and birth are presented in Section 6.

4.8 Women having a home birth

A relatively small number of the women (3.3%) who responded to the survey gave birth to their baby at home. This is slightly higher than the most recent 2005 routine statistics for England and Wales which give a rate of 2.6% of births[29].

Three-quarters of the women who gave birth at home did so having planned a home birth. Whether the home birth was accidental or planned and the age distribution of mothers delivering at home is shown in Table 4.14.

27 Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2003;(3).
28 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1988.
29 Office for National Statistics. Birth statistics: Review of the Registrar General on births and patterns of family building in England and Wales, 2005. Series FM1 no. 34. London: Office for National Statistics, 2006.

Table 4.14 *Numbers and proportions of home births to study women*

Age (years) %	Planned home birth n=75	Accidental home birth n=22	Main sample n=2934
16-19	0.0	4.6	3.9
20-24	8.0	13.6	15.4
25-29	20.0	40.9	23.9
30-34	34.5	27.3	32.7
35-39	29.3	13.6	20.5
40+	8.0	0.0	3.4

The most common reasons women gave for having a home birth was the positive view that home was more relaxing and comfortable (78%) and that they wanted the freedom to do things as they wished (61%). Nearly half of those choosing to give birth at home and doing so (46%), saw it as a way to avoid unnecessary technology which was perceived to be associated with hospital birth.

Table 4.15 *Reasons given by women who planned and experienced a home birth*

Reasons for having home birth %	n=97
Wanted the same midwife to be there throughout	36.2
Wanted family members present	25.5
Hospital couldn't provide the services wanted	8.5
Wanted freedom to do things as wished	60.6
Wanted to avoid unnecessary technology	45.7
Home more relaxing and comfortable	77.7
Did not want to leave other children	34.0
Other e.g. previous experience	22.3

The women who planned and experienced a home birth were asked about the support available from health professionals to do so and about the information that was available to them in their decision-making and in the planning of a home birth.

Table 4.16 *Support from health professionals for women who planned and experienced a home birth*

Health professional	Supported me % (n)		Some did/some didn't % (n)		Did not support me % (n)		Did not apply (did not see) % (n)	
Midwife / midwives n=74	93.2	(69)	4.1	(3)	0.0	(0)	0.0	(0)
GP (family doctors) n=64	51.6	(33)	7.8	(5)	10.9	(7)	29.7	(19)
Hospital doctors n=59	13.6	(8)	2.7	(2)	11.9	(7)	62.7	(37)
Hospital / midwifery managers n=59	18.6	(11)	10.2	(6)	3.4	(2)	67.8	(40)

The main support identified by women wanting a home birth was midwives. Midwives were involved in the care of all women having a home birth and almost all women reported that their midwives had supported them in their wish to have their baby at home. Small proportions of women indicated that their GP, hospital doctor or midwifery manager was not supportive, though for many women GPs and managers were not involved in their care at all.

Almost all the women who had a home birth were provided with information about key features of the type of maternity care available at home.

Table 4.17 *The type of information women planning and experiencing a home birth received about specific aspects of maternity care*

Type of information	Yes % (n)	No % (n)	Don't know/can't remember % (n)
The pain relief available at home	96.0 (71)	4.1 (3)	0.0
The monitoring of the baby possible at home	89.2 (66)	9.5 (7)	1.4 (1)
The distance and location of the nearest hospital	97.3 (72)	2.7 (2)	0.0
The emergency back-up services that would be available if needed	91.9 (68)	6.8 (5)	1.4 (1)

All but one of the women who planned a home birth and had their baby at home stayed there after the birth (98%). Most (75%) of those who delivered their baby at home accidentally also stayed at home, though a small proportion of the babies born following unplanned birth at home were admitted to hospital subsequently.

Care at home after the birth was provided by midwives, who stayed a variable length of time following delivery. For the majority of women this involved one or more midwives staying between 2 and 4 hours after the birth (52%), though some left after less than 2 hours (43%) and a small proportion stayed for longer.

Table 4.18 *Postnatal care at home and transfers to hospital for women and their babies who experienced a birth at home*

After the birth at home	Planned home birth n=75 % (n)		Accidental home birth n=20 % (n)		Total n=95 % (n)	
Woman stayed at home	98.7	(74)	75.0	(15)	93.7	(89)
Woman went to hospital	1.3	(1)	25.0	(5)	6.2	(6)
Baby went to hospital	0.0	(0)	10.0	(2)	2.3	(2)

4.9 Summary of care during labour and birth

The data on care during labour and birth show that almost all babies are born in hospital, that for most women labour starts naturally and that women use a variety of methods for pain relief. Some differences by parity were evident and first time mothers were more likely to give birth in hospital, be induced, use pethidine, have an epidural for pain relief, have an assisted vaginal birth, have an episiotomy, have a serious tear and have a caesarean section. They were less likely to give birth in water or on the floor, to deliver standing, squatting or kneeling and for their baby to be delivered by a midwife.

Changes over time are evident, with less continuous fetal monitoring, more women delivering in a standing, squatting or kneeling position, less use of pethidine and a higher rate of caesarean section in 2006, but no difference in the use of epidural anaesthesia for pain relief, and a slightly lower episiotomy rate.

Birth at home accounted for a small proportion of all births and the survey documented the care of those women who planned home birth and those for whom it was accidental.

5. The postnatal care provided

The findings presented in this section focus on postnatal care in hospital and differences in length of stay, women whose babies were admitted to neonatal care, patterns of postnatal home visiting, health visitor contacts and postnatal checks. Data on infant feeding and care and support for these are also included.

5.1 Postnatal care in hospital

Evolving patterns of maternity care more generally, have resulted in changes to the organisation of postnatal care, including the duration of stay following birth in hospital.

Table 5.1 *Duration of stay for women following different types of birth*

Type of birth		Length of postnatal stay in days Mean (median) range
Vaginal birth*:	**Primiparous women**	2.8 (2) 1-42
	Multiparous women	2.0 (1) 1-23
Instrumental birth*:	**Caesarean**	4.1 (4) 1-40
	Forceps	2.8 (2) 1-13
	Ventouse	2.4 (2) 1-22
	Total	2.3 (2) 1-22

* Significant difference by parity and by type of delivery

Women reported that their postnatal stays in hospital were quite short, being approximately two days for first time mothers and one day for women who had previously given birth (Table 5.1 and Figure 5.1).

There were clear differences in duration of stay for women experiencing different modes of delivery with those women having a caesarean section staying for longer (Figure 5.2).

For women having a vaginal birth without ventouse or forceps, the median length of stay for first time mothers was two days and for second or subsequent time mothers, it was one day. Following caesarean section, the median length of stay was four days. There was a minority of women who stayed in hospital substantially longer than this.

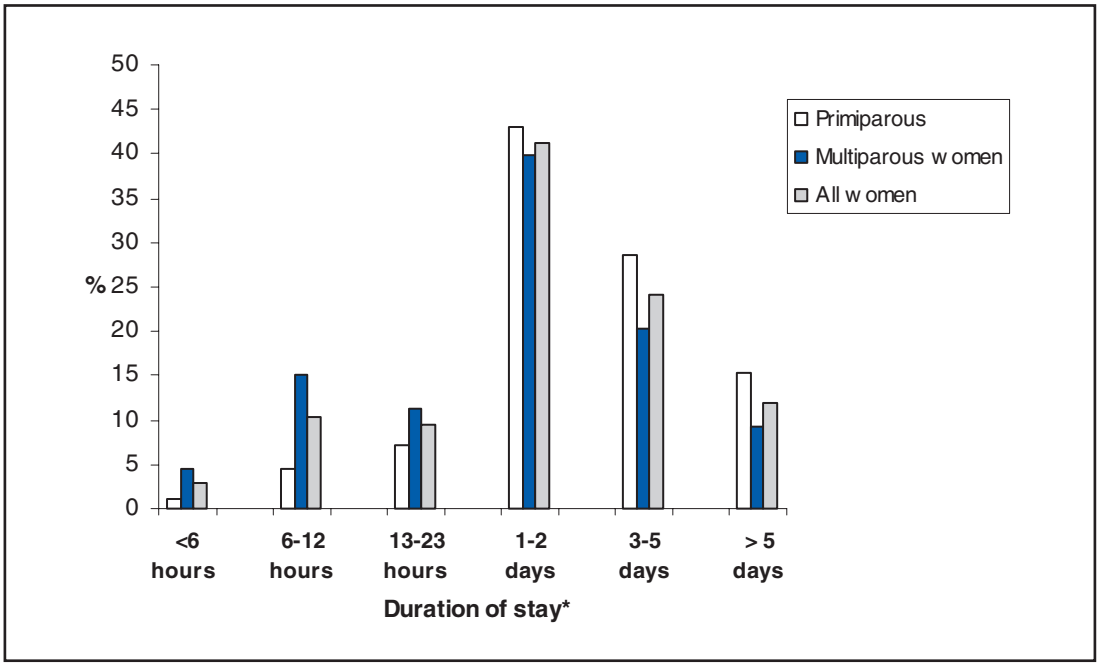

Figure 5.1 *Proportions of women experiencing different durations of postnatal stay (* Significant difference by parity)*

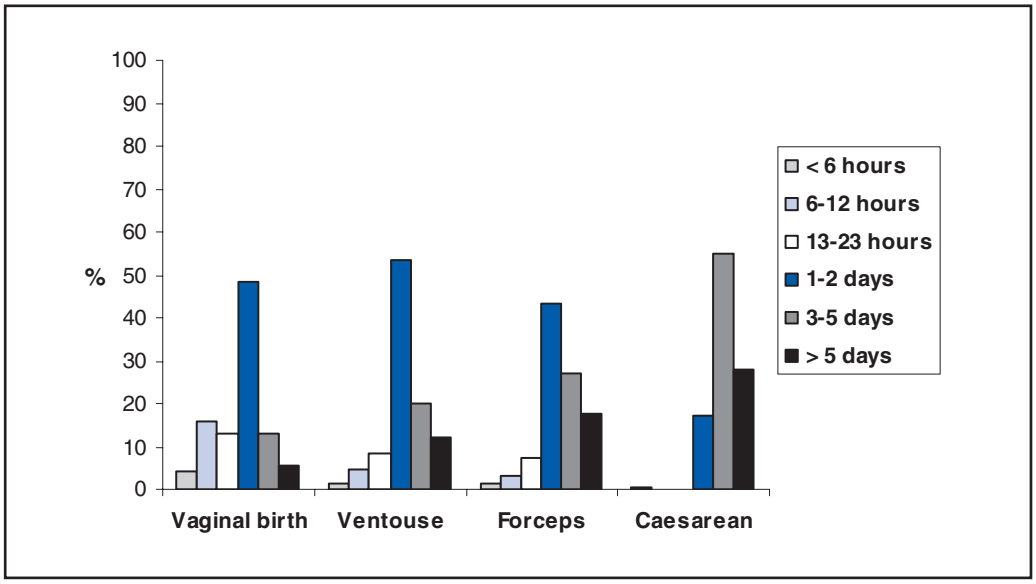

Figure 5.2 *Proportions of women experiencing types of birth and different durations of postnatal stay (Significant difference by type of delivery)*

The length of women's postnatal stay in hospital was significantly lower than that reported for 1995 (Figure 5.3). 64% of women stayed two days or less (compared with 53% in 1995), with fewer women in 2006 (24% compared with 35%) staying between three and five days.

Women's views on the quality of postnatal care are presented in Section 6.

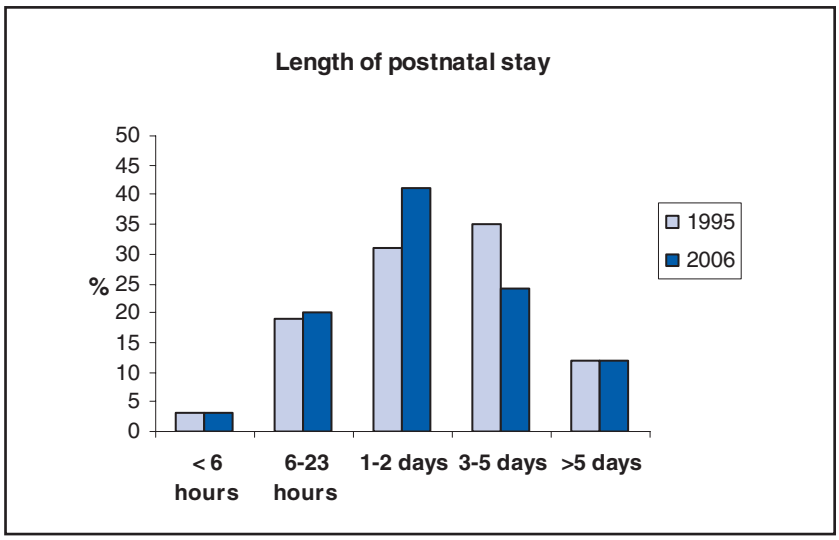

Figure 5.3 *Duration of postnatal stay in 1995 and 2006*

5.2 Mothers of babies needing special care

A relatively small proportion (10%) of women had babies who were admitted to a neonatal unit. The admission of a newborn for more specialist neonatal care than can be provided on a postnatal ward has practical implications for a woman's care as well as psychosocial implications for her and her family. These mothers were likely to have been separated from their sick or small babies, being cared for on a postnatal ward without their baby or even in a different hospital. The most common reasons for admission were prematurity and a need for respiratory support (Table 5.2). Smaller numbers of babies were admitted with feeding problems or for observation. 35% of the babies admitted to a neonatal unit were low birthweight (<2500g) and 39% were born at less than 37 weeks gestation.

Table 5.2 *Reasons for babies' admissions to neonatal units*

Reasons	%	n=242
Preterm		45.9
Breathing problems		25.6
Feeding difficulties		12.8
Observation		22.7
Other e.g. infection, jaundice, hypoglycaemia		30.6

Respondents could tick more than one option

It is important to ensure appropriate and effective postnatal care for women who have had a baby admitted to a neonatal unit, which may be in a different hospital to that which the woman gave birth. Also, a higher proportion of mothers with babies receiving this type of care are likely to have delivered by caesarean section; in this instance 43%, with 68% of these women having the CS carried out after labour had started. Following surgery, commonly as an emergency procedure, women whose babies are resident in a neonatal unit are a group whose needs are not always addressed effectively[30].

'I had a caesarean and was completely bed ridden for the first day, my catheter bag was full to bursting before anyone thought to empty it. No staff were available to take me up to SCBU to see my baby, I only got to see him 7 hours after they took him. No staff were available to help me get up for the first time.'

'I had a caesarean and my baby went to SCBU for 4 days. I felt 'lost' as I had to keep walking between SCBU and the ward to breastfeed 3 hourly, this meant I missed meals and the drug round, an added complication is my diabetes. I felt I could have been supported more.'

'After the baby was delivered I was hoping that I would be kept in hospital until my son could go home as he was in the neonatal unit … I was sent home on the 3rd day. It was very difficult for me to come to the hospital every day for long hours, sometimes 12-14 hrs, to look after my baby, even from the 3rd day of my operation … I was tired and exhausted … some more time should be given for the women who have a c-section and especially those whose babies go to the neonatal unit.'

'I had dreadful aftercare once from my GP I came home, because baby was in NNU, I was forgotten and not accommodated for, with respect to appointments. My midwife and health visitor were excellent. I am 14 wks post and am still getting infections and problems with my scar.'

Frequent visits to the neonatal unit, often to feed or provide breast milk can mean that a mother misses out on the postnatal care she requires. A greater proportion of mothers who had a baby admitted for neonatal care were not seen by a midwife at home (15%) compared with women whose babies did not require this kind of care (1%). The comparable figure for women with a baby admitted to a neonatal unit and who did not have any postnatal home visits was 12% in 1995. The length of time that babies stayed in a neonatal unit varied considerably (median 5 days). A small proportion of those admitted were still in hospital at the time of the survey (4%), at least three months after birth. The timing of the last postnatal contact for this group of mothers was later, at an average of 19 days (median 15, range 2-91 days), compared with an average of 15 days for other mothers (median 12, range 1-85 days).

Table 5.3 *Duration of baby's stay in neonatal unit*

Baby in NNU	Primiparous women		Multiparous women		All women	
	mean median (range)	n	mean median (range)	n	mean median (range)	n
Duration of stay (days)	13.1 5 (1-91)	116	13.2 4 (1-112)	126	13.1 5 (1-112)	253

30 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

5.3 Postnatal care after leaving hospital

The pattern of home visiting has changed over recent years[31 32]. Almost all women were visited by a midwife at home (98%) for an average of 5 postnatal visits. No significant differences were found in relation to parity or type of birth, though women whose self-reported health was poor were more likely to report more home visits by their midwife. Some women were also visited by a maternity support worker or maternity care assistant (19%) and this was more common for women who had not previously given birth.

Table 5.4 *Details of postnatal visiting*

Postnatal home visits	Primiparous women %	Primiparous women (n)	Multiparous women %	Multiparous women (n)	All women %	All women (n)
Visited at home by midwife	97.8	1133	98.3	1641	98.1	2883
Visited at home by maternity care assistant*	22.1	255	15.7	261	18.8	550
If not visited:	**n=22**		**n=26**		**n=51**	
Not offered	3		7		10	
Seen in clinic	3		4		7	
Mother near baby in NNU	13		13		28	
Moved home	1		0		1	
Did not want to be visited	1		0		1	
Number of times MW visited:						
Mean (median) range	5.1 (4) 1-19		4.9 (4) 1-58		4.9 (4) 1-58	

* Significant difference by parity

The timing of the last contact with the midwife was variable: women having their first baby and women who had undergone caesarean section were significantly more likely to be visited for longer, as were women whose self-reported health was poorer. A longer duration of contact, however, did not necessarily mean more visits, as irrespective of the timing of the last visit, 45-56% of women had 4-6 visits. Where the last contact was later there was a slight tendency for women to have more visits.

A comparison of 2006 data with 1995 shows the changing pattern of care, with home visits from a midwife tending to take place over a longer period (Figure 5.4). More women had home visits after 28 days in 2006 (7%) than in 1995 (2%). These changes and the variability in timing of the last contact suggest a flexibility that was less a decade ago.

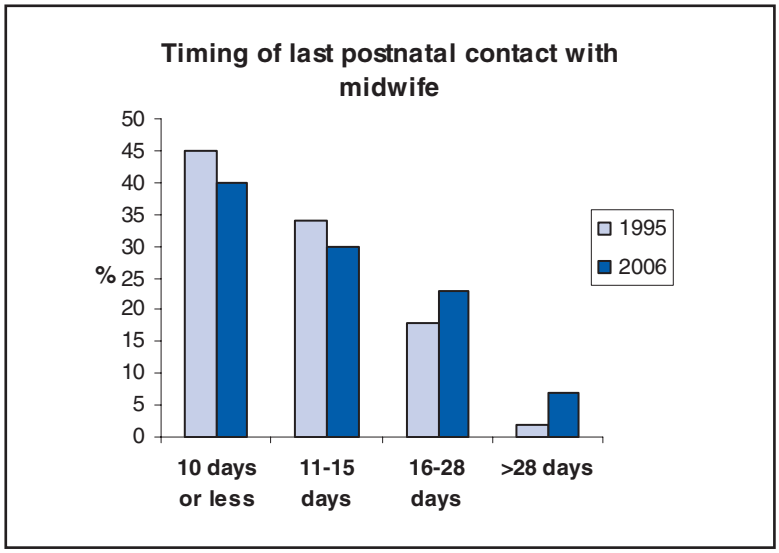

Figure 5.4 *Timing of the last postnatal midwife contact in 1995 and 2006*

31 National Institute for Clinical Excellence. Routine postnatal care of women and their babies. London: NICE, 2006.

32 MacArthur C, Winter HR, Bick DE, Knowles H, Lilford R, Henderson C, et al. Effects of redesigned community postnatal care on womens' health 4 months after birth: a cluster randomised controlled trial. Lancet 2002;359:378-85.

Table 5.5 *Proportions of women having different times for last visit or contact with midwife*

Timing of last contact with midwife* %	Primiparous women n=1161	Multiparous women n=1544	All women n=2705
<= 10 days	32.4	45.6	40.0
11-15 days	31.7	29.0	30.2
16-28 days	27.2	20.8	23.2
> 28 days	8.7	4.6	6.7

* Significant difference by parity

Almost all women had a postnatal check on their own health after the birth of their baby (90%). Of the women who gave reasons for not having a check half (51%) said this was not offered and 19% that they did not wish to have a check. A variety of other reasons were given which included missing appointments, not getting round to making an appointment and their baby being unwell.

Table 5.6 *Postnatal checks of women's health*

Postnatal checks %	Primiparous women n=1064	Multiparous women n=1532	All women n=2691
Carried out by health professional *	89.6	90.9	90.1
GP (family doctor)	85.3	89.8	87.9
Community midwife	5.8	4.5	5.0
Hospital midwife	1.8	0.6	1.0
Hospital doctor	2.5	1.6	2.0
Other e.g. practice nurse, health visitor	4.5	3.6	4.0

* Significant difference by parity

5.4 Infant feeding and care

Women were asked if their midwife had discussed infant feeding with them and about their plans in pregnancy with regard to infant feeding. Three-quarters of the women in the study (76%) indicated that their midwife had discussed infant feeding during their pregnancy, with no difference between women having their first baby and women who had previously given birth. The majority of women said they had planned to breastfeed exclusively (66%), with smaller proportions planning to use formula only or together with breast milk.

Table 5.7 *Women's plans during pregnancy with regard to infant feeding*

During pregnancy Planned to feed* %	Primiparous women n=1159	Multiparous women n=1674	All women n=2944
Breast milk (or expressed breast milk only)	73.3	60.1	65.7
Breast and formula (bottle) milk	8.7	13.9	11.9
Formula (bottle) milk only	15.1	23.8	19.9
Not sure	2.9	2.2	2.5

* Significant difference by parity

All the women in the study were asked if they had ever put their baby to the breast. A total of 80% had done so, with relatively little difference between women who had previously given birth and those for whom this was their first baby. This compares with 78% recorded by the most recent Infant Feeding Survey[33]. During the first few days after birth exclusive breastfeeding dominated (Figure 5.5). Women who had not previously had a baby were more likely to use both formula and breastfeeding, although the rate of exclusive breastfeeding at this time did not differ significantly (60% and 59%) between the groups. Little difference was found in relation to type of birth. While a high proportion of women had put their baby to the breast and even breastfed them for the first few days, by the time their baby was more than three months of age the rate for exclusive breastfeeding had diminished to only 26%, with little difference by parity. However, a further 17% of women were breastfeeding and also giving formula milk to their babies at this time.

33 Bolling K. Infant Feeding Survey 2005: Early Results. London: Office for National Statistics, 2005.

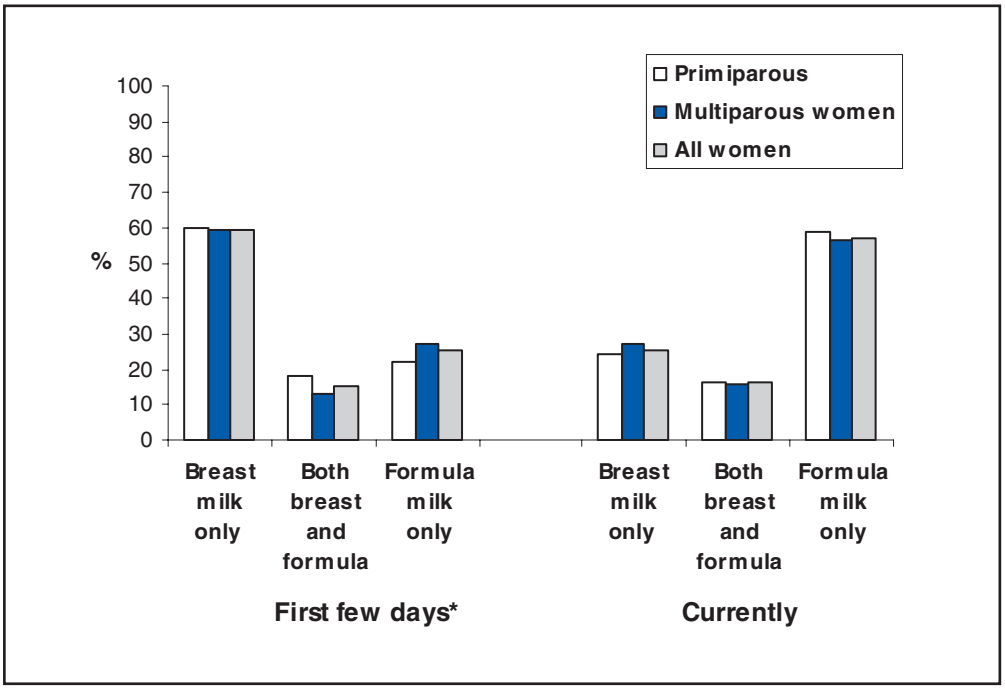

Figure 5.5 *Infant feeding methods used during the first few days after birth and currently (infant aged 3-4 months) (* Significant difference by parity)*

Women in the study were asked about the advice and support available from health professionals in relation to infant feeding. Approximately a third of women said they always received consistent advice, practical help and support. However, between 18% and 21% of the respondents indicated that their midwives and other carers did not provide any of these. Women having a first baby reported receiving significantly less consistent advice, although they were given more practical help.

Table 5.8 *Help with infant feeding received from midwives and other health professionals*

Help received	Yes always % (n)	Yes generally % (n)	No % (n)	Didn't want this help % (n)
Consistent advice	32.7 (952)	43.9 (1279)	20.8 (605)	1.9 (55)
Practical help	30.9 (891)	44.8 (1293)	19.4 (559)	4.0 (115)
Active support and encouragement	35.8 (1040)	42.8 (1243)	17.8 (518)	2.4 (69)

A question was specifically asked about advice and help with other aspects of infant care as this was an area where women in their free-text responses in the pilot study and other studies had suggested more help was needed. Although not all mothers felt the need for this kind of advice and support, others expressed a need in many of the areas listed (Figure 5.6). While less help was needed in relation to their baby's general health and progress, over a quarter of women expressed a need for more advice and help about their baby's skin care, handling and bathing their baby and more than a third needed this in relation to crying, settling to sleep and colic.

The need for advice and support in the postnatal period was illustrated by some women's responses, often those of new mothers, to an open-ended question about how their experience of postnatal care could have been better. Issues focusing on feeding and infant care were commonly mentioned in relation to where their care could have been better:

> *'Everything, I really feel that my postnatal care in hospital was a huge let down. I had no help whatsoever with breast feeding, after a lot of encouragement during my pregnancy to do so. There was no support or preparation for me and my baby to return home.'*

> *'I feel first time mothers need a lot more help and guidance as to what to do and how to care for their babies'*

> *'No one offered to show me how to breastfeed, bath or change my baby, and I was shouted at for falling asleep and not feeding the baby although he hadn't woken up either.'*

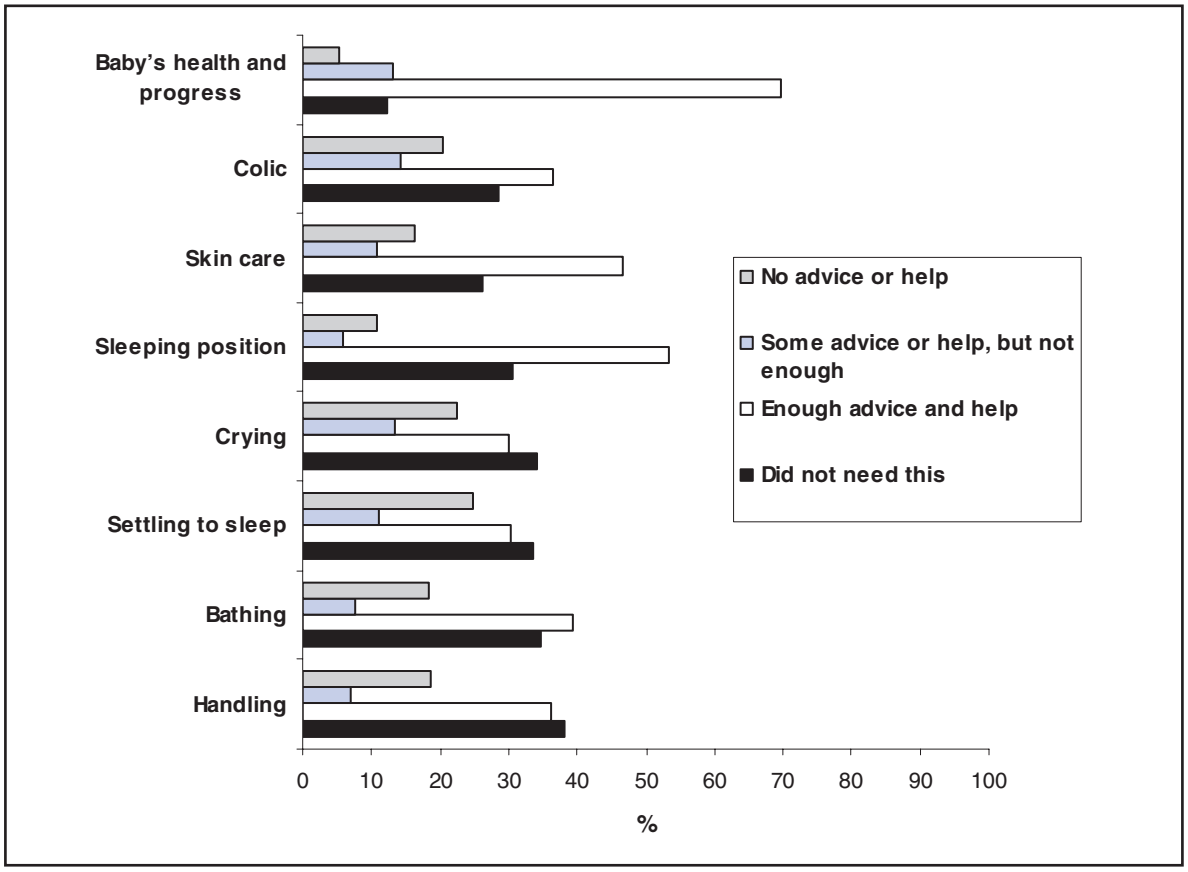

Figure 5.6 *Advice and help with baby care received from health professionals in the six weeks following the birth*

'More help and information about caring for a new baby. All the mums were left to get on with it. I could have asked for assistance but felt I would have been viewed as 'awkward new mum', and all the staff appeared very busy. I ended up going home the next day with a baby who still had blood in his hair and mucous in his ears and I had no idea how to bathe him properly'.

'All midwives were really helpful, the only problem is they were very under staffed, so although they were there for you, I often felt that they couldn't spend as much time explaining things as they wanted as there were other new mums waiting to be seen'

Women were asked if they had seen or spoken to a health visitor since the birth. A health visitor had visited almost all of them at home (94%) and other contacts were made during clinic visits or by telephone.

Table 5.9 *Proportion of women experiencing different types of postnatal health visitor contact by parity*

Health visitor contact %	Primiparous women n=1158	Multiparous women n=1674	All women n=2945
At home	94.3	94.4	94.2
At the clinic	66.3	64.0	64.9
By phone	29.6	27.1	27.9
Did not want to see a health visitor	1.3	0.1	0.1
No contact	0.6	0.7	0.6

Respondents could tick more than one option

Many women valued the input and support received from their health visitor and local centres in the early postnatal months:

'The care and support I have received from my health visitor has been fantastic. She came out to visit me and my baby in our home every week until I felt well enough to attend the local clinic.'

'The care I have received, especially since my daughter's birth has been excellent. My health visitor is great. I suffer from post-natal depression and she has been really supportive and helpful, slowly it is getting better, and she has helped with this so much.'

'When my baby was almost 3 months old I was invited to post-natal classes, which were extremely helpful, not only from the information given by our fantastic health advisor, but for meeting with other mums.'

'My child is now 3 months old. We have established a very good relationship with the surgery health visitors, from the antenatal classes, to home visits through to the baby clinic and mother and baby group each week. I have seen the same team and feel confident with them … I've now been told that I have to be seen by health visitors from a surgery that is a car ride away … Up until now our care has been exceptional … I am now feeling extremely let down by the introduction of this new system.

5.5 Summary of postnatal care

Changes have occurred in postnatal care, with shorter stays in hospital, and a longer period of postnatal contact with the midwife once home. Duration of stay was linked with parity and type of birth. Maternity care assistants (or maternity support workers) have been introduced and are currently providing some postnatal care. Women whose babies were admitted to a neonatal unit experienced additional difficulties after the birth and some did not receive postnatal visits at home. However, almost all women had been visited at home by a health visitor by the time of the survey and most had been given some kind of postnatal check.

Data on infant feeding show that this continues to be an issue of some concern with a rapid drop off in exclusive breastfeeding over the early months, although 43% of babies were receiving some or all of their feeds as breast milk at the time of the survey. Most women had seen a health visitor since they had been discharged home and had a postnatal check of their own health. A need for more support and help both with feeding and infant care more broadly was expressed by many women.

Data on women's views of postnatal care in hospital and at home are presented in sections 6.4 and 6.5.

6. Women's experience of care

The emphasis in the NSF is on the provision of high quality care that takes account of the needs of individual women. Previous evidence from the 1995 survey about the importance of respect, kindness and individualised care showed the power that a negative experience with an individual health professional had in colouring a woman's attitude towards her maternity care. This section focuses on women's perceptions of the care provided, the choices and information available, continuity and overall satisfaction. Women's free text responses are used to illustrate their experience of particular aspects of care.

6.1 Options for care

One of the cross-cutting themes that runs through the survey and the report is choice and the options that women have available to them about their maternity care. A range of questions relating to the different stages of care addressed this point.

Women were asked about the options they had at the start of their pregnancy for where their baby could be born. More than half of the women said they had more than one option for where they could have their baby (61%), some said they had a choice which included a birth centre or midwifery-led unit separate from a hospital (10%) and over a third (38%) said home birth had been a possible option for them at that stage (Table 6.1). However, choice in relation to place of birth seemed quite limited for some women, with 39% indicating that they only had the option of going to one hospital. Comparisons between 2006 and 1995 show that most recently fewer women reported only having one option for place of birth (45% in 1995) and that home birth is now more commonly seen as an option (18% in 1995).

Table 6.1 *Options for place of birth at the start of pregnancy*

Choice about place of birth at the start of pregnancy %	Primiparous women n=1149	Multiparous women n=1656	All women n=2919
A choice that included home birth as an option	38.5	37.8	37.9
A choice that included a birth centre separate from hospital*	12.1	8.9	10.1
A choice of different hospitals only	19.1	18.1	19.8
Option of only going to one hospital in particular	36.8	40.2	38.8

* Significant difference by parity. Respondents could tick more than one option

Options for where antenatal checks could be carried out and about which health professional would undertake these was limited, with only 27% and 19% of women indicating that they had a choice about these aspects of care. A question was not asked about the way women perceived the frequency and timing of antenatal contact, although some women indicated a preference in relation to these aspects of antenatal care:

> *'I would have liked more antenatal appointments. It would have helped to have an appointment with a midwife well before the first scan/booking appointment as this was when I felt most ill and a bit scared and unsure and my GP wasn't much good in this area.'*

> *'I would have preferred to have just one or two midwives looking after me whilst pregnant. Instead, there was a team so I just saw whoever was on duty on the day of my appointment. It didn't give me a chance to get to know them and vice versa, so there wasn't one/two midwives who knew everything that was going on in my pregnancy. This isn't a criticism of the midwives who were, in general, very good.'*

> *'I found it very worrying that between 19 weeks (when I had my anomaly scan) and 28 weeks I was not required to have an antenatal appointment. In my previous pregnancies I had always had an antenatal appointment at 24 weeks which I found very reassuring.'*

Women's awareness of having a choice in relation to blood tests and screening for Down's syndrome was evident, though not universal, as the guidelines suggest[34]. With regard to ultrasound scans, both for dating the pregnancy

34 National Library for Health. National Screening Committee policy – Down's Syndrome screening. Available at: URL:http://www.library.nhs.uk/screening/viewResource.aspx?catID=2007&resID=35689/. Accessed Nov 27, 2006.

and the later anomaly scan, approximately three-quarters of women (75% and 76%) felt they had a choice about whether to have the scans or not.

Table 6.2 *Choices available to women in the course of antenatal care*

Antenatal checks:	%	Primiparous women	Multiparous women	All women
Where AN check-ups would take place	n=2934	25.9	27.6	27.0
Who would carry out AN check-ups	n=2922	16.5	20.1	18.6
Whether to have blood tests at all in pregnancy	n=2944	79.8	82.5	81.5
Whether to have screening for Down's syndrome	n=2896	86.3	88.0	87.1
Whether to have a dating scan	n=2614	72.9	75.6	74.7
Whether to have a '20 week' or 'anomaly' scan *	n=2803	73.8	77.5	76.2
Offered antenatal classes *	n=2937	88.5	58.8	71.4

* Significant difference by parity

Few differences were found in relation to choice about antenatal checks and parity. None were found in relation to options for location and health professional involved, having blood tests, having Down's syndrome screening or a dating scan. However, significantly more multiparous women indicated that they felt they had a choice about the anomaly scan. For women choice in relation to where antenatal checks would take place and who would carry these out seems to have diminished since 1995, though choice about blood tests and scans seems greater in 2006. Differences in question format make it difficult to quantify these differences without further analyses.

Another aspect of antenatal care where women had a choice concerned antenatal classes. More than two-thirds of women overall (71%) indicated that these had been offered. However, being offered classes differed by parity: almost all first time mothers were offered these (89%) compared with only 59% of mothers who had previously given birth. In their open text responses women reported that the provision and quality of antenatal classes was variable:

> *'I was only offered 2 antenatal classes which 'skimmed' over the actual birth experience and what to expect. There wasn't any advice given on how to breathe etc during labour which I would have found helpful.'*

> *'My local area only provided 2 antenatal classes - (birth and breastfeeding) and this was totally inadequate, classes needed to cover more about post-natal support to the mother.'*

> *'I was appalled by the lack of antenatal classes available to me. I had to ring around everyday, chasing midwives and leaving messages. Eventually, one session was arranged, which I found inadequate. Antenatal classes were something I'd looked forward to about being pregnant. I have no friends with babies/pregnant and I would have benefited from meeting other women in my situation.'*

> *'Antenatal and postnatal classes were very informative and useful. My local midwives also ran the 'aqua-natal' classes at the local swimming pool which was very useful (and fun!)'*

However, for some women, their midwife may have been an alternative source of support and information:

> *'The care I received during my pregnancy and labour was excellent although I was very disappointed there weren't any antenatal classes offered to me in my area. This was my first pregnancy and with this in mind, was an anxious time for me as I was very worried about giving birth, I did, however ask many questions of my midwife who was more than happy to go through things at great length and depth with me.'*

Several questions were asked that reflected women's ability to make a choice about some aspects of their labour and birth. Less than a third of women felt they had a choice about induction. However, the reasons women gave for induction suggested that they saw this as a necessary process for their own health and wellbeing and that of their baby. Of those that were induced this was attributed to concerns about the baby's condition by 27% of mothers (e.g. having twins, meconium stained liquor present, baby's size, reduced fetal movement) and to their own health and medical problems by 24% (e.g. high blood pressure and proteinuria, diabetes, cholestasis). Of the very small number of women who were induced whose decision was framed by them as 'choice' (less than 1%), half referred to their previous experience of childbirth as an explanation for the choice.

Table 6.3 *Indicators for choices available to women in the course of labour and birth*

Choice in labour and birth	%	Primiparous women	Multiparous women	All women
About induction	n=2101	26.7	32.4	30.3
About being able to move around and choose positions in labour most of the time (% of those having labour)*	n= 2587	46.9	59.6	54.2
Used an alternative to bed for vaginal birth (floor, birthing pool) (% of those having vaginal birth) *	n= 2246	6.7	14.9	11.6
Used standing, squatting, kneeling for vaginal birth (% of those having vaginal birth) *	n= 2249	9.0	18.7	14.8
Presence of partner or companion as much as wished	n= 2927	94.2	94.2	94.3

* Significant difference by parity

Choice about position in labour differed according to parity, with women who had previously given birth indicating that they had more choice at this time (60% compared with 47%). However, women's experiences differed, with nearly one in five women (19%) feeling that they were not able to move around and choose the position which made them most comfortable at all (23% of new mothers and 16% of women who had previously given birth).

The following responses to an open-ended question about what women felt they needed during labour and birth, but did not have, illustrate some of the issues relating to choice and an appreciation that choice was not always the main priority:

> *'I did not get the birth I asked for or planned for. I wanted an epidural - doc was in a c section and I asked for the pool but was told there was not enough staff to man it. Birth was great though, but I didn't have choice at all.'*

Some focused on induction:

> *'I was given syntocinon during labour via a drip. I don't feel I had a choice in this and I was not consulted when the dosage was increased, which made contractions very painful at times.'*
>
> *'When they first induced me I had a gel pessary. I went to the postnatal ward and they just left me. They didn't continue with my labour because they didn't have enough beds on the labour ward.'*

Others on pain relief:

> *'Pain relief didn't seem an option and wasn't offered'*
>
> *'Was offered Tens machine but didn't get given one until hours later. They apologised for forgetting about me'*
>
> *'I requested analgesia on several occasions, which I was refused and was told my contractions were mild."*
>
> *'I was informed in labour that I was unable to have an epidural as all the anaesthetists were in theatre. The midwife then came in with pethidine. I felt a bit like I had no control'*
>
> *'Luckily the first midwife I encountered finished her shift and I had a different midwife who was fantastic and respected my wishes to allow my labour to be as natural as possible. The first midwife almost forced me to consider an epidural and even got a chair to take me.'*

Or monitoring:

> *'The only thing was that I wanted to move around more but having had a caesarean previously, they wanted to keep monitor on permanently but I would have preferred intermittent checks to allow me to move.'*

Other areas where women would have liked choice were mentioned:

> *'I would have liked to have had a water birth and although facilities were available there was not enough staff for me to have one'*
>
> *'We planned to have our baby in hospital, however we ended up having 31 hours of labour at home and only had 30 mins in the hospital before our baby was born. I found this quite stressful, but understand the hospital was very full and had no room.'*

Choice was to some extent implicit in what some women said they would have liked:

'A midwife that listened to me instead of insisting I go home and come back in established labour, discussion at 12.35am, baby born 1.30am. Midwife left room and just arrived for baby being born'

'One of the midwives to have actually listen to me when I knew by baby's head was stuck and she told me I wasn't trying hard enough, then ending up having forceps.'

Some just wanted to be heard:

'My midwife didn't believe I was in labour'

'The midwife that delivered my baby did everything by the book but I feel she didn't listen to me. When I went into the last stage of labour she wasn't even in the room, she'd left to get some pethidine which was administered too late.'

'The midwife in the birth centre did not believe that I had strong contractions and refused to give me any pain relief for 2 - 3 hours until I insisted on the transfer to the main labour ward where I was given an epidural.'

'I told them about my first birth and I didn't want the same to happen again. For some reason they didn't believe I was going to have the baby for hours when I knew it was coming so I was rushed, worried and uncomfortable during labour.'

The women in the study were not asked if they had a choice about where to give birth such as on a bed or other place. However, actually not giving birth on a bed, as was most common, but using alternatives, such as the floor, a birthing pool or using a stool, may indicate choice. 11% of women having a vaginal birth used these alternatives, with twice as many women who had previously given birth doing so (14% compared with 6%). Similarly, the position adopted for birth may reflect choice, although some positions may be required for medical reasons. While 9% of first time mothers used a standing, squatting or kneeling position to deliver their baby, more of those who had previously given birth delivered in this way (19%).

While there was little difference in choice in relation to induction and to being able to move around in labour, comparisons with 1995 show that in 2006 more women felt able to use alternative positions for labour and birth (15% compared with 6%). The presence of student midwives or doctors during labour and birth was an issue for some women, although a benefit for others that was mentioned in the free text responses:

'A student doctor sewed me up after my episiotomy and no-one asked me if this was ok.'

'I had a student midwife but didn't feel comfortable with her. I wanted a qualified midwife but she came in and said she wasn't needed, I requested for her to stay but she didn't.'

'I had a student with the midwife. This was very good as someone was with me throughout labour.'

'I had a midwife on hand throughout my whole labour … I also enjoyed having a lovely student midwife attend the birth - she was brilliant and I'm glad I was able to allow her to add another birth to her list!'

For women the presence of a partner or companion of their choice for labour and birth as much as they wished, like the location and position for birth, reflects choice. Almost all women had someone of their choice with them at this time (94%) (see Section 4). The respondents in the study were asked about the length of postnatal stay they experienced in hospital (Table 6.4) (See Section 5). While not asked about choice directly, their responses reflect a match or mismatch between their actual duration of stay and what they would have preferred. More than two-thirds of women thought their stay was of the right length (69%) and the remainder were split between those who would have liked a longer stay in hospital (13%), and those who would have liked a shorter stay (15%). Parity affected the responses to this question, with women who had previously had a baby being more likely to describe their length of stay as 'about right' and less likely to say it was 'too short'.

Table 6.4 *Women's views on length of postnatal hospital stay*

Postnatal stay	**%**	**Postnatal stay**			
		Too long	**Too short**	**About right**	**Not sure/Don't know**
Primiparous women	**n=1144**	14.9	14.1	66.6	4.5
Multiparous women	**n=1585**	15.2	12.2	70.0	2.5
All women	**n=2831**	14.9	13.1	68.6	3.4

Some women who responded in open text about changes that could have been made to their postnatal care in hospital indicated they would have liked a longer stay, but that staffing levels, care or food or hygiene conditions made them feel that home was a better option.

The data on women's views about length of postnatal stay show little difference in relation to the type of birth experienced (Table 6.5).

Table 6.5 *Women's views on length of hospital postnatal stay following different types of birth*

Type of birth	%	Postnatal stay			
		Too long	Too short	About right	Not sure/Don't know
Normal (vaginal) birth	**n=1796**	15.0	12.7	69.0	3.3
Caesarean	**n=665**	13.5	13.8	69.5	3.2
Forceps	**n=148**	20.3	14.2	62.2	3.4
Ventouse	**n=222**	14.4	13.5	67.1	5.0
Total sample	**n=2831**	14.9	13.1	68.6	3.4

Women were asked about their postnatal contact with midwifery staff once home. More than three-quarters were satisfied with the frequency with which they saw a midwife.

Table 6.6 *Women's views on postnatal contacts with a midwife*

Postnatal contact with midwife*	%	Needed more often	Needed less often	Saw as much as wanted
Primiparous women	**n=1150**	21.5	3.7	74.8
Multiparous women	**n=1662**	15.3	4.0	80.6
All women	**n=2923**	18.3	3.9	77.8

* Significant difference by parity

First time mothers were more likely to say that they would like to have seen a midwife more often and small proportions of experienced and inexperienced mothers said they would like to have seen their midwife less often.

6.2 The quality of care during pregnancy

It is not easy to assess the quality of care experienced by women during their maternity care. Feeling respected and having effective communication with the health professionals providing care are markers for quality of care from a woman's perspective. Some of the same question formats were used about the three main stages of maternity care; antenatal care, care during labour and birth and postnatal care. Similar tables are presented which reflect women's responses to statements about their experience of care with which they could agree or disagree. Women may be cared for by many individuals from different professional groups and this approach to the questions allowed respondents to respond to both positive and negative statements about the care they received. Also it allowed different responses relating to the two main professional groups responsible for that care.

Table 6.7 *Women's perceptions of communication and respect at their booking appointment*

At the booking appointment	%	Agree	Disagree	Not sure
I was spoken to in a way I could understand		97.9	1.3	0.8
I was treated with respect		96.1	2.4	1.5
I was treated with kindness and understanding		94.8	2.9	2.4

Almost all women felt that staff communicated well with them during their booking appointment and that they were treated with respect and kindness (Table 6.7).

Women's views of the way that staff cared for them during their pregnancy were generally similar, although some women's experience included receiving care from one or more midwives and doctors who they felt did not talk to them in a way that they could understand (13% and 14% respectively) (Table 6.8). Similar proportions of women also felt that they were not treated with respect by one or more midwives (14%) or doctors (11%) during their pregnancy care.

Table 6.8 *Women's perceptions of communication and respect during antenatal care*

Antenatal care from midwives	**%**	**Agree**	**Disagree**	**Not sure**
Midwives talked to me in a way I could understand		96.9	2.2	0.9
One or more midwives did **not** talk to me in a way I could understand		13.2	84.0	2.8
Midwives treated me with respect most of the time		94.8	3.8	1.4
One or more midwives did **not** treat me with respect		13.9	83.5	2.6
Antenatal care from doctors	**%**	**Agree**	**Disagree**	**Not sure**
Doctors talked to me in a way I could understand		94.1	4.5	1.5
One or more doctors did **not** talk to me in a way I could understand		13.8	83.5	2.8
Doctors treated me with respect most of the time		94.6	3.6	1.9
One or more doctors did **not** treat me with respect		11.1	86.4	2.6

As women were able to respond in a variable way to the statements shown in Table 6.8, their individual responses were examined to see the extent to which their responses in this regard were entirely negative, entirely positive or mixed (Table 6.9). It seems that only a very small proportion of women, approximately 1%, were completely negative about this aspect of their care from midwives or doctors during pregnancy. The experience of women having a first baby differed little from that of those who had previously given birth and many more had a mixed experience of interacting with health professionals at this time, some of which is illustrated in the open text responses in this and other sections.

Table 6.9 *Perceptions of communication and respect from midwives and doctors during antenatal care*

Views expressed about care from midwives	**%**	**Primiparous women n=1162**	**Multiparous women n=1676**	**All women n=2952**
Wholly positive		72.9	75.0	74.0
Mixed views		26.2	24.4	25.2
Wholly negative		1.0	0.6	0.8
Views expressed about care from doctors	**%**	**n=1147**	**n=1625**	**n=2880**
Wholly positive		75.9	75.3	75.5
Mixed		23.2	23.3	23.3
Wholly negative		0.9	1.4	1.2

6.3 The quality of care during labour and birth

Women were asked the same questions about the care they received during labour and birth. A similar pattern of response to that reported for their pregnancy care is evident, although slightly fewer women felt they were not spoken to in a way that they could understand by one or more midwives (9%) or doctors (9%) or treated with respect by one or more midwives (11%) or doctors (7%) at this stage of their care (Table 6.10).

Table 6.10 *Women's perceptions of communication and respect during their labour and birth*

Care from midwives	**%**	**Agree**	**Disagree**	**Not sure**
Midwives talked to me in a way I could understand		96.2	2.6	1.2
One or more midwives did **not** talk to me in a way I could understand		9.1	88.8	2.1
Midwives treated me with respect most of the time		94.4	4.3	1.2
One or more midwives did **not** treat me with respect		11.0	87.1	2.0
Care from doctors	**%**	**Agree**	**Disagree**	**Not sure**
Doctors talked to me in a way I could understand		92.8	3.8	3.4
One or more doctors did **not** talk to me in a way I could understand		8.5	87.5	4.0
Doctors treated me with respect most of the time		94.1	2.7	3.2
One or more doctors did **not** treat me with respect		6.9	89.2	4.0

In categorising the responses from individual women concerning this aspect of care in labour and delivery (Table 6.11) very few were wholly negative. Fewer women reported having a mixed experience in labour and delivery when

compared with care during pregnancy, though approximately 1 in 5 indicated a mixed experience of midwives and doctors in response to the structured questions used.

Table 6.11 *Perceptions of care from midwives and doctors during labour and birth*

Views expressed about care from midwives **%**	**Primiparous women n=1160**	**Multiparous women n=1665**	**All women n=2938**
Wholly positive	78.3	80.5	79.2
Mixed views	20.7	18.3	19.7
Wholly negative	1.0	1.2	1.1
Views expressed about care from doctors **%**	**n=1038**	**n=2317**	**n= 2411**
Wholly positive	79.9	80.7	80.3
Mixed	19.0	18.3	18.6
Wholly negative	1.3	0.9	1.1

No differences were found between the responses of first time mothers and women who had previously given birth. Differences between women's experience of doctors and midwives during labour and birth was minimal, with approximately 80% of women responding positively about both groups.

The question formats used in 2006 differentiated between women's views of the midwives and doctors involved in their care, while the 1995 survey did not consistently do this. However, in both surveys women were asked separately if midwives and doctors talked to them in a way that they could understand. While almost all women in 2006 and 1995 agreed with the statement about midwives (96% and 93%), the view of doctors had changed considerably, with 93% now being seen as talking in a way women understand compared with 66% in 1995.

Communication of information was an issue that women themselves raised in the open text responses, having recognised their own need to understand what was happening to them and the nature of possible interventions during labour and birth. Respondents referred to their information needs:

> *'On admission to the ward I was not informed on the process for caring for women in labour. Simply left on ward, not told anything. To be informed would have made a big difference'*

> *'This was my second labour so I knew what questions to ask, but despite my birth plan I felt I still had to ask questions; information was not freely given'*

> *'We were transferred from one hospital to another. Hospital 1 had not told us what would be happening and hospital 2 assumed they had.'*

Particularly when there was concern:

> *'At stage two of my labour (pushing) it lasted 2.5 hours which I knew wasn't right. The midwife never explained what was happening and that's the only time I felt nervous and worried about anything.'*

> *'No-body explained why things and what things were happening to me or my husband. It left my husband concerned and distressed for weeks and still now he doesn't like to talk about it.'*

> *'I would have liked to have been told what was happening a bit more. Especially when the baby was in distress'*

> *'The midwife could have been more communicative about what her concerns for me and the baby were - felt like she was trying to protect me from worry but I was worried anyway - would've preferred her to be more frank'*

> *'The reason for transferring me to hospital (possible cord compression) wasn't explained. I only realised the reason when I read my labour notes after leaving hospital'*

Women were also asked about how staff communicated with each other about their care during labour and birth. The data on women's views of the inter-professional communication are shown in Table 6.12. More than half the women in the study thought that staff communicated very well about their care at this time. However, one in ten women did not feel this was the case and this view is reflected in the open text responses to a question about anything else that women felt they needed in labour in the way of support, help or information that was not provided.

Table 6.12 *Women's views about the way staff communicated with each other about their care in labour and delivery*

Views expressed about staff communication with each other %	Primiparous women n=1157	Multiparous women n=1650	All women n=2920
Very well	55.1	57.8	56.7
Fairly well	34.0	33.4	33.7
Not very well	7.7	5.3	6.3
Not at all	3.1	3.5	3.3

Adjective checklists have been used in a range of studies looking at the experience of women and parents in relation to their own care and that of their baby or child. The list used in the survey is based on that used by Green et al in two studies[35 36], modified to consist of eight pairs of positive and negative terms laid out in an unbiased way[37]. Respondents could select as many terms as they wished in describing the staff who cared for them. In this way the checklist facilitates the emergence of a more detailed picture of care from the woman's point of view, while asking all women the same question.

The selection of the positive and negative terms is shown separately (Figures 6.1 and 6.2).

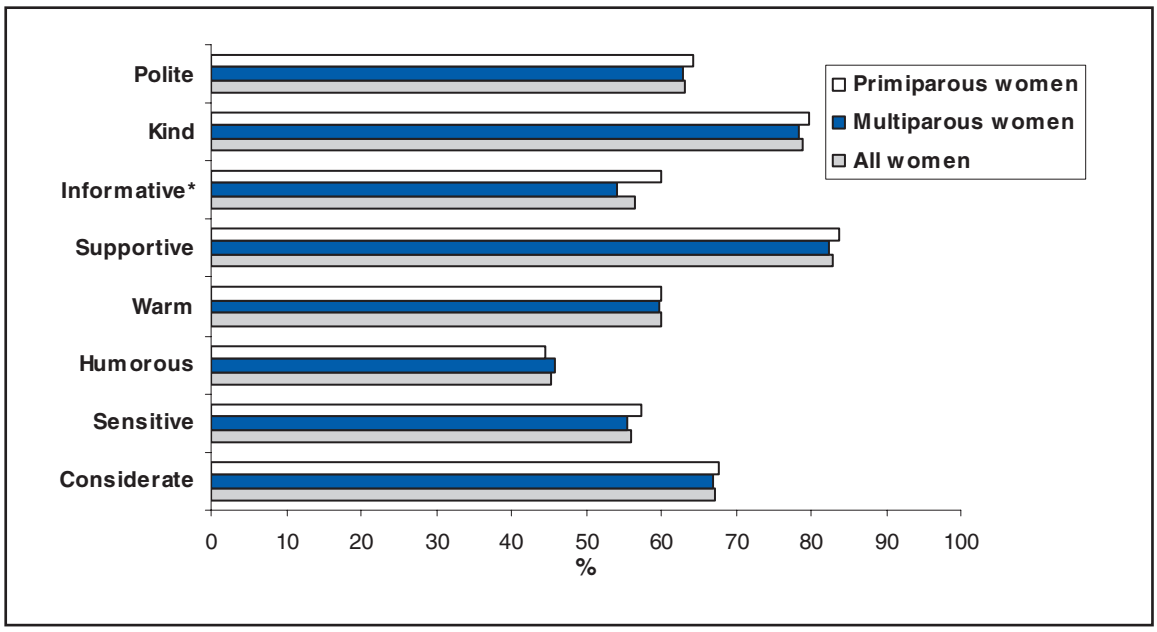

Figure 6.1 *Positive terms selected by women to describe the staff caring for them during labour and birth (* Significant difference by parity)*

More than four out of five women (83%) selected the term 'supportive' to describe the staff who looked after them during labour and birth. A similarly high proportion selected the term 'kind' (79%). The terms 'sensitive' and 'warm' were selected less often (56% and 60%), but by over half the women in the study. It is difficult at this stage to interpret the way in which women did not select some of the positive terms.

The more negative descriptors of care were chosen less often altogether, with 'rushed' being the most common (16% of women), followed by 'bossy' (12%). Much smaller numbers of women perceived staff as 'off-hand' (7%), 'inconsiderate' (5%) or 'unhelpful' (6%). While women overall chose similar terms, some terms were used more by women having their first baby than by women who had previously given birth. First time mothers were more likely to indicate that staff had been 'informative', 'rude', 'bossy' and 'inconsiderate'.

35 Green JM, Coupland VA, Kitzinger JV. Great expectations. A prospective study of women's expectations and experiences of childbirth. 2nd ed. Hale, England: Books for Midwives Press, 1988.

36 Green J, Baston H, Easton S, McCormick F. Greater Expectations? Summary Report. Mother and Infant Research Unit, University of Leeds, 2003

37 Redshaw M, Harris A. Maternal perceptions of neonatal care. Acta Paediatr. 1995 Jun;84:593-8.

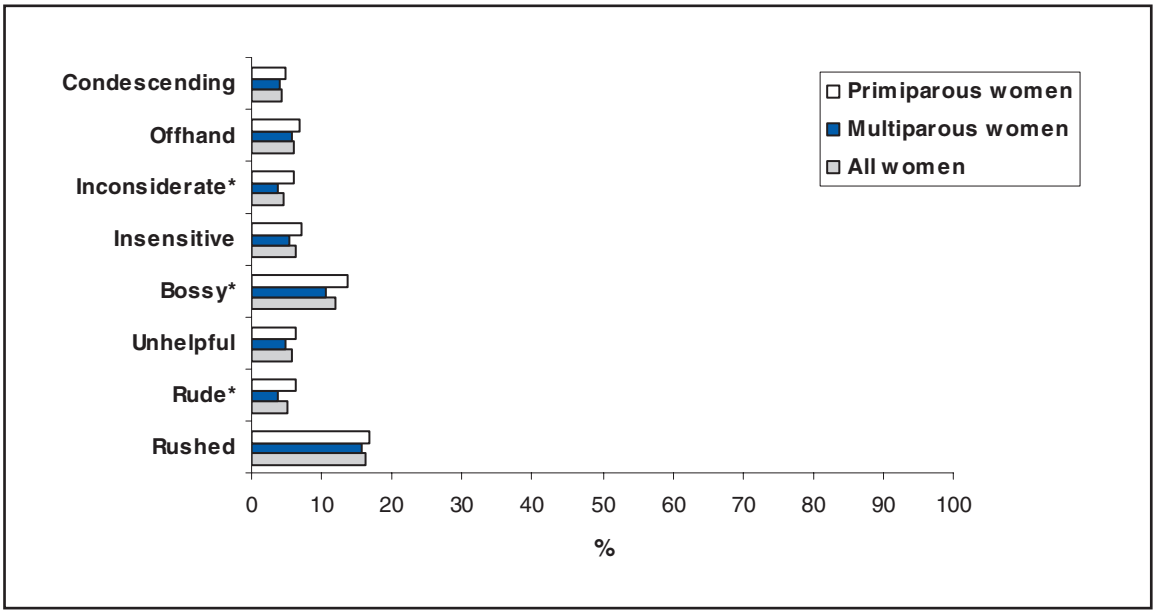

Figure 6.2 *Negative terms selected by women to describe the staff caring for them during labour and birth (* Significant difference by parity)*

The women in the study also expressed their views in their responses to unstructured questions. While being listened to was identified by them as important, they valued the presence of a midwife while they were in labour and sensitive and supportive care:

> *'I would like to comment on the excellent care I was given during labour, the midwife was completely understanding and she let me do what I wanted to do. I was scared I was going to tear and have to have stitches but she helped me through my fear and I had an excellent labour and delivery.'*

> *'I would have liked more continuous time with the midwife - she had to keep leaving the room'*

> *'I feel that being sensitive and supportive would help a lot. That would give the feeling of having a friend with you.'*

> *'One midwife was a bit too bossy, I responded better to a gentle approach when I was scared.'*

> *'I had no support at all. My labour progressed very quick and midwives didn't believe me, and treated me like I was a drama queen. Was left alone during most of labour and when a midwife did come to check me very reluctantly, I was 10cm dilated and the baby was coming. This was very scary and painful time and still gives me nightmares'*

> *'I was delighted with the actual delivery of my baby, it was very relaxed and calm, the midwife who delivered her was fantastic, very helpful and caring. I would say that of all my 4 pregnancies the fourth was by far the best'*

Being treated as an individual and receiving personalised care was key:

> *'The staff could have been more considerate, sensitive and helpful in my case. They were rushed, busy and not very concerned with me as an individual.'*

> *'Labour and delivery was very fast, baby was breech I was alone and very scared, staff dealt with me in the best way, they had to be very strict with me. I did need a bit more understanding but there was no time'*

> *'Privacy - hospital staff felt free to come into the room during my labour and delivery without asking whether I felt comfortable for them to do so. This made me feel very embarrassed.'*

When asked about what else was needed, some women said 'nothing' and then made it clear that they had a really good experience during labour and birth:

> *'The hospital staff and midwives were great in every way and made me feel safe brave and content could not have been any better'*

'Excellent care during labour and on admission prior to labour. Fantastic it was so local to home. Made to feel special by midwife in hospital who was also very supportive to my husband.'

'Despite the fact that my labour was nothing like I had intended, I felt that it was overall a good experience, aided by lovely staff.'

6.4 The quality of postnatal care in hospital

The same questions about communication and respect were asked about women's experience of postnatal care in hospital as had been used in relation to care during pregnancy and labour and birth. Most of the care on the postnatal women is provided by midwifery staff, but also includes some medical staff and healthcare assistants working in that setting.

Table 6.13 *Women's perceptions of communication and respect during their hospital postnatal stay*

Care from staff %	Agree	Disagree	Not sure
Staff talked to me in a way I could understand	91.5	6.6	1.9
One or more members of staff did **not** talk to me in a way I could understand	16.0	81.8	2.2
Staff treated me with respect most of the time	89.2	8.9	1.9
One or more members of staff did **not** treat me with respect	22.2	75.1	2.7

Women were more critical of staff during this phase of their care than during pregnancy or labour and delivery, with 16% indicating that one or more members of staff did not communicate with them effectively and 22% that they were not treated with respect by one or more members of staff. Women sometimes contrasted aspects of their experience:

'Overall I had great care during my pregnancy, at the birth and afterwards. However one midwife on the ward after I had had baby could have changed all that. She spoke down to me, in a rude arrogant, aggressive and bossy manner. My baby was only a few hours old and she very nearly had me in tears! She could have ruined a good experience had I let her. All the other staff from cleaners to consultants were superb!'

'I was really happy with my experience at the hospital. Apart from one midwife everyone was absolutely fantastic and I couldn't have asked for better treatment.'

The majority, however, were wholly positive about the interpersonal aspect of care, with a small minority having a wholly negative experience (Table 6.14). Women who had previously given birth, who had shorter labours and who had shorter postnatal stays were more likely to be positive in the views expressed and it may be that both expectations and experience are contributing here.

Table 6.14 *Women's perceptions of care during their hospital postnatal stay*

Views expressed about care from staff* %	Primiparous women n=1148	Multiparous women n=1586	All women n=2847
Wholly positive	63.8	69.4	66.8
Mixed	30.7	27.7	29.1
Wholly negative	5.6	2.9	4.1

*Significant difference by parity

Table 6.15 *Women's perceptions of being treated as an individual during their postnatal stay in hospital*

Views expressed about care from staff* %	Primiparous women n=1141	Multiparous women n=1571	All women n=2821
Always	50.4	55.2	53.1
Sometimes	36.2	36.4	36.2
Rarely	9.2	6.2	7.6
Never	4.2	2.2	3.2

* Significant difference by parity

The value of individualised care is something that women themselves recognised. While being on the postnatal ward just over half of the respondents (53%) felt they were always treated as an individual by staff (Table 6.15), though one in ten (11%) felt they were never or only rarely treated in this way. Women who had previously given birth were significantly more positive about this aspect of their care as were women who did not have an instrumental delivery of some kind. The inexperience of new mothers and uncertainty about their role, expressed by some in the open text responses, may also have contributed to this view.

The responses of women in their own words to a question about what they would like to change about postnatal care in hospital illustrate a set of diverse but interrelated issues about their care that to a great extent echo what was reported in 1995:

> *'I felt that some of the midwives were a little rude, as if the job was a chore rather than something they enjoy. I can understand that thousands of women have babies every day, but we still need a little reassurance and help even if it is not your first baby. I discharged myself from hospital a day early because I felt I didn't get the support I needed from some members of staff.'*
>
> *'Because this was my second baby I felt I didn't get as much attention as other mums, they seemed to be priority whereas I was left to my own devices. I had to stay in hospital for a few days because my waters broke but I didn't immediately go into labour so my baby was at risk of infection. I wanted to go straight home with baby'*
>
> *'I would have liked to stay longer to feel more confident of basic care and of breastfeeding, but felt as I was expected to go as soon as physically well enough. Was slightly scary as first baby'*

Many women mentioned staffing problems in relation to their experience of postnatal care:

> *'Very little care provided. Left alone most of the time. Lack of personal contact. An attitude that they were too busy to help. Never saw the same midwife twice - changed constantly. Strong feeling that they didn't know me as an individual or particularly care. Basic tests like blood pressure often missed due to changes in staff.'*
>
> *'Didn't really get much aftercare. Staff were rushed off their feet. I was mostly left alone and wanted to go home but needed a doctor to check the baby. I had no monitoring after labour, and no checks.'*
>
> *'Staff needed to be more available or maybe there needs to be more staff! A sister on the ward was extremely rude to me when I enquired as to the whereabouts of the bathroom when I just arrived on to the ward. My experience in the labour suite was fantastic but I felt let down and isolated once on the main ward.'*
>
> *'The staff was brilliant! There just weren't enough of them! They are so badly understaffed but were excellent given the circumstances'*

A feeling of 'being left' was evident, especially for new mothers:

> *'I felt that I was just left, when I went onto my ward I didn't have anything explained to me, I was just took to my bed by my midwife and left, the other girls on my ward explained everything I needed to know. It was little things like where the showers and toilets were, and where I got the milk from to feed by baby, (so I would change the way you are just left)'*
>
> *'After having the baby you are just left to get on with it most of the time, and you are left to feel guilty if you ring your buzzer for assistance. Was glad to be home'*
>
> *'More help with the baby at night. I could hardly walk and was left to get on with it. When I called for help, I was sometimes given the impression that I was being a pain! Because of this I got myself discharged early before I was really ready, as I was so exhausted and wanted help during the night'*

6.5 The quality of postnatal care at home

Relatively little was asked about how women perceived postnatal care at home. However one question was asked about confidence in the midwives women saw at this stage in their care. A total of 2% of women were not visited at home by a midwife, with no difference between first time mothers and other women. Of those who were visited more than two-thirds always felt confident in the midwives they saw. However, first time mothers were significantly less likely than mothers with a previous birth to say they always felt confident about their midwifery care. Little difference was evident in this perception between 1995 and 2006.

Table 6.16 *Women's confidence expressed in midwives providing postnatal care at home*

Views expressed about care from midwives* %	Primiparous women n=1119	Multiparous women n=1625	All women n=2855
Always	65.9	71.0	68.9
Sometimes	29.6	25.7	27.3
Rarely	3.7	2.6	3.0
Never	0.9	0.7	0.8

* Significant difference by parity

Some women contrasted the care they had in hospital with that received once they were home:

'I felt let down by the "care" provided to me in hospital, and as a consequence left hospital 2 days after an emergency c-section. There was only one member of the nursing staff who took time to talk to me in the 2 days I was there. I was given no support after a very traumatic birth, until I got home with my community midwife, who was excellent.'

6.6 Continuity and maternity care

Effective and valid assessment of continuity of maternity care by questionnaire survey is difficult as a consequence of the varied locations and different health professionals who may have been involved in each woman's care. This is particularly true of antenatal care. Some women raised the issue of continuity at this time themselves, often in relation to making appointments:

'This like the first pregnancy when the midwife treated me on her "own", that is to say she took the trouble to book the post natal appointments a day when she knew she would be working so I was fortunate enough just to see her for all post-natal care; in other pregnancies I have seen a wide variety of midwives'

'During pregnancy it was very difficult to see the midwife she was only at the surgery one day a week, and appointments were booked up more than 4 weeks in advance.'

'During pregnancy it was really difficult to book routine follow-up appointments, due to GP's booking system. (Could only book about a week in advance) Had to keep putting dates to ring in diary and if I forgot to ring at 8:30, being told sessions were full. Kept seeing different midwives.'

The women who participated in the study were asked about the numbers of midwives involved in their labour and birth and in their postnatal care. Approximately one in five women had one midwife caring for them during labour and while giving birth (19%) (Table 6.17). Women who had longer labours were more likely to have more midwives caring for them during labour and birth, with a third of the women whose labour lasted more than 24 hours having five or more midwives to care for them (34%). Medical induction of labour was also associated with more midwives caring for individual women.

Women who were having their first baby, with significantly longer labours and more interventions such as induction, forceps, ventouse or caesarean section, were more likely to be cared for by more midwives during their labour and birth, with over half having three or more.

Table 6.17 *Numbers of midwives involved in labour and birth*

Labour and birth* %	Primiparous women n=1144	Multiparous women n=1639	All women n=2893
One midwife	11.9	23.8	18.5
Two midwives	33.7	42.3	38.9
Three or more midwives	54.4	33.9	42.6

* Significant difference by parity

While women were appreciative of the care they received, they would have preferred care from a small number:

'The support was great, but it would have been better to just have one or two midwives to get used instead of five'

'Would have liked less midwives, as I felt I had to keep repeating myself. Couldn't build a bond, but very nice midwife and student midwife who delivered my baby.'

'I would have preferred to have antenatal visit midwife for delivery but mine were nice anyway I would have liked to have met the midwives who were with me during labour before. At times I had no idea who was looking after me. One constant midwife would have made me feel calm'.

Similar differences occurred with the numbers of midwives seen postnatally (Table 6.18). Women who saw more midwives were more likely to be first time mothers. This may be associated with maternal health and wellbeing at this time and a longer duration of postnatal contact before discharge from midwifery care as first time mothers were also more likely to be seen over a longer time period and to report being in poorer health in the first few days after the birth.

The proportion of women who had previously met all or some of the midwives who saw them after the birth of their baby was quite high (78%). However, there was a difference between the experience of those who already had at least one baby, and that of new mothers, with the latter less likely to have met all the midwives they saw in the postnatal period.

Table 6.18 *Numbers of midwives involved in postnatal care at home*

Postnatal care at home %	Primiparous women	Multiparous women	All women
Number of midwives visited*	**n=1123**	**n=1625**	**n=2859**
One	15.3	14.4	15.0
Two	36.4	42.1	39.5
Three or more	47.9	42.7	44.8
Previously met midwives*	**n=1120**	**n=1620**	**n= 2849**
All of them	23.7	28.0	26.0
Some of them	51.7	51.7	51.5
None of them	24.6	20.3	22.5

* Significant difference by parity

Some changes in continuity are evident when comparisons are made between 2006 and 1995 (Figure 6.3), with slightly more women having three or more midwives visit them at home in 2006 (45% compared with 41%), and fewer having met all those who visited before (26% compared with 32%).

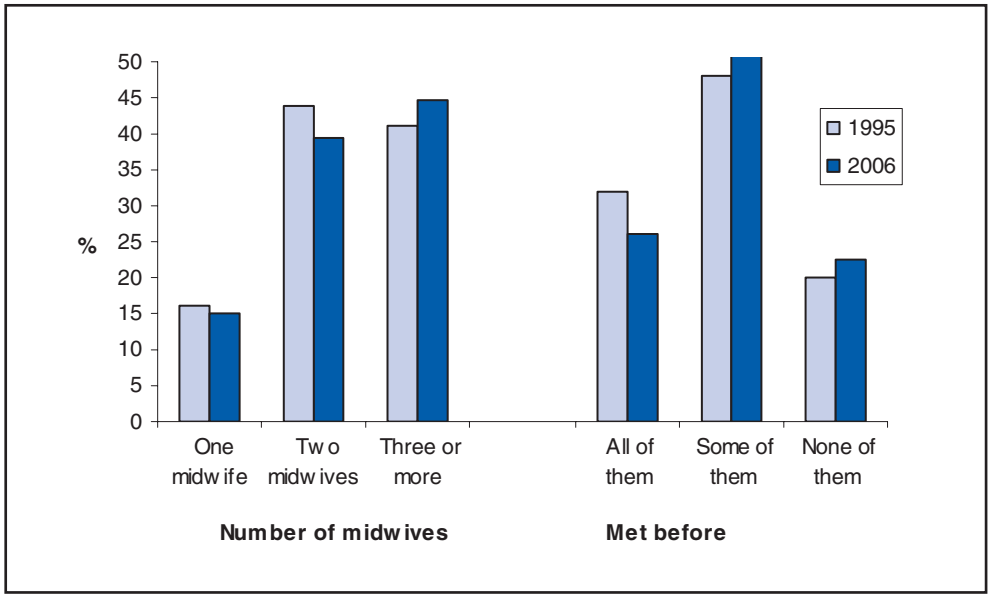

Figure 6.3 *A comparison of the numbers of midwives involved in postnatal visits and whether women had previously met them in 1995 and 2006*

6.7 Information needs

The information needs of individual women vary. Women who have previously had a baby have a different experience and knowledge base compared with women having their first baby. Information and possible sources of information and support were identified at key points in pregnancy and after the birth and questions focused on these (Table 6.19).

Women can utilise many different sources of information about pregnancy and birth. However, health professionals are an important source of information about many aspects of care and the health of mothers and babies. While almost all the study women felt they were given the information they needed at the booking (91%), over a third (37%) did not receive 'The Pregnancy Book'. Three-quarters (74%) of women having their first baby received the book, and just over half of those who had previously given birth (54%) though some of this group still retained a copy they had been given in a previous pregnancy.

Table 6.19 *Information and contacts during maternity care*

Information %	Primiparous women	Multiparous women	All women
Given 'The Pregnancy Book' at booking appointment *	74.2	54.1	63.0
Given the information I needed at booking appointment *	88.4	93.0	91.0
Had the name and contact details of a midwife could contact if worried during pregnancy *	89.8	91.9	90.8
Had the name and contact details of a midwife could contact if worried after the birth	95.2	96.6	95.9
Given information or advice about contraception during postnatal check	90.2	90.9	90.4
Talked to health professional about what happened during labour and birth	40.0	36.9	38.2

* Significant difference by parity

Key aspects of information are the name and contact details of a midwife that women could contact during pregnancy and after their baby was born. A total of 9% of women did not have this information available antenatally and 4% postnatally.

Differences in relation to parity occurred with some aspects of information-giving: multiparous women were less likely to be given 'The Pregnancy Book'; women who had previously given birth were also less likely to feel they had the information they needed at booking and to be given the name of a midwife they could contact if they were worried during their pregnancy. No parity differences postnatally were found with midwife contact details, information about contraception or about what had happened during the labour and birth after the event.

Women were asked if, during the antenatal period the reasons for specific procedures associated with screening had been explained to them (Table 6.20). While most women received explanations, not all were informed in this way. A smaller proportion of women were given explanations about the reasons for all blood tests (82%), than for the other screening procedures (90-93%). However, even with the proportion of women being informed, for example, about screening for Down's syndrome, this means, that 1 in 10 women did not feel they had received clear explanations about the rationale for the procedure.

Table 6.20 *Reasons for antenatal screening tests explained to women*

Reasons for tests explained %	Primiparous women n=1161	Multiparous women n=1674	All women n=2949
Blood tests			
Yes, for all	82.0	81.7	81.7
Yes, for some	13.1	13.9	13.7
No	4.9	4.4	4.6
Screening for Down's syndrome			
Yes	89.0	89.1	88.9
No	11.0	10.9	11.1
Dating scan			
Yes	92.9	93.8	93.4
No	7.1	6.2	6.6
Anomaly scan			
Yes	93.1	93.4	93.3
No	6.9	6.6	6.7

For 38% of respondents a health professional talked over with them what happened during the labour and birth. The type of health professionals who talked to women in this way are shown in Table 6.21.

Table 6.21 *Proportions of women for whom a health professional talked over what happened during labour and delivery*

Health professional %	Primiparous women n=453	Multiparous women n=595	All women n=1088
Doctor/midwife present at birth	22.3	21.8	22.3
Another doctor/midwife not present at birth	54.3	49.2	51.1
GP	31.8	33.3	32.5
Health visitor	60.7	59.5	59.8
Other	4.4	0.0	3.2

Respondents could tick more than one option

A further proportion of women (36%) did not have this, but would have liked to be able to do so. Women who had experienced an instrumental birth were significantly more likely to have been able to talk over what happened during their labour and birth with a health professional.

6.8 Perceptions of the hospital environment

In previous studies of maternity care, using both qualitative and quantitative methods, women have reported details about the hospital environment which concerned them or affected their stay[38]. This ranged from having single rooms and multi-bedded bays to hygiene in the showers and bathrooms. In this survey respondents were asked a general question about aspects of the environments for labour and delivery and for postnatal care that needed improvement.

Approximately half of first time mothers and of those who had previously given birth thought that no improvements were needed to labour and delivery areas (48% of primiparous women and 50% of multiparous women). Fewer women thought that no improvements were necessary for the postnatal ward areas (23% of primiparous women and 28% of multiparous women). The aspects of the environment about which women were critical were slightly different (Figures 6.3 and 6.4). In labour and delivery areas approximately one in ten women were critical of cleanliness and hygiene (9%), temperature (12%), furnishings (10%) and decoration (11%).

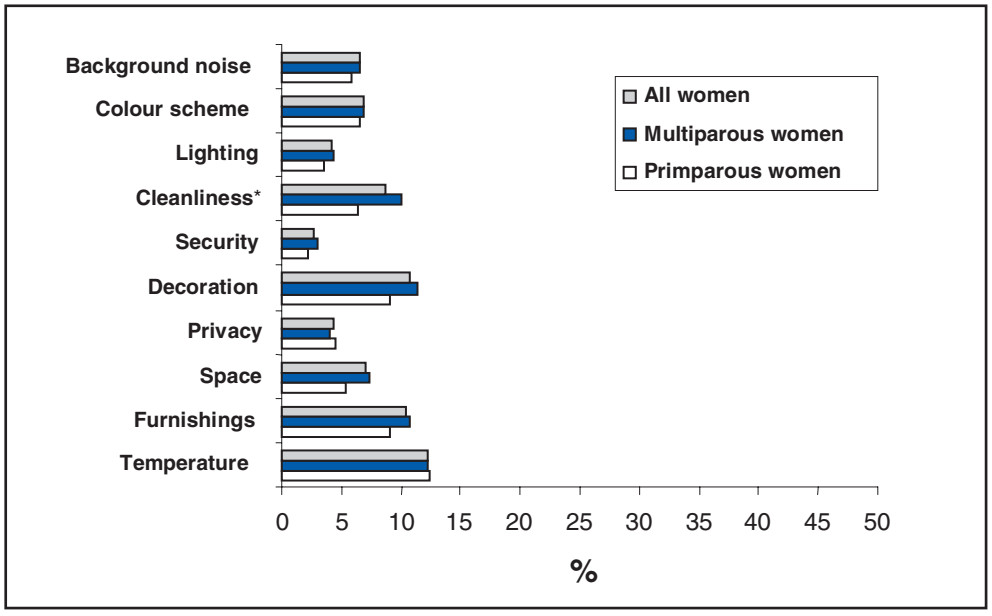

Figure 6.4 *Aspects of labour and delivery environment needing improvement (* Significant difference by parity)*

38 Garcia J, Redshaw M, Fitzsimons B, Keene J. First Class Delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

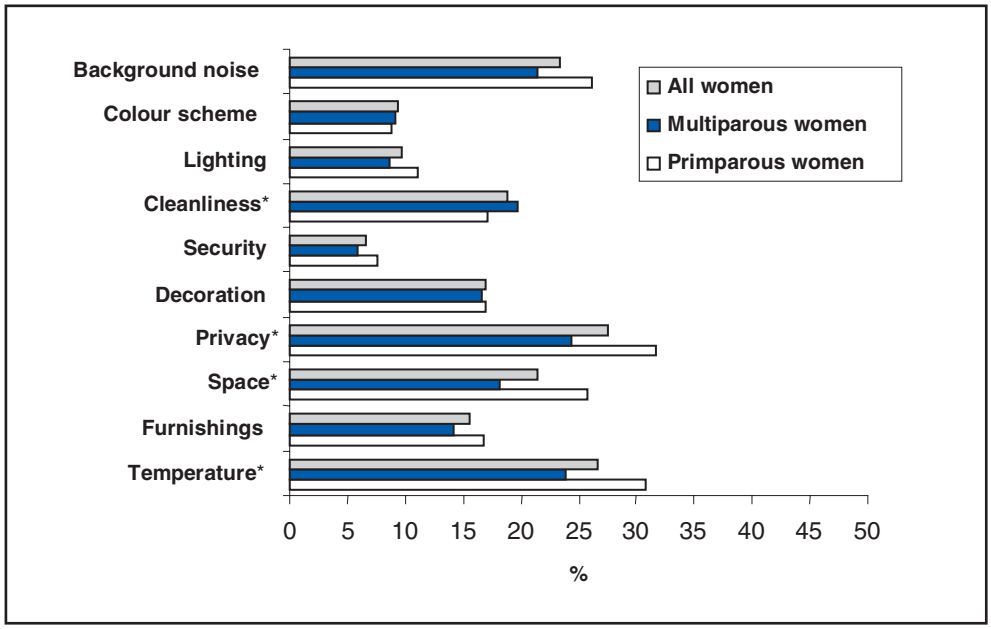

Figure 6.5 *Aspects of postnatal ward environment needing improvement (* Significant difference by parity)*

They were generally more critical of the postnatal ward environment: privacy (28%), space (22%), temperature (27%), cleanliness (19%) and background noise (23%), perhaps reflecting their changing needs in the different phases of care.

There were also exposure effects, with women who had longer labours being significantly more critical of the labour and delivery environment and those who had longer postnatal stays being more critical of the postnatal environment.

Among the responses to an open-ended question about what the women did not have, but would have liked during the labour and birth were comments about the environment and facilities:

> *'All equipment should be replaced when not working as after my delivery I had no bed as bed in the room had been broken and not replaced. I had to sit in a chair with a bean bag and wait 6 hours to be discharged. Postnatal ward was full and they needed my delivery room for the next patient, so I had to go to a different room.'*
>
> *'A bath in the same room, only a shower was available and it didn't work properly'*
>
> *'An extra pillow!'*
>
> *'I had hoped to have my baby in the home away from home rooms but both of them were in use so I had to have a 'conventional' room, which was not as relaxed, or spacious and communal bathroom. Need more home away from home rooms'*

The following responses were made to a similar question about changes to the postnatal ward:

> *'A quiet space (the induction and 10 hours of labour was in a very loud and crowded maternity ward).'*
>
> *'The cleanliness. The delivery suite was very clean and could not fault it, but the ward afterwards was dirty.'*
>
> *'The hospital room was very dirty, the bathroom (on-suite room) was not cleaned everyday. The shower curtain was full of mildew. The bed linen wasn't changed every day. The food was horrible and not healthy at all. They didn't allow my husband to stay overnight in the room with me and I needed him to be there'*
>
> *'Told they preferred curtains open in the morning - midwife opened without permission. I wanted to breast feed in private and to check I hadn't leaked any blood whilst in bed. There were a lot of male partners and siblings on the ward at this point. It was a bit off-putting. In my cubicle, lamp not working, phone broken so partner couldn't contact me and I couldn't call out which I desperately wanted to.'*

6.9 Satisfaction with maternity care

Despite the difficulties of asking women specifically about satisfaction with care, a general question was included in the survey so that women could give their overall impression of the care they received.

Table 6.22 *Women's satisfaction with the different phases of maternity care*

Maternity care %	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
During pregnancy n=2943	48.2	38.2	8.3	4.3	1.1
During labour and birth* n=2939	56.4	30.1	6.2	4.4	3.0
After the birth* n=2943	39.4	40.4	9.7	7.0	3.4

* Significant difference by parity

Highest levels of satisfaction were reported for antenatal care and labour and birth. As reported in other studies and in the earlier survey of recent mothers, this is a common finding.

Satisfaction with antenatal care during pregnancy was not significantly different for first time mothers and women who had previously given birth, though the difference was significant for care during labour and birth and postnatal care. Women who had previously given birth were more satisfied with these aspects of care. Satisfaction with care in pregnancy was not affected by mode of delivery, though satisfaction with care in labour and birth and postnatal care were associated with length of labour and type of birth. Women who had experienced a longer labour or an instrumental delivery were less likely to be as satisfied with their care.

6.10 Summary of women's experience of care

This section focuses on women's views of their care with data using structured question formats and in some instances illustrated by open-text responses in their own words. The findings present a patchwork of experience, with women having many positive perceptions, and rarely having a wholly negative view of their maternity care.

The data on options for care show that while for many women there was relatively little choice about where they could give birth, the proportion of women feeling they had the option of home birth has more than doubled in comparison with those in the 1995 survey.

There is a general sense that there was more choice about some aspects of care than others. Almost all women had a partner of their choice with them during labour and birth; most thought they could move around in labour and find a position that suited them; most took a positive view of the length of the postnatal stay and of the number of postnatal visits made by their midwife. However, they were most critical about the quality of postnatal care in hospital.

Interaction with the health professionals was not something that all women found satisfactory. Though most women were positive about the interpersonal aspect of their care, small proportions of women felt that they were not treated with respect by one or more midwives or doctors or talked to in a way that they could understand, and more than one in five had a mixed experience of this aspect of care.

> *'I felt like a number during my pregnancy!! I understand that the local midwives had a lot of pregnant women to check but it felt like I was number twenty on a list of forty. My care from the midwives during labour and birth was fantastic although I had never met them before.'*

> *'Generally the midwives were very helpful. However, on a few occasions while pregnant and in hospital I found some to be very unhelpful … I had one midwife that did my booking visit, my parenting class and my postnatal care, she was wonderful, very helpful because I saw her on a number of occasions we were able to build a relationship. Some midwives on my antenatal visits and one in hospital made me feel uncomfortable and stupid in how I was feeling and the questions I had to ask, this is not helpful in a first pregnancy, when you worry about most things'*

Although continuity of care has been emphasised as a desirable objective, there was little evidence that this aspect of care had improved and for labour and birth it seems that women are being cared for by more midwives in 2006

than in 1995. What seems to be more important to women is that they are treated as individuals, that there is an effective handover and that their wishes are respected.

Most women were confident about their midwifery care, though some of the open text responses provide examples showing that this was not universal. The need for full and consistent information, both before and during labour, and in relation to breastfeeding and infant care, women recognised as important and while most were provided with the information they needed, some gaps were identified.

The way in which the environment of care impacts on women is difficult to assess. The length of time women spent on the labour and postnatal wards was associated with how critical they were and individual women identified aspects of the ward environment and routine that mattered to them. It was one element in feeling valued and cared for, and in conjunction with the clinical care, interaction and support provided, contributed to women's views of their care and satisfaction with their maternity care as a whole.

To what extent the perceptions described reflect care or attitudinal differences associated with changing expectations is not possible to determine. While what women have to say that is critical may be more salient, the evidence presented here shows that most were satisfied with their maternity care, although this does not mean they could see no room for change or improvement. Appropriate individualised care, respect and sensitive communication were all elements of their maternity care that women valued:

> *'The midwives and doctors were absolutely wonderful, I was treated with consideration at all times, as an older mum I had many questions and all were explained in a way I understood and they didn't think any of my questions were 'daft'. From the minute I found out I was pregnant to the day I left hospital with my little girl, everyone was fantastic and should be commended!'*

> *'My care at my local doctors has been excellent from midwives to the GP and also health visitors. They are very informative, caring people with an attitude that wants to help and care for you the best they can. My hospital care was much the same. It was good to have such people around me during this very special time'*

> *'Having had my 2 daughters in hospital, due to complications, I had my son at a birthing centre. Although I was due to have him in a hospital, it never happened, as I managed to have him naturally. Due to the care, patience and support of the midwives at the birthing centre, I had a truly fantastic experience. It was a traumatic but a wonderful experience, which left me very proud of myself and my achievement, something I never thought I would manage.'*

7. Women's health and wellbeing

7.1 Health problems during pregnancy

During pregnancy women can experience a wide range of what may be considered minor health problems. The women in the study were asked about these using a checklist and the proportions of those experiencing the different problems are shown (Figure 7.1).

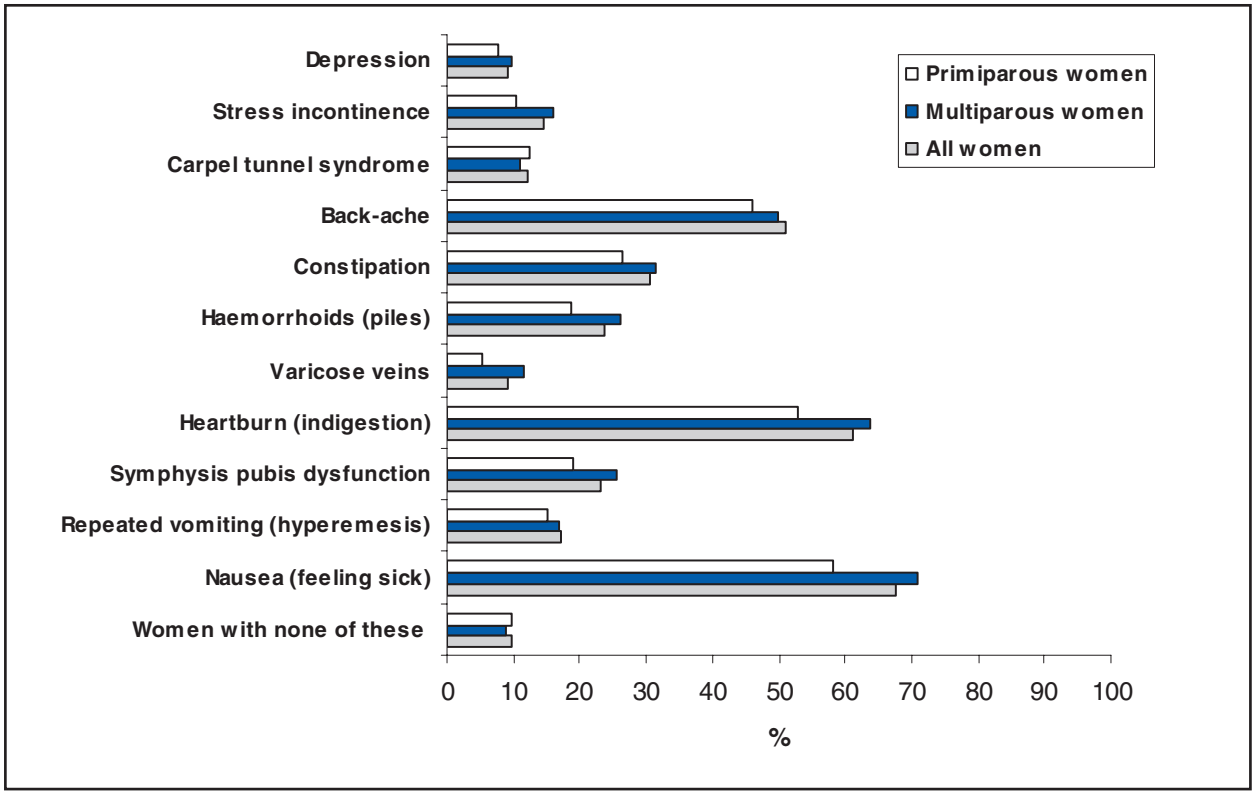

Figure 7.1 *Proportions of women experiencing a range of health problems during pregnancy by parity*

Most women (90%) had one or more of the symptoms or problems of pregnancy listed in Figure 7.1. The most common were nausea, indigestion and back-ache, with more than 50% of women reporting at least one of these. Less common symptoms, but which nevertheless impact on daily life, were stress incontinence, haemorrhoids and constipation. Depression during their pregnancy was reported by 10% of women. While many women reported suffering from one or more of these problems, nearly half (44%) did not seek help from a health professional.

The proportions of women seeking help from a health professional for the different health problems in pregnancy are shown in Figure 7.2. The most common problem for which women sought help was heartburn or indigestion; 24% of women sought help for this. Around 15% of women reported seeking help for nausea, symphysis pubis dysfunction or back-ache.

7.2 Worries and concerns

Pregnancy for many women, especially first time mothers, is marked by changes in emotional wellbeing, uncertainty, fear of pain, worries about loss of control and concern about interventions that may be necessary during labour and birth. Additional stresses come from life circumstances which may also affect maternal wellbeing. Women in the study were asked about some of the key areas of concern that may have impacted on their wishes and decisions regarding the management of their labour and birth.

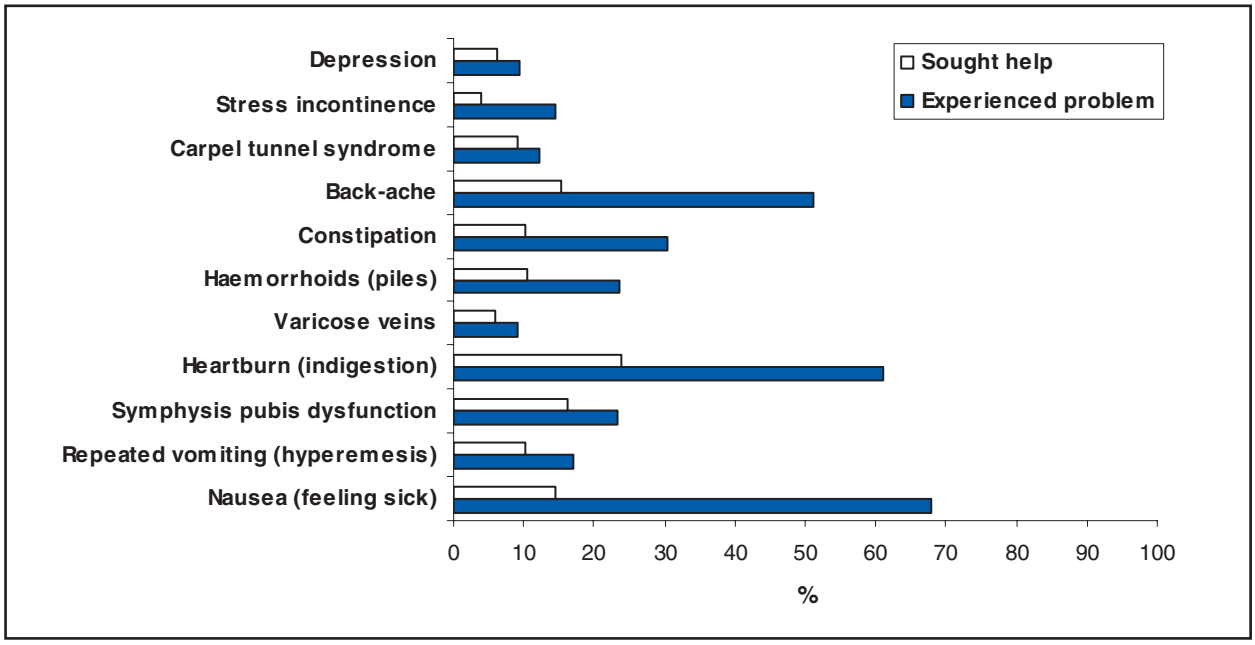

Figure 7.2 *Proportions of women experiencing health problems during pregnancy and those seeking help*

Table 7.1 *Proportions of women worrying to different degrees about specific aspects of labour and birth*

Worries before the birth n=2871 %	Very worried	Quite worried	Not very worried	Not at all worried
Not knowing when I would go into labour	14.8	31.6	31.2	22.4
Getting to the hospital in time	11.3	23.9	34.9	29.9
Having to be induced	20.8	28.9	27.4	23.0
Having a long labour	32.6	31.8	21.1	14.6
Pain and discomfort of labour	33.9	32.0	22.4	11.6
Getting effective pain relief	16.5	27.8	34.8	21.1
Not knowing how long labour would take	20.4	32.9	28.1	18.5
Having a forceps or ventouse delivery	30.5	26.3	24.4	18.4
Embarrassment	10.1	14.7	29.8	45.5
Needing a caesarean	33.1	25.8	22.6	18.5

Uncertainty about when labour would occur and about how long it would take were identified as common concerns. Women were also worried about the interventions that might be required, particularly caesarean section and the use of forceps or ventouse. While many were 'very worried' and 'quite worried' about the pain and discomfort they might experience (66%), less concern was evident in relation to embarrassment (25%).

There were significant differences between the first time mothers in the study and those who had previously given birth on all the aspects of labour and birth listed (Table 7.2), with primiparous women having more concerns.

7.3 Postnatal health and wellbeing

Postnatal health and wellbeing was assessed using the same question about the first few days after birth and at the time of completing the questionnaire. Significant differences by parity were evident as were differences in relation to mode of delivery (Tables 7.3 and 7.4). First time mothers were more likely to report poorer wellbeing at this time as were women who had experienced an instrumental birth.

Table 7.2 *Proportions of women worried ('very worried' and 'quite worried') about specific aspects of labour and birth*

Worries before the birth n=2871 %	Primiparous women	Multiparous women	All women
Not knowing when I would go into labour*	57.5	37.6	46.4
Getting to the hospital in time*	34.1	35.9	35.2
Having to be induced*	53.4	46.5	49.7
Having a long labour*	74.7	56.0	64.3
Pain and discomfort of labour*	75.6	58.2	66.0
Getting effective pain relief*	52.7	37.1	44.2
Not knowing how long labour would take*	63.0	30.6	53.4
Having a forceps or ventouse delivery*	66.4	49.3	56.8
Embarrassment*	36.0	16.2	24.8
Needing a caesarean*	61.3	57.0	58.9

* Significant difference by parity

Table 7.3 *Women's health in the first few days after the baby was born by parity*

Physical health after the birth* %		Very well	Quite well	Tired and uncomfortable	Exhausted all the time	Very ill
Primiparous women	**n=1161**	16.5	26.4	37.8	12.1	7.3
Multiparous women	**n=1677**	29.2	1.5	26.4	7.6	5.3
All women	**n=2951**	23.6	29.4	31.3	9.5	6.3

* Significant difference by parity

Table 7.4 *Women's health in the first few days after the baby was born by type of delivery*

Physical health after the birth* %		Very well	Quite well	Tired and uncomfortable	Exhausted all the time	Very ill
Normal (vaginal) birth	**n=1901**	30.4	32.4	26.1	8.2	3.1
Ventouse	**n=222**	13.1	21.6	41.0	14.4	9.9
Forceps	**n=148**	10.8	15.5	46.0	12.2	15.5
Caesarean	**n=668**	10.9	25.9	39.7	11.2	12.3

* Significant difference by parity

Table 7.5 *Women's health problems 10 days after birth*

Symptoms and health problems %	10 days after birth		
	Primiparous women n=1150	Multiparous women n=1624	All women n=2884
'The blues'*	42.3	31.5	36.2
Painful stitches*	44.3	24.2	33.2
Breastfeeding problems*	42.9	28.9	35.1
Depression*	10.3	7.2	8.7
Wound infection*	8.9	6.8	7.8
Stress incontinence	13.9	17.4	14.4
Fatigue/severe tiredness*	44.0	32.8	37.8
Backache	29.5	26.8	28.1
Difficulties/pain during intercourse*	6.3	3.1	4.5
Sleep problems (not related to the baby)*	6.7	5.5	6.1
'Flash-backs' to the labour or birth*	13.9	9.3	11.3
Other	3.0	2.5	2.7

* Significant difference by parity

Symptoms and health problems were identified from a checklist focusing on three time points: 10 days, 1 month and 3 months after the birth (Tables 7.5, 7.6 and 7.7). At ten days the predominant symptoms or health problems were 'the blues', 'painful stitches', breastfeeding problems, back-ache and tiredness (28-38% of women). Breastfeeding problems were more commonly reported in 2006, particularly at 10 days (36% of women compared with 24% in 1995). However, in 2006 in the first few days after birth a greater proportion of babies were exclusively breastfed (59% compared with 48%).

At one month the problems had mostly diminished, though tiredness, backache, 'the blues' and breastfeeding problems were reported by 15-28% of women.

Table 7.6 *Women's health at one month after birth*

Symptoms and health problems %	One month after birth		
	Primiparous women n=1150	Multiparous women n=1624	All women n=2884
'The blues'	17.1	15.6	16.1
Painful stitches*	15.0	6.9	10.5
Breastfeeding problems*	20.1	11.6	15.2
Depression	8.5	8.4	8.5
Wound infection*	5.8	3.7	4.8
Stress incontinence	10.6	10.2	10.3
Fatigue/severe tiredness	29.3	26.5	27.7
Backache*	23.0	18.5	20.2
Difficulties/pain during intercourse*	13.4	7.0	10.0
Sleep problems (not related to the baby)	4.5	4.9	4.7
'Flash-backs' to the labour or birth*	9.4	5.4	7.1
Other	2.4	1.9	2.1

* Significant difference by parity

Three months after the birth tiredness and backache had decreased, although these and pain during sexual intercourse were then the most commonly reported problems (11-18% of women).

Table 7.7 *Women's health at three months after the birth*

Symptoms and health problems %	3 months after birth		
	Primiparous women n=1150	Multiparous women n=1624	All women n=2884
'The blues'	5.7	7.0	6.4
Painful stitches*	3.4	1.7	2.4
Breastfeeding problems	4.9	4.1	4.5
Depression	5.4	5.5	5.6
Wound infection	1.1	1.4	1.2
Stress incontinence	5.5	6.7	6.0
Fatigue/severe tiredness*	9.1	12.5	11.0
Backache	20.2	15.6	17.9
Difficulties/pain during intercourse*	14.0	7.9	10.6
Sleep problems (not related to the baby)	3.7	5.2	4.5
'Flash-backs' to the labour or birth*	6.6	3.7	4.9
Other	1.7	1.3	1.5

* Significant difference by parity

A small proportion of respondents indicated that they had pre-existing physical or mental health problems (4%) and for two-thirds of these women this affected their day to day activity. With no further detail available about their disability further analyses have not been carried out for this sub-group. Women's general health and wellbeing three months or more after the birth had improved, though for some women there were continuing problems.

7.4 Relationships with care and other factors

It is likely that how women feel, both during pregnancy and after the birth is affected by a range of factors including their physical health. These also include social and demographic factors. As a longer term objective it is planned to explore these relationships more fully.

Using a general measure of wellbeing, however, it is possible to look at associations between, for example, parity and mode of delivery (Tables 7.8 and 7.9). Women's health at the time of the survey, three or more months after the birth of their baby, was good for 90% of women. However, women who had just had their first baby fared better than women who had previously given birth. No significant difference was found in relation to the kind of birth a woman had experienced, though this was linked with maternal wellbeing in the few days immediately following the birth.

Table 7.8 *Women's health three or more months after the birth, by parity*

Current physical health*	%	Very well	Quite well	Tired and uncomfortable	Exhausted all the time	Very ill
Primiparous women	**n=1158**	54.1	36.8	5.7	2.9	0.6
Multiparous women	**n=1670**	51.0	38.3	5.0	5.2	0.5
All women	**n=2939**	52.0	37.7	5.4	4.3	0.5

* Significant difference by parity

Table 7.9 *Women's health three months or more after the baby was born, by type of delivery*

Physical health after the birth	%	Very well	Quite well	Tired and uncomfortable	Exhausted all the time	Very ill
Non-instrumental vaginal birth	**n=1893**	53.4	36.7	5.4	4.3	0.3
Ventouse	**n=222**	52.3	40.5	5.4	1.8	0.0
Forceps	**n=147**	50.3	36.7	6.1	4.8	2.0
Caesarean	**n=665**	48.7	39.6	5.6	5.1	1.1

7.5 Summary of women's health and wellbeing

It is important to understand women's health problems and their needs for care and support while they are pregnant and after birth. During pregnancy the women in the study suffered from a range of health problems and conditions, for which many of them did not seek treatment. Some however, had admissions to hospital associated with their own health as well as that of their baby (see Section 3). They had considerable worries and concerns during pregnancy about labour and birth, particularly in relation to pain and instrumental methods of delivery. These and some of the other concerns could be addressed by appropriate information from their midwife or the other health care professionals in the course of antenatal checks, antenatal classes and home visits.

After birth women also suffered from a range of health problems that included some that occurred during pregnancy. Their physical health improved over time and it appears that women having their first baby recover better by three months or so after birth, than women who have given birth before. However, some women continued to have poor health in the months that followed birth, so that even several months later small proportions reported both physical and psychological problems that are likely to continue to affect their emotional wellbeing.

8. The care and experience of specific groups of women

The National Service Framework envisages "flexible, individualised services … with emphasis on the needs of vulnerable and disadvantaged women"[39]. Within such inclusive services women should be able to choose "the place they would like to give birth", receive "women-focused care" and the service should be "proactive in engaging all women, particularly women from disadvantaged groups and communities early in their pregnancy". While it is recognised that the survey may not have reached some disadvantaged or vulnerable groups, it is clear that many women from a wide range of diverse backgrounds participated by giving their views about their recent experience of pregnancy and childbirth and the care provided. The findings presented represent the first steps in hearing about their experiences.

8.1 Data analysis

This section of the report includes an exploration of differences in the care experienced by women from particular sub-groups of the total sample. We describe some of the experiences and views of women in four groups and make four comparisons: Black and Minority Ethnic (BME) women compared with white women, Black and Minority Ethnic women born outside the UK (non UK BME) compared with white women born in the UK, women in the highest quintile of deprivation (using the Index of Multiple Deprivation) compared with women in the other four quintiles and single women compared with women living with partners.

All the differences listed in the tables in Section 8 are significant at $p<=0.05$ and some important points on which there were no statistically significant differences are also shown. The tables in this section are a crude comparison of the responses to the questionnaire from these sub-groups and it is recognised that these groups overlap to variable degrees. It is important to be cautious about the apparent findings, as there are characteristics of these sub-groups which make the experiences reported by the women more difficult to interpret. For example, single women in the study sample were more likely to be in the most deprived group and this needs to be taken into account when interpreting the findings. Also, where statistically significant differences have been found it is important to consider the size of the observed difference.

A preliminary regression analysis was undertaken to adjust for some of the factors that could have caused the observed differences between the groups in the crude analysis. Data from the regression are discussed at the end of each sub-group analysis. The selected outcomes were the same for all four regression analyses and focused on issues that reflect the quality of care:

- Number of options for place of birth
- Offer of antenatal classes
- Being treated with respect by midwives during antenatal care
- Being treated with respect by doctors during antenatal care
- Being treated with respect by staff during postnatal care
- Number of midwives that provided care during labour and birth
- Length of postnatal stay
- Postnatal contact with midwife
- Satisfaction with maternity care during pregnancy
- Satisfaction with maternity care after birth

8.2 Women from Black and Minority Ethnic groups

A total of 368 women who responded to the survey identified themselves as coming from a BME group, representing 12.6% of the main sample (See Appendix D for sample details). The responses of this group are compared with

39 Department of Health. Maternity Standard, National Service Framework for Children, Young People and Maternity Services. London: DH Publications, 2004.

those of the 2551 white respondents. There was no difference in parity between the groups; 41% of both groups were first time mothers.

8.2.1 The care provided

The statistically significant findings from the descriptive analyses on the different stages of care for the BME women in the study are summarised in Table 8.1. Some non-statistically significant findings of interest where no differences were found are also listed. As a group, BME women accessed antenatal care slightly later and were less likely to report being offered or to report having Down's syndrome screening. No difference in caesarean section rate was reported but BME women were more likely to have an episiotomy. Postnatally, there was no difference in the number of home visits from a midwife. BME women were less likely to have discussed breastfeeding with a midwife but more likely to have put their baby to breast and to be exclusively breastfeeding at the time of the survey.

Table 8.1 *Care for minority ethnic women in pregnancy, during labour and birth and postnatal care*

Black and Minority Ethnic women		
Antenatal care	**BME**	**White**
Antenatal Checks		
• **Recognised pregnancy later**[1] (weeks)	6.3 (6)	5.6 (5)
• **First saw a health professional about pregnancy later**[1] (weeks)	8.6 (8)	7.7 (7)
• **Had booking appointment later**[1] (weeks)	12.3 (12)	10.8 (10)
• **Less likely to see a midwife initially**	10.4%	13.0%
• No difference in proportion having any antenatal care	97.5%	99.3%
• **Fewer antenatal checks**[1]	9.8 (9)	10.6 (10)
• No difference in having midwife only care	48.5%	49.1%
• **More likely to have a hospital admission during pregnancy**	26.9%	20.2%
Screening		
• **More likely to not recall offer or to report no offer of screening for Down's syndrome**	22.0%	12.8%
• **More likely to not recall or to not have screening for Down's syndrome**	44.7%	36.5%
• **Less likely to have a dating scan**	81.2%	87.0%
• **Less likely to have an anomaly scan**	92.5%	97.2%
Antenatal education		
• **Less likely to be offered classes**	68.4%	72.0%
• **Less likely to attend classes**	36.2%	41.8%
• **Less likely for husband/partner to attend classes**	43.5%	69.8%
Care during labour and birth		
• **More likely to have a birth in hospital**	97.0%	94.3%
• No difference in use of epidural only pain relief	17.6%	17.2%
• No difference in caesarean section rate	21.0%	23.1%
• If caesarean section, no difference in proportion resulting from unforeseen circumstances	53.5%	53.3%
• **More likely to have an episiotomy**	32.1%	22.6%
• No difference in proportion with one midwife providing care	15.5%	19.0%
• **More likely to have met midwives before**	31.8%	25.9%
• **Less likely to have presence of companion**	93.9%	97.2%
• **Less likely to be left alone in labour**	40.2%	57.7%
• **Less likely to be left alone shortly after the birth**	56.7%	65.7%
• **More likely to be worried if left alone after birth**	10.4%	6.9%
Postnatal care		
• **More likely to have stay longer than 24hrs**	86.6%	75.8%
• No difference in being visited by a midwife at all	97.8%	98.2%
• No difference in number of home visits by a midwife[1]	4.8 (4)	5.0 (4)
• No difference in proportion with one midwife providing care	16.1%	14.8%
• **More likely to be visited at home by a maternity care assistant**	24.7%	17.8%
• **Timing of last contact with midwife later**[1] (days)	17.7 (14)	14.8 (12)
• **Less likely to have postnatal check**	85.5%	90.9%
• **Less likely to have discussed feeding with midwife**	66.9%	76.9%
• **More likely to have put baby to breast**	92.8%	78.3%
• **More likely to be breastfeeding exclusively at time of survey**	32.5%	24.7%

[1] mean (median)

8.2.2 The care experienced

The significant findings about the perceptions of care of the BME women in the study are summarised in Table 8.2. Some findings where no statistically significant differences were evident are also shown. There were several differences in the perceptions BME women had of being treated with respect and being talked to in a way they could understand.

Table 8.2 *Black and Minority Ethnic women's perceptions of quality of care*

Black and Minority Ethnic women Quality of antenatal care	BME	White
• No difference in feeling positive about care at booking	94-97%	95-98%
• **More likely to feel not treated with respect by one or more midwives**	18.8%	13.1%
• **More likely to feel not talked to by midwives in a way they could understand**	21.6%	11.9%
• **More likely to feel not treated with respect by one or more doctors**	12.9%	10.8%
• **More likely to feel not talked to by doctors in a way they could understand**	18.0%	13.2%
Quality of care during labour and birth		
• **More likely to feel not treated with respect by one or more midwives**	17.9%	10.0%
• **More likely to feel not talked to by midwives in a way they could understand**	15.6%	8.2%
• **More likely to feel not treated with respect by one or more doctors**	10.6%	6.3%
• **More likely to feel not talked to by doctors in a way they could understand**	11.9%	7.9%
Quality of postnatal care		
• **More likely to feel not treated with respect by staff**	26.0%	21.6%
• **More likely to feel not talked to by staff in a way they could understand**	22.5%	15.1%
• No difference in feeling treated like an individual	87.7%	89.6%

The responses of BME women and white women to the question about labour and birth which used an adjective checklist are shown in Figures 8.1 and 8.2. Both groups selected a much higher proportion of positive terms compared to negative terms. However, BME women described their care during labour and birth significantly less positively and though they selected fewer negative terms overall, were more likely to describe staff providing their care as unhelpful and rude.

Options for care in a number of areas appeared more limited for BME women (Table 8.3). While some aspects of information-giving were satisfactory, BME women were more likely to report not having contact details of a midwife antenatally and postnatally (Table 8.4).

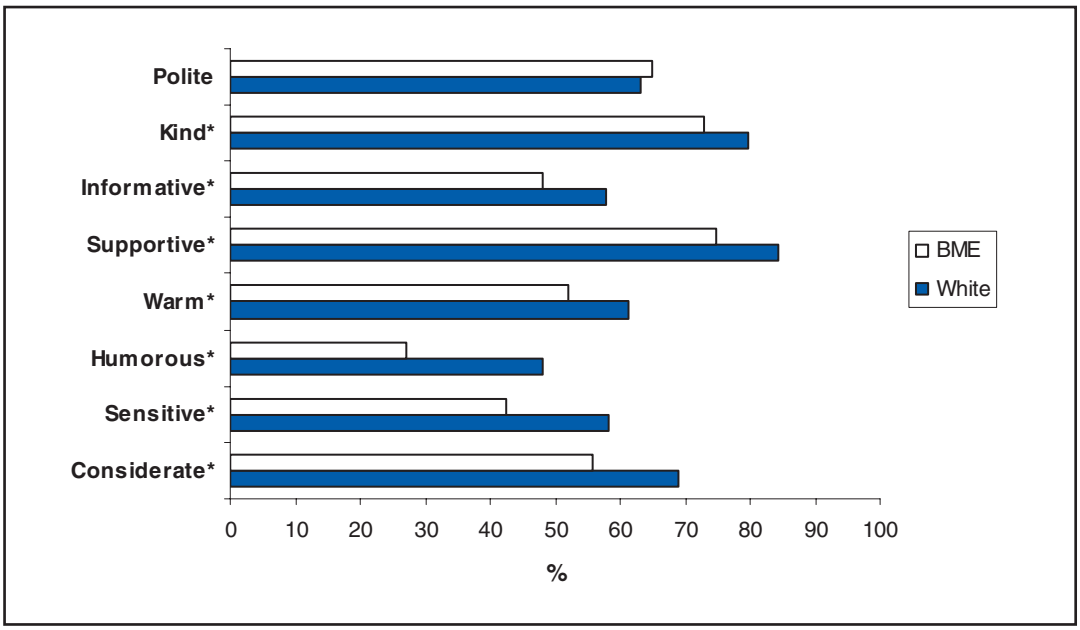

Figure 8.1 *Positive terms selected by women to describe the staff who cared for them during labour and birth (* Significant difference by group)*

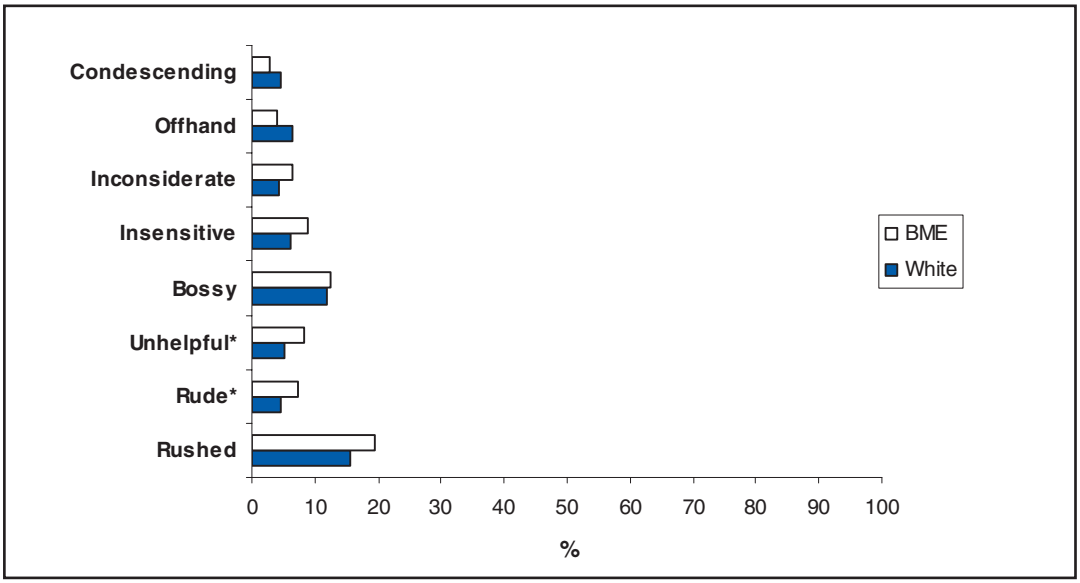

Figure 8.2 *Negative terms selected by women to describe the staff who cared for them during labour and birth (* Significant difference by group)*

Table 8.3 *Black and Minority Ethnic women's perceptions of options for care*

Black and Minority Ethnic women Options for care	BME	White
• **More likely to only have going to one hospital as an option**	51.7%	36.9%
• **Less likely to have been offered home birth as an option**	25.3%	39.8%
• **Less able to move around in labour**	77.6%	82.0%
• **Less able to have partner/companion as much as wished during labour and birth**	93.4%	97.2%
• **More likely to feel postnatal hospital stay was too short**	16.2%	12.6%
• **Would have preferred more frequent home visits**	37.2%	15.2%

Table 8.4 *Information provision for Black and Minority Ethnic women*

Black and Minority Ethnic women Information	BME	White
• **More likely to be given 'The Pregnancy Book'**	75.8%	61.2%
• No difference in being given the information needed at booking	89.3%	91.4%
• **Fewer had contact details of a midwife during pregnancy**	83.2%	92.0%
• **Fewer had contact details of a midwife postnatally**	92.6%	96.4%
• **Fewer given advice about contraception at postnatal check**	86.3%	91.2%
• No difference in talking over the birth with a health professional	37.4%	38.2%

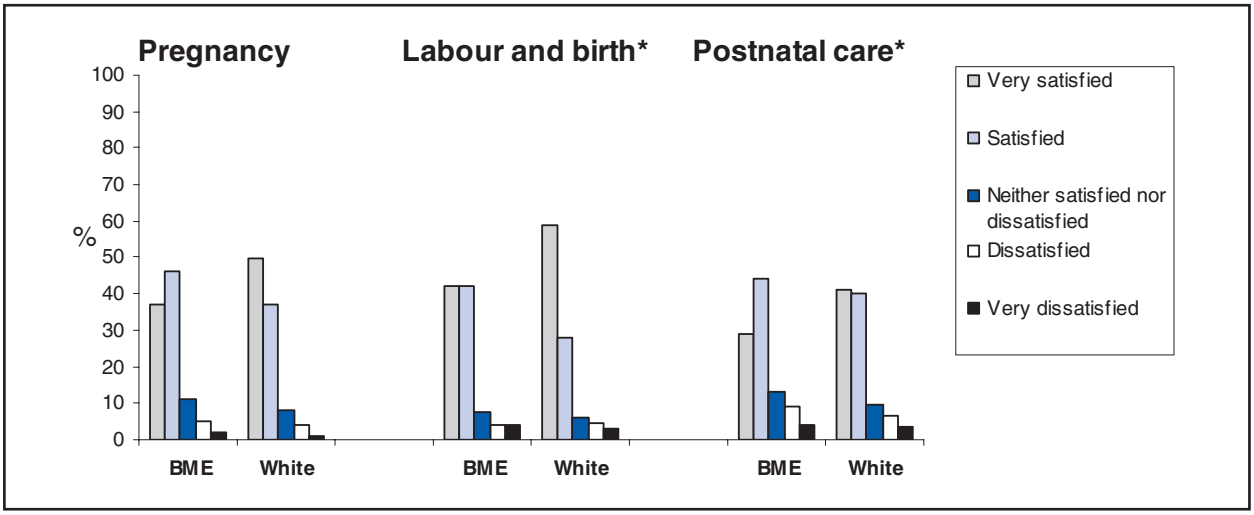

Figure 8.3 *Women's satisfaction with the different phases of maternity care by ethnicity (* Significant difference by group)*

BME women's self-reported health was significantly poorer after the birth and at 3-4 months post partum, a factor which will be explored in future analyses.

Satisfaction with the care in pregnancy did not differ between the groups, though there were significant differences in satisfaction with care during labour and birth and postnatally (Figure 8.3).

8.2.3 Adjusting for differences between the groups

The analysis, using logistic regression with the ten selected outcomes, adjusted for parity, mode of delivery, IMD, mother's age, partner status and born in the UK. The selected outcomes showed that even with adjustment, the BME women in the study were significantly less likely to have more than one option for place of birth, would have liked more postnatal visits from a midwife and were less satisfied with care in the postnatal period.

8.3 Women from Black and Minority Ethnic groups born outside the UK

The comparison in this section is between non UK born BME women (229) and white women born in the UK (2253). This minority group is a sub-set of the previous group considered and may be more disadvantaged in that it

Table 8.5 *Pregnancy, labour and birth, and postnatal care for ethnic minority women born outside the UK*

Black and Minority Ethnic women not born in the UK **Antenatal care**	**Non UK BME**	**UK White**
• **Antenatal Checks**		
• **Recognised pregnancy later**[1] (weeks)	6.3 (6)	5.6 (5)
• **First saw a health professional about pregnancy later**[1] (weeks)	8.6 (8)	7.7 (7)
• **Had booking appointment later**[1] (weeks)	12.3 (12)	10.8 (10)
• **Fewer women had any antenatal care**	97.4%	99.4%
• **Fewer antenatal checks**[1]	9.1 (9)	10.6 (10)
• No difference in having midwife only care	48.5%	49.1%
• **More likely to have a hospital admission during pregnancy**	26.9%	20.2%
Screening		
• **More likely to not recall offer or to report no offer of screening for Down's syndrome**	26.7%	12.7%
• No difference in not recalling having or not having screening for Down's syndrome	28.5%	32.6%
• **Less likely to have a dating scan**	81.2%	87.0%
• **Less likely to have an anomaly scan**	92.5%	97.2%
Antenatal education		
• **Less likely to be offered classes**	68.4%	72.0%
• **Less likely to attend classes**	34.3%	40.8%
• **Less likely for husband/partner to attend classes**	43.5%	69.8%
Care during labour and birth		
• **More likely to have a birth in hospital**	97.0%	94.3%
• No difference in use of epidural only pain relief	19.2%	16.7%
• No difference in caesarean section rate	19.7%	23.5%
• If caesarean section, no difference in proportion resulting from unforeseen circumstances	53.1%	53.6%
• **More likely to have an episiotomy**	32.1%	22.6%
• **Less likely to have a husband or companion in labour**	93.9%	97.2%
• **Less likely to be left alone in labour**	33.2%	58.7%
• **Less likely to be left alone shortly after the birth**	50.7%	66.4%
• No difference in being worried if left alone in labour	25.9%	17.2%
• No difference in proportion with one midwife providing care	15.5%	18.8%
• **Less likely to have met midwives before**	60.7%	69.6%
Postnatal care		
• **More likely to have stay longer than 24hrs**	88.7%	75.7%
• No difference in being visited by a midwife at all	97.8%	98.1%
• No difference in numbers of home visits by a midwife[1]	4.3 (4)	5.0 (4)
• No difference in proportion with one midwife providing care	15.1%	14.4%
• **Less likely to have met midwives before**	14.7%	27.8%
• **More likely to be visited at home by a maternity care assistant**	29.7%	17.1%
• **Timing of last contact with midwife later**[1] (days)	18.9 (14.5)	14.7 (12)
• **Less likely to have postnatal check**	85.0%	91.3%
• **Less likely to have discussed feeding with midwife**	66.8%	77.4%
• **More likely to have put baby to breast**	94.1%	77.4%
• **More likely to be breastfeeding exclusively at time of survey**	35.2%	23.2%

[1] mean (median)

is likely to include more women who are relatively recent migrants and whose first language may not be English[40]. There was no difference in parity between the groups; 40% of non UK BME women were first time mothers compared to 41% of white women born in the UK.

8.3.1 The care provided

The significant findings from the descriptive analyses on the different stages of care for the non UK BME women are summarised in Table 8.5. Some findings where there was no statistically significant difference between the groups are also shown. The results reflect the overlap between these groups and the previous comparison groups.

Differences are evident in relation to accessing antenatal care, antenatal education and reported offer of screening. Hospital birth was more common for non UK BME women. Postnatally, while women in this group may not have met their midwives before, they had a later final contact with midwives and were more likely to breastfeed.

8.3.2 The care experienced

Data on the perceptions of the quality of care for non UK BME women show that they were more likely to feel that they had not always been treated or spoken to with respect and understanding by medical or midwifery staff during their care (Table 8.6).

Table 8.6 *Perceptions of quality of care of Black and Minority Ethnic women born outside the UK*

Black and Minority Ethnic women not born in the UK **Quality of antenatal care**	**Non UK BME**	**UK White**
• **More likely to feel not talked to in a way they could understand at booking**	2.7%	1.1%
• **More likely to feel not treated with respect by one or more midwives**	17.4%	13.1%
• **More likely to feel not talked to by midwives in a way they could understand**	22.6%	11.5%
• **More likely to feel not treated with respect by one or more doctors**	16.3%	10.5%
• **More likely to feel not talked to by doctors in a way they could understand**	20.3%	13.0%
Quality of care during labour and birth		
• **More likely to feel not treated with respect by one or more midwives**	15.6%	9.8%
• **More likely to feel not talked to by midwives in a way they could understand**	13.8%	8.1%
• **More likely to feel not treated with respect by one or more doctors**	10.7%	5.8%
• **More likely to feel not talked to in by doctors a way they could understand**	11.6%	7.8%
Quality of postnatal care		
• **More likely to feel not talked to by staff in a way they could understand**	20.4%	15.1%
• No difference in feeling treated with respect by hospital staff	22.2%	21.7%
• No difference in feeling treated like an individual	89.5%	89.6%

The responses to the checklist for perceptions of staff in labour and delivery are similar to those of the previous comparison groups with which this one overlaps, though fewer of the negative terms were selected.

The non UK BME women were significantly less likely to select many of the positive terms (Figure 8.4), though no differences were found in relation to the selection of the negative terms (Figure 8.5).

Similar differences in relation to the options for care and information occurred with this comparison as were found with the previous analysis using data from all the BME participants compared to all white women in the sample. Options for care seem to have been more limited, with less access to sources of information about maternity care (Table 8.7).

40 Dex S, Joshi H. Children of the 21st Century: from birth to nine months. London: Policy Press, 2006.

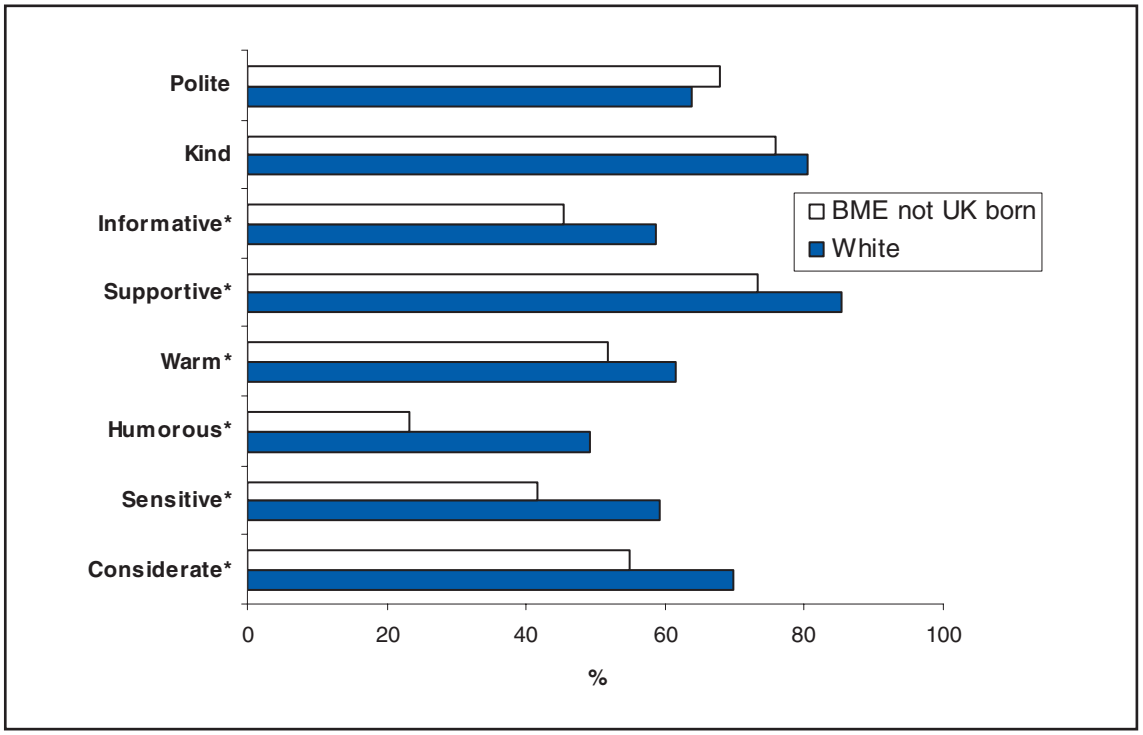

Figure 8.4 *Positive descriptions of care during labour and birth by ethnicity and place of birth (* Significant difference by group)*

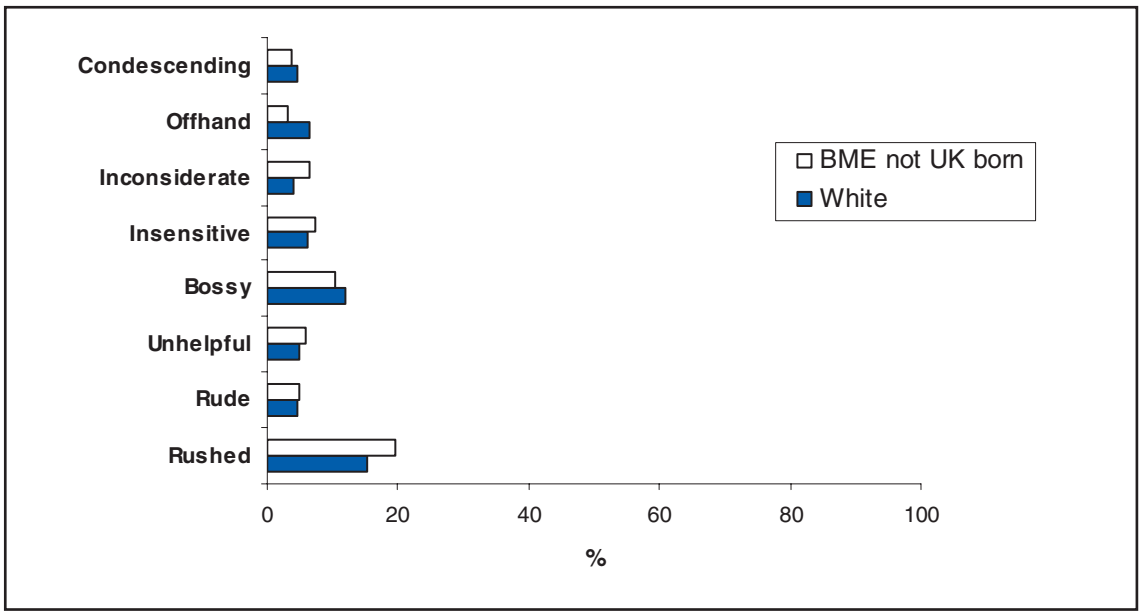

Figure 8.5 *Negative descriptions of care during labour and birth by ethnicity and place of birth*

Table 8.7 *Perceptions of options for care for Black and Minority Ethnic women born outside the UK*

Black and Minority Ethnic women not born in the UK Options for care	Non UK BME	UK White
• **More likely to only have going to one hospital as an option**	58.5%	36.1%
• **Less likely to have been offered home birth as an option**	21.9%	40.6%
• No difference in being able to move around in labour	49.5%	54.7%
• No difference in being able to have partner/companion as much as wished during labour and birth	93.3%	97.3%
• **More likely to feel postnatal hospital stay was too short**	15.7%	12.0%
• **Would have preferred more frequent home visits**	40.4%	14.4%

Table 8.8 *Information provision for Black and Minority Ethnic women born outside the UK*

Black and Minority Ethnic women not born in the UK Information	Non UK BME	UK White
• **More likely to be given 'The Pregnancy Book'**	79.7%	61.4%
• **Less likely to be given the information needed at booking**	87.6%	92.4%
• **Fewer had contact details of a midwife during pregnancy**	81.2%	92.7%
• **Fewer had contact details of a midwife postnatally**	89.7%	96.8%
• **Fewer given advice about contraception at postnatal check**	84.4%	91.2%
• No difference in talking over the birth with a health professional	36.8%	38.2%

The self-reported health of non UK BME women was significantly poorer after the birth and at the time of the survey, 3-4 months post partum. This is a similar finding to that reported for the whole group of BME women in the previous sub-group analysis and is a factor which will be explored in further analyses.

There were significant differences between the groups in the levels of satisfaction expressed about care during pregnancy, labour and birth and postnatally (Figure 8.6), with the non UK BME group being less positive about their maternity care.

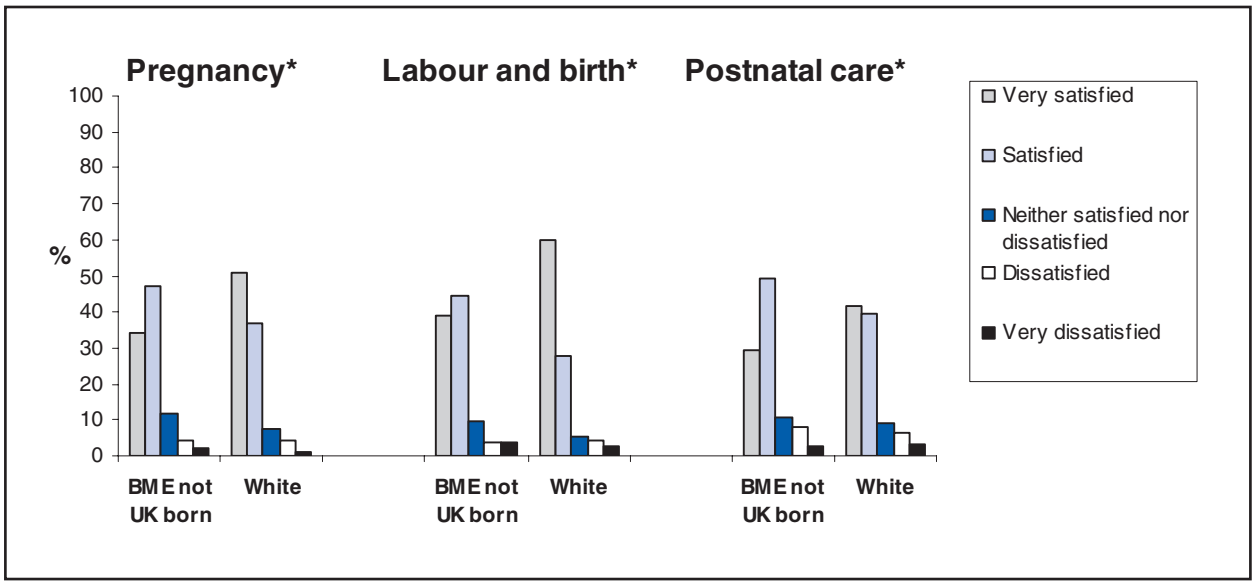

Figure 8.6 *Women's satisfaction with the different phases of maternity care by ethnicity and mother's place of birth (* Significant difference by group)*

8.3.3 Adjusting for differences between the groups

The analysis, using logistic regression with the ten selected outcomes, adjusted for parity, mode of delivery, IMD, mother's age and partner status. The selected outcomes showed that even with adjustment, the non UK born BME women were significantly less likely to have more than one option for place of birth, less likely to be offered antenatal classes, felt one or more doctors did not treat them with respect during antenatal care, and would have liked more visits from the midwife in the course of their postnatal care.

8.4 Women living in the most deprived areas

Women's experience of pregnancy and child birth can be greatly affected by the resources they have available. These include social, educational, financial and emotional resources which impact on the general quality of life for women and their families. The Index of Multiple Deprivation (IMD) 2004 is a measure of multiple deprivation at the small area level which allows us to look at the social context of the women who participated[41]. The model on which the IMD is based assumes that there are distinct dimensions to deprivation which can be measured separately and these reflect the experience of individuals living in that area. The domains of deprivation included relate to income, employment, health and disability, education and training, housing, the living environment and

41 Office of the Deputy Prime Minister. The English Indices of Deprivation 2004 (revised). London: Office of the Deputy Prime Minister, 2004.

crime. Each woman was assigned an IMD score based on their postcode. The group was divided into quintiles and the analysis presented utilises the scores 1-5, with 5 representing the most deprived quintile according to IMD and 1 representing the least deprived quintile. The comparison made is between the highest quintile, score 5 (most deprived) and the lower quintiles score 1-4, representing a less deprived group. A total of 601 (20%) women were in the most deprived group and 2353 in the less deprived group on which the analysis is based. The groups did not differ by parity (42% first time mothers in the most deprived group and 41% in the comparison group).

Table 8.9 *Pregnancy, labour and birth and postnatal care for women in most deprived group*

Most deprived women **Antenatal care**	**Most Deprived**	**Other**
Antenatal Checks		
• **Recognised pregnancy later**[1] (weeks)	6.3 (5)	5.5 (5)
• **First saw a health professional about pregnancy later**[1] (weeks)	8.5 (8)	7.7 (7)
• **Had booking appointment later**[1] (weeks)	11.4 (11)	10.9 (10)
• No difference in proportion with GP as first health professional seen	81.8%	82.3%
• No difference in proportion having antenatal check at all	98.3%	99.2%
• No difference in number of antenatal checks[1]	11.2 (10)	10.3 (10)
• **More likely to have midwife only care**	55.3%	47.0%
• **More likely to have a hospital admission during pregnancy**	26.8%	19.7%
Screening		
• **More likely to not recall offer or report no offer of screening for Down's syndrome**	16.8%	13.2%
• **More likely to not recall having or not to have screening for Down's syndrome**	47.7%	34.9%
• **Less likely to have a dating scan**	94.7%	97.1%
• No difference in number of ultrasound scans during pregnancy	82.3%	87.3%
Antenatal education		
• No difference in being offered classes	70.2%	71.8%
• **Less likely to attend classes at hospital or local clinic**	32.1%	42.9%
• **Less likely for husband/partner to attend classes**	47.9%	69.9%
Care during labour and birth		
• No differences in giving birth in a hospital	95.8%	94.4%
• No difference in use of epidural only pain relief	15.6%	17.8%
• **More likely to have a non-instrumental vaginal birth**	70.9%	63.0%
• No difference in episiotomy rate	22.9%	24.1%
• **If caesarean section, more likely as a result of unforeseen circumstances**	62.1%	51.6%
• No difference in proportion with one midwife providing care	16.6%	14.6%
• No difference in having met midwives before	49.0%	52.1%
• No difference in presence of companion	92.8%	94.6%
• No difference in being left alone during labour	52.9%	56.1%
• **More likely to be worried when left alone during labour**	24.3%	17.3%
Postnatal care		
• **More likely to have stay longer than 24 hours**	74.4%	64.7%
• No difference in being visited by a midwife at all	98.7%	98.0%
• No difference in number of home visits by a midwife[1]	5.1 (4)	4.9 (4)
• No difference in proportion with one midwife providing care	20.5%	18.5%
• No difference in having met midwives before	69.7%	73.7%
• **More likely to be visited at home by a maternity care assistant**	23.4%	17.7%
• **Timing of last contact with midwife later**[1] (days)	16.6 (14)	14.8 (12)
• **Less likely to have a postnatal check**	83.0%	91.9%
• No difference in having discussed feeding with midwife	76.6%	76.6%
• **Less likely to have put baby to breast**	69.2%	83.1%
• **Less likely to be breastfeeding exclusively at time of survey**	18.1%	27.7%

[1] mean (median)

8.4.1 The care provided

Some differences are evident in the care provided for the women in this more disadvantaged group: they were more likely to access antenatal care later, to be admitted to hospital during pregnancy, to have midwife only antenatal care and to have more checks, to have pethidine for pain relief in labour and to have a non-instrumental birth, to have a longer postnatal stay and a longer period of postnatal midwife contact.

8.4.2 The care experienced

The more disadvantaged women were more likely to feel that staff had not communicated with them in a way they could understand during all phases of perinatal care and did not always feel they were treated with respect or as an individual.

Table 8.10 *Perceptions of quality of care for women in most deprived group*

Most deprived women **Quality of antenatal care**	**Most Deprived**	**Other**
• No difference in feeling positive about care at booking	95-96%	95-98%
• **More likely to feel not talked to by midwives in a way they could understand**	17.1%	12.2%
• **More likely to feel not talked to by doctors in a way they could understand**	16.7%	13.0%
Quality of care during labour and birth		
• **More likely to feel not treated with respect by one or more midwives**	14.4%	10.1%
• No difference in feeling not treated with respect by one or more doctors	7.3%	6.8%
Quality of postnatal care		
• **More likely to feel not treated with respect by staff**	26.5%	21.2%
• **More likely to feel not talked to by staff in a way they could understand**	22.3%	14.4%
• **Less likely to feel always treated as an individual**	47.9%	54.5%

Both groups chose similar terms to describe their care, though significantly fewer of the most deprived group described the staff as 'supportive', 'informative', 'sensitive' and 'considerate' in caring for them. Fewer differences were found in the selection of negative terms, though 'unhelpful' and 'rude' were more likely to be selected by the most deprived group.

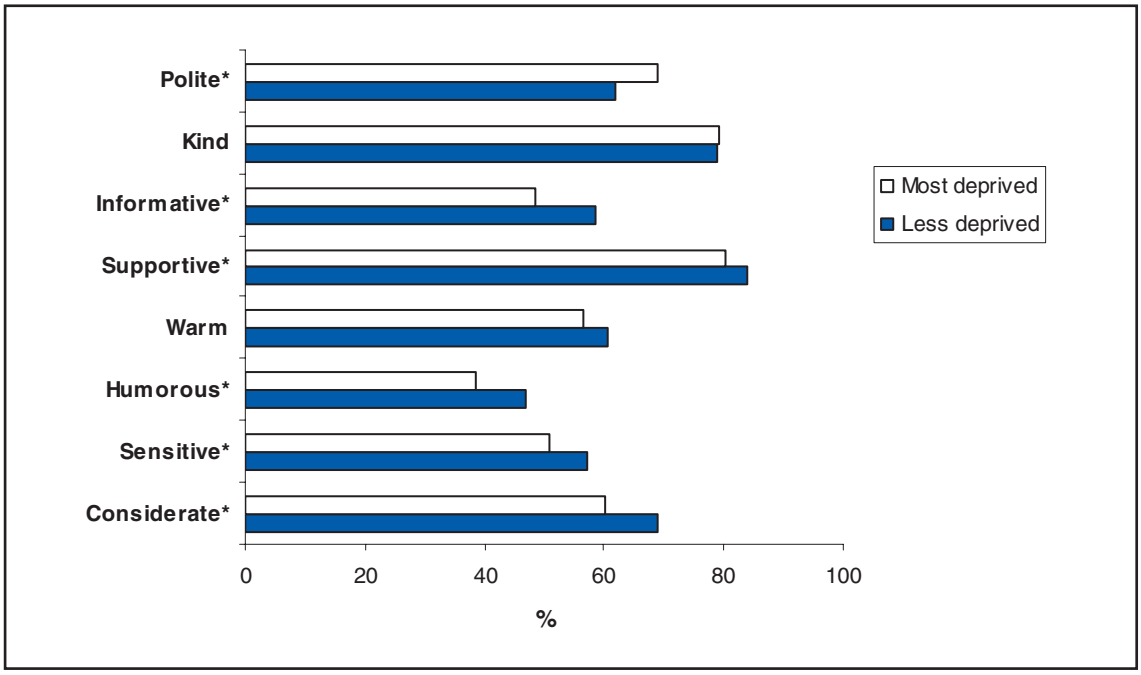

Figure 8.7 *Positive descriptions of care during labour and birth by deprivation*
(Significant difference by group)*

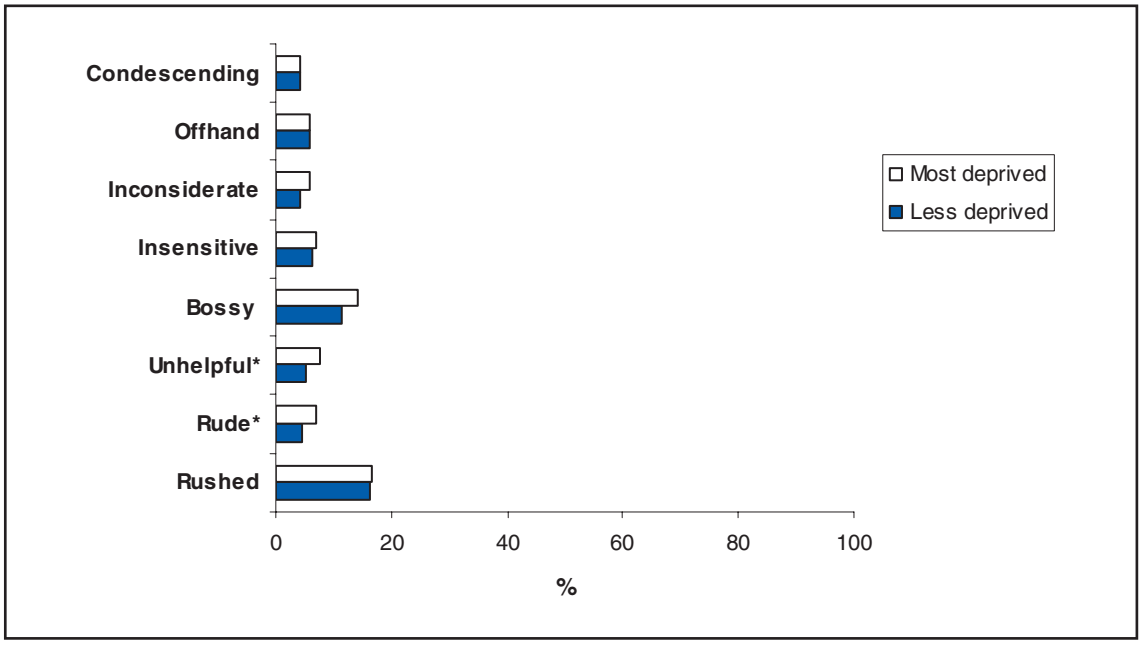

Figure 8.8 *Negative descriptions of care during labour and birth by deprivation (* Significant difference by group)*

Options associated with labour and place of birth were more limited for the women who lived in the most deprived areas. Similar to the women in the other sub-groups analysed, women from the most deprived areas would have liked more postnatal home visits. Fewer choices were available to this group and access to information was more limited, though they were more likely to have been given 'The Pregnancy Book'.

Table 8.11 *Perceptions of options for care for women in most deprived group*

Most deprived women Options for care	Most Deprived	Other
• **More likely to only have going to one hospital as an option**	49.3%	36.3%
• **Less likely to have been offered home birth as an option**	31.3%	39.4%
• **Less able to move around in labour**	47.2%	56.0%
• No difference in being able to have partner/companion as much as wished during labour and birth	94.3%	97.4%
• No difference in feeling postnatal hospital stay was too short	13.0%	12.6%
• **Would have preferred more frequent home visits**	24.9%	16.6%

Table 8.12 *Information provision for women in most deprived group*

Most deprived women Information	Most Deprived	Other
• **More likely to be given 'The Pregnancy Book'**	69.8%	61.2%
• No difference in being given the information needed at booking	89.8%	91.3%
• **Fewer had contact details of a midwife during pregnancy**	88.3%	91.5%
• **Fewer had contact details of a midwife postnatally**	94.3%	96.4%
• **Fewer given advice about contraception at postnatal check**	87.1%	91.2%
• **Less likely to have been able to talk over the birth with a health professional**	31.9%	39.8%

The self-reported health of the most deprived group in comparison with the less deprived group was no different in the first few days after the birth, but perceived as poorer subsequently. No difference in satisfaction with care in pregnancy or during labour and birth was evident, though the most deprived group were less satisfied with postnatal care (Figure 8.9).

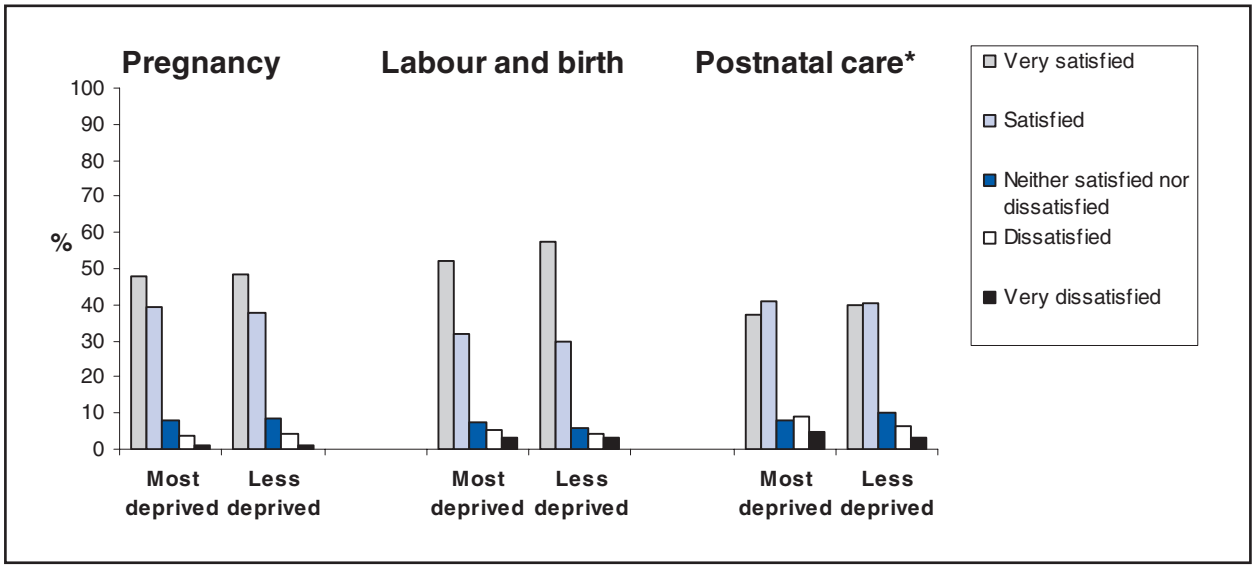

Figure 8.9 *Women's satisfaction with different phases of maternity care by deprivation (* Significant difference by group)*

8.4.3 Adjusting for differences between the groups

The analysis, using logistic regression with the ten selected outcomes, adjusted for parity, mode of delivery, ethnic group, mother's age, partner status and born in the UK. The selected outcomes showed that even with adjustment, the women living in the most deprived circumstances were significantly less likely to have more than one option for place of birth, felt one or more staff did not treat them with respect during postnatal care and were less likely to have had three or more midwives present at the labour and birth.

8.5 Single Women

Single parents living alone with their young children or without the support of a partner are thought to be at a disadvantage in caring for themselves and their family. The comparison in this section is between 352 single women and 2592 women who identified themselves as living with a partner. The groups differed a little by parity (44% first time mothers compared with 40% in the comparison group). There were differences in terms of ethnicity. Single women were almost twice as likely to be from a BME group (20.2% of single women) compared to women living with a partner (11.6% of single women). A total of 41% of single women in the study were in the most deprived quintile as categorised by the IMD. Thus, single women were over-represented in the previous analysis which used the IMD quintiles.

8.5.1 The care provided

Women who were single parents accessed antenatal care later and while they had as many antenatal checks, were less likely to be offered and to take up antenatal screening and to attend antenatal classes. They were more likely to have a non-instrumental vaginal birth and not to have an episiotomy. The postnatal care provided differed very little between the two groups, though this group of single parents were likely to be less engaged with breastfeeding.

Table 8.13 *Pregnancy, labour and birth and postnatal care for single women*

Single women Antenatal care	Single	Other
• **Antenatal Checks**		
• **Recognised pregnancy later**[1] (weeks)	6.8 (6)	5.5 (5)
• **First saw a health professional about pregnancy later**[1] (weeks)	9.0 (8)	7.7 (7)
• **Had booking appointment later**[1] (weeks)	12.0 (12)	10.9 (10)
• No difference in proportion having any antenatal care	97.7%	99.3%
• No difference in number of checks[1]	11.0 (10)	10.5 (10)
• No difference in having midwife only care	51.9%	48.3%
• No difference in admission to hospital during pregnancy	24.6%	20.7%
Screening		
• No difference in not recalling offer or reporting no offer of screening for Down's syndrome	15.7%	13.7%
• **More likely to not recall having or not to have screening for Down's syndrome**	37.3%	31.3%
• **Less likely to have a dating scan**	81.2%	86.9%
• **Less likely to have an anomaly scan**	94.3%	97.0%
• No difference in proportion with 1-2 ultrasound scans	42.6%	39.9%
Antenatal education		
• No difference in being offered classes	70.8%	71.6%
• **Less likely to attend classes**	26.9%	43.0%
• **Less likely for husband/partner to attend classes**	24.2%	70.3%
Care during labour and birth		
• No differences in having a birth in hospital	96.3%	94.5%
• No difference in use of epidural only pain relief	16.1%	17.3%
• **More likely to have a non-instrumental vaginal birth**	70.3%	63.9%
• **Less likely to have an episiotomy**	19.8%	24.5%
• No difference in proportion with one midwife providing care	16.8%	14.7%
• No difference in having met midwives before	67.7%	68.4%
• **Less likely to have presence of companion**	90.3%	97.6%
• **Less likely to be left alone shortly after the birth**	57.8%	65.2%
• No difference in being worried when left alone	9.3%	7.2%
Postnatal care		
• No difference in having stay longer than 24 hours	78.3%	76.9%
• No difference in being visited by a midwife at all	98.3%	98.1%
• No difference in number of home visits by a midwife[1]	5.0 (4)	5.0 (4)
• No difference in proportion with one midwife providing care	16.8%	14.7%
• No difference in being visited by a maternity care assistant	19.2%	18.8%
• No difference in timing of last contact with midwife[1] (days)	15.2 (13)	14.9 (12)
• No difference in having not met midwives before	25.4%	26.2%
• **Less likely to have a postnatal check**	81.7%	91.3%
• **More likely to have discussed feeding with midwife during pregnancy**	77.1%	75.3%
• **Less likely to have put baby to breast**	68.9%	81.8%
• **Less likely to be breastfeeding exclusively at time of survey**	13.5%	27.3%

[1] mean (median)

8.5.2 The care experienced

The quality of care as evidenced by women's experience of their interaction with health professionals shows that there were differences between single women and women with partners in communication and feeling treated with respect.

Table 8.14 *Perceptions of quality of care for single women*

Single women Quality of antenatal care	Single	Other
• No difference in feeling positive about care at booking	94-96%	95-98%
• **More likely to feel not talked to by doctors in a way they could understand**	16.9%	13.3%
Quality of care during labour and birth		
• **More likely to feel not treated with respect by one or more midwives**	14.2%	10.5%
• **More likely to feel not talked to by midwives in a way they could understand**	14.2%	8.4%
• No difference in feeling not talked to in a way they could understand by doctors	8.8%	8.4%
Quality of postnatal care		
• **More likely to feel not treated with respect by staff**	24.9%	21.8%
• No difference in feeling treated like an individual	86.7%	89.7%

Single women were less likely to select positive terms such as 'considerate', 'polite' and 'informative' and more likely to choose negative ones such as 'rude' and 'unhelpful' than women with partners. However, on the whole the views of both groups were generally positive.

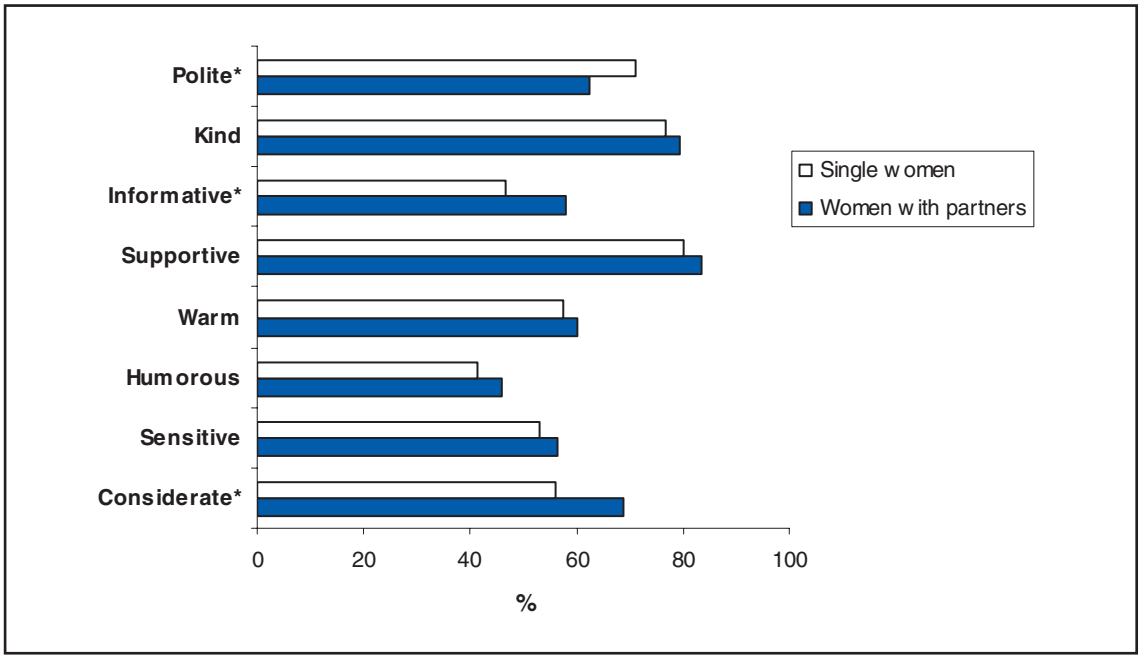

Figure 8.10 *Positive terms for care during labour and birth by partner status (* Significant difference by group)*

Options for care were limited with respect to place of birth for single women. There were few differences in the extent to which women felt their information needs had been addressed.

Table 8.15 *Perceptions of options for care for women in most deprived group*

Single women Options for care	Single	Other
• **More likely to only have going to one hospital as an option**	43.2%	38.2%
• **Less likely to have been offered home birth as an option**	32.8%	38.6%
• **Less able to move around in labour**	47.4%	55.1%
• No difference in being able to have partner/companion as much as wished during labour and birth	91.3%	94.6%
• No difference in feeling postnatal hospital stay was too short	14.1%	12.9%
• **Would have preferred more frequent home visits**	23.1%	17.6%

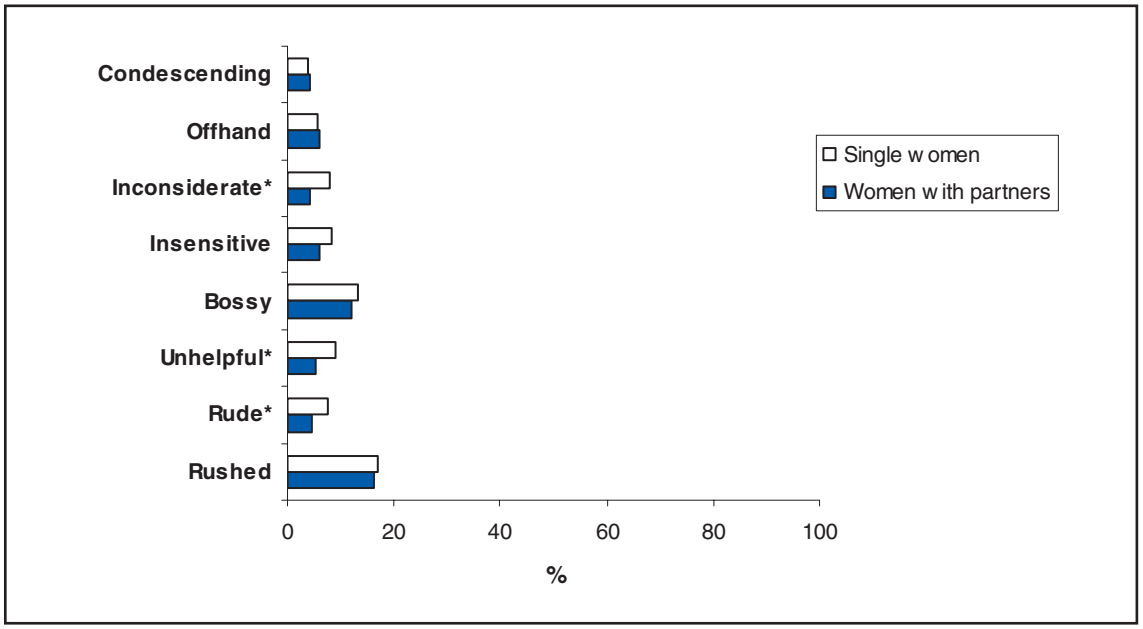

Figure 8.11 *Negative terms for care during labour and birth by partner status (* Significant difference by group)*

Table 8.16 *Information provision for women in most deprived group*

Single women Information	Single	Other
• **More likely to be given 'The Pregnancy Book'**	69.3%	62.1%
• No difference in being given the information needed at booking	89.2%	91.2%
• No difference in having details of a midwife during pregnancy	90.0%	91.2%
• No difference in having details of a midwife postnatally	94.3%	96.1%
• No difference in being given advice about contraception at postnatal check	88.2%	90.6%
• **Less likely to have been able to talk over the birth with a health professional**	30.1%	39.2%

There was no difference in self-reported health in the first few days after birth, though there was a difference at the time of the survey when single women indicated that their health was poorer.

No difference in satisfaction with care between the groups was found for any stage of pregnancy (Figure 8.12).

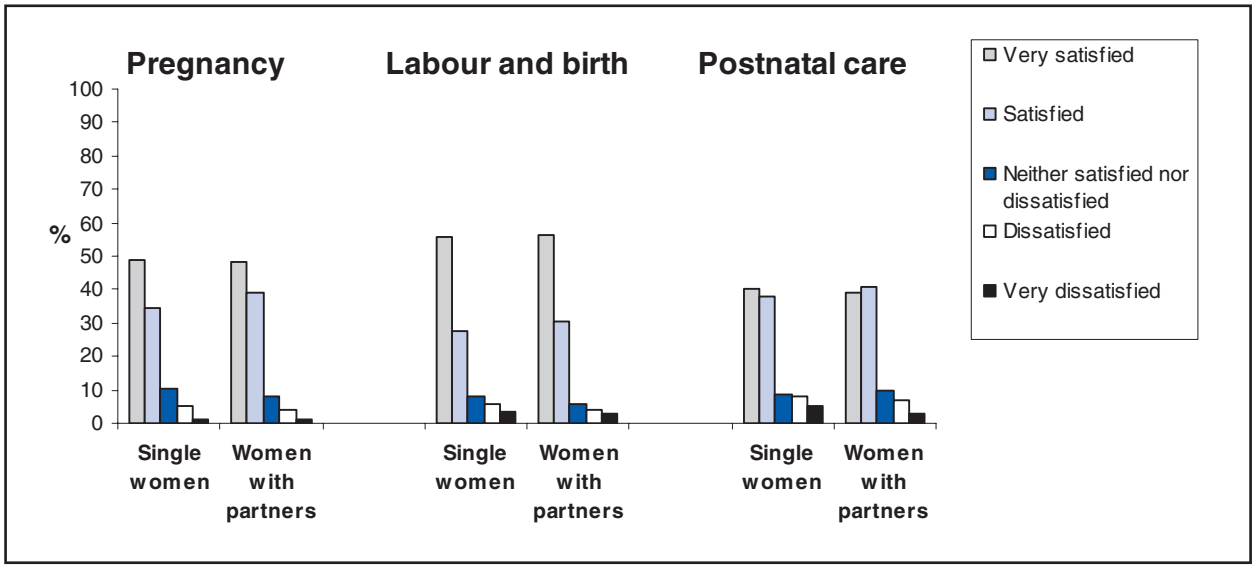

Figure 8.12 *Women's satisfaction with different phases of maternity care by partner status*

8.5.3 Adjusting for differences between the groups

The analysis, using logistic regression with the ten selected outcomes, adjusted for parity, mode of delivery, ethnic group, mother's age, IMD and born in the UK. The analysis showed that with adjustment, the only selected outcome with a statistically significant difference was one which showed single women as less likely to feel their postnatal stay was long enough.

8.6 Summary of the care and experience of specific groups of women

The groups on which analyses were carried out present a range of issues that are similar and that are common to more disadvantaged groups[42]. Women in all the groups were more likely to recognise their pregnancy later, first see a health professional about their pregnancy care later and book for antenatal care later. Women from some of these groups were less likely to recall whether they were offered screening, to report not being offered screening and less likely to report having screening, but these differences were not consistent across all groups. In general, care in labour and delivery was little different, though the women in these groups were more likely to have longer postnatal stays and to be visited for longer at home.

With regard to relationships with staff and communication there were differences in the way that care was perceived. Women from these groups were less likely to have felt that they were treated with respect and talked to in a way that they could understand by one or more members of staff during pregnancy, labour and birth and during postnatal care. Differences were also evident in overall satisfaction about some phases of care for three of the four groups.

While there are commonalities, the individual analyses also show some differences, but many of these demonstrate the overlap between the groups and the way in which multiple disadvantages may affect access to care and the way that it is experienced. Further analyses are required to explore the way that possible disadvantage affects women's access to and experience of maternity care.

42 Dex S, Joshi H. Children of the 21st Century: from birth to nine months. London: Policy Press, 2006.

9. Conclusion

The data present a picture of current practice and women's personal experience of maternity care in 2006. The representativeness and pattern of response is similar to that of other surveys of women after childbirth, with more married women, women who were born in the UK and living in less deprived areas and fewer Black and Minority Ethnic women and women living in London who participated. Nevertheless the usable response rate was an acceptable 63%, 13% of the participants were from BME groups and 17% had been born outside the UK.

9.1 The findings

The data reflect the changing expectations and experience of women receiving care and the way in which they articulate their views. However, the extent and way in which these women's view and perceptions of their maternity care reflect changing expectations is not possible to assess. The analyses by parity show generally expected differences in patterns of care and experience; however, the analyses carried out on the more vulnerable groups provide a different perspective. Changes in the pattern and content of antenatal care, reductions in length of postnatal hospital stay and changes in postnatal home visiting which have taken place since the Audit Commission survey in 1995, have all impacted on the experience of women becoming new mothers and those having another child. The comparisons made with 1995 show the extent of some of these changes.

A more flexible approach to care as it is currently provided is evident, particularly in relation to pregnancy and to labour and birth. This is less obvious in postnatal care in hospital, though once home, midwifery care seems more flexible and more likely to be tailored to individual needs.

The qualitative data in the form of open-text responses in the respondents' own words have yet to be analysed formally, but are used here in an illustrative way to enrich the picture of current care and the issues from a user perspective. While valuing these it is important to hold in mind the characteristics of those who were more likely to respond in this way.

The data also reflect the principles for care that are contained in the NICE Antenatal and Postnatal Guidelines and the ways in which care has changed since Changing Childbirth[43] and the 1995 Maternity Survey were published. The emphasis on the need for 'woman-centred care' has continued and is evident in the changes to care since that time. The data also provide information about the gaps in care and where there is a mismatch between what is current practice and experience and what is needed from the perspective of individual women receiving care and in implementing the National Service Framework for Children, Young People and Maternity Services[44].

9.2 Looking forward

Identified un-met needs of some of the women in the study and some goals for the future relate to:

- Easy access to midwives as first pregnancy contact
- Antenatal education and support of the quality women need
- Information, so that women can access appropriate sources (including health professionals) and be informed about their care and the wider context of pregnancy and childbirth
- Staff working with women at this time having appropriate interpersonal skills and support to facilitate more individualised care
- Responsive and flexible postnatal care and support, in the early days in relation to breastfeeding, infant care and self care (especially for women who have had a difficult birth), and more broadly in relation to practical baby care and the woman's role as a parent

Changes in the organisation of care, particularly the development of Children's Centres may guide the way in which these needs are addressed. Clearly many women feel they were cared for very well and they presented positive views of their experience. This was particularly true for those who women who have long term health problems and those who had a poor previous obstetric history.

43 Report of the Expert Maternity Group. Changing Childbirth. London: HSMO, 1993.
44 Department of Health. National Service Framework for Children, Young People and Maternity Services. London: DH Publications, 2004.

Among the lessons for health professionals working in maternity care and policymakers, the quantitative and qualitative responses emphasise the importance of:

– listening to women as an integral part of care, particularly those in labour

– remembering and learning from what women say they take away with them

– treating women as individuals with kindness and respect

– continuing to ask women about their views and listening to what they have to say about their care, locally and nationally

Areas for further analysis and future research will involve the use of multivariate analysis to fully explore the relationships between key variables in maternity care, demographic factors and women's experience of care. Analysis of the qualitative data will be undertaken separately as this requires a different approach.

The findings will provide a baseline for future change and a national point of comparison in time. The data-set and analyses will also enable individual health trusts and maternity units to make comparisons with their own performance in terms of user views and experiences, in 2007 as part of the programme of surveys carried out for the Healthcare Commission, and over a longer time frame.

9.3 Listening to women

The data on aspects of clinical care, as experienced by a large random sample of recent mothers, are of interest to a wide audience. Linked with the information provided about service organisation and delivery, and about women's individual experiences, these enable a more complete picture of the women's perspective in the context of the care they received. Policy makers, commissioners and health professionals working in maternity care may reflect on the evidence which comes directly from women themselves. It shows that those designing services and caring for women at this important time in the women's lives are in a powerful position to make a difference to that care.

Appendix A. Scope of the questionnaire

Section A. **Dates and your baby**	Date and time of birth Singleton or multiple Gestation Birth weight
Section B. **Antenatal care**	Access to health professionals The booking appointment Contact with health professionals Timing and method of contact Tests and scans: explanations, offer and uptake Preferences for contact and care Health problems in pregnancy Antenatal education availability and uptake Perceptions of care
Section C. **Your labour and the birth of your baby**	Options for place of birth Prior worries about labour and birth Place, location and position for birth Length of labour Induction Monitoring Methods of pain relief Transfers in labour Mode of delivery, attempted delivery Reasons for caesarean section Episiotomy and tears Contact with health professionals Continuity of carer Presence of partner or companion Being left alone Perceptions of care Needs not addressed
Section D. **Babies born at home**	Planned birth at home Reasons for birth at home Health professional support for home birth Information regarding home birth Contact with health professionals Transfers
Section E. **Care in hospital after the birth**	Duration of stay Perceptions of care Changes needed in postnatal care
Section F. **The hospital environment**	Perceptions of labour ward and delivery Perceptions of postnatal ward
Section G. **Feeding your baby**	Plans in pregnancy Feed type first few days and currently Support and advice with feeding
Section H. **Babies needing special care**	If baby was cared for in a neonatal unit Reasons for admission Duration of stay If baby still in neonatal unit

Section J. **Care at home after the birth**	Access to health professionals Contacts with different health professionals Continuity of carer Age of baby at last contact with midwife Help and advice about caring for baby Perceptions of care Maternal health and wellbeing Postnatal check Talked over the labour and birth with health professional Satisfaction with care received
Section K. **Previous pregnancies and childbirth**	Previous pregnancies Number of birth Fetal or maternal health problems in pregnancies Previous caesarean section
Section L. **You and your household**	Age Age on leaving full-time education Members of household Employment status Ethnicity Country of birth Language Disability

Appendix B. Membership of the project management group

Department of Health

Sandra Williams, Chief Research Officer – Child and Maternal Health, Sexual Health, Research and Development, Standards and Quality Group

Anne Barker, Team Leader – Maternity and Women's Health Partnerships for Children, Families and Maternity Group

Jane Verity, Team Leader – Maternity and Women's Health Partnerships for Children, Families and Maternity Group (took over from Anne Barker in October 2006)

Health and Social Care Information Centre

Richard Bond, Population Survey Manager, London

Andy Sutherland, Branch Head, Leeds

Alison Crawford, Survey Officer, Leeds

Healthcare Commission

Ian Seccombe, Staff and Patient Survey Lead

Sue Eardley, Strategy Manager, Children and Maternity

Stephanie Freeth, Survey Manager

NPEU

Maggie Redshaw, Social Scientist

Rachel Rowe, Researcher

Chris Hockley, Statistician

Peter Brocklehurst, Professor of Perinatal Epidemiology and Director

Appendix C. Membership of the stakeholder consultation group

A stakeholder group meeting was held in order to gain a more complete understanding of the issues and to address different perspectives of different groups: users and user groups, professional bodies and researchers. The draft questionnaire was circulated, comments received and the final document informed by further consultation with the project management group and the stakeholders.

Membership of the group:

Beverley Beech, Chair, Association for Improvements in Maternity Services (AIMS), Surbiton

Professor Alison Macfarlane, Professor of Perinatal Health, Department of Midwifery, City University

Rona McCandlish, Chair of the Board, National Collaborating Centre for Women's and Children's Health

Gail McConnell, Chair, Barnet, Enfield and Haringey MSLC, Enfield PCT, Barnet

Maddie McMahon, Chair, Rosie Maternity Hospital MSLC, Cambridge and member of Doula UK

Heather Mellows, FRCOG, Consultant Obstetrician & Gynaecologist, Doncaster & Bassetlaw Hospitals NHS Foundation Trust, Nottinghamshire

Mary Newburn, Head of Policy Research, The National Childbirth Trust, London

Professor Shaughn O'Brien, Vice-President, Standards, Royal College of Obstetricians and Gynaecologists, London

Professor Jane Sandall, Professor of Midwifery and Women's Health, King's College, London

Louise Silverton, Deputy General Secretary, Royal College of Midwives, London

Professor Allan Templeton, President, Royal College of Obstetricians and Gynaecologists, London

Jean Robinson, Association for Improvements in Maternity Services (AIMS), Oxford

Appendix D. Methods, sample and response

1. Methods

The 2006 survey of recent mothers used a similar cross-sectional design and postal survey method to that employed in the 1995 Audit Commission study and covered many of the same topics. The questionnaire allowed women to describe the care they received, to express their views in responding to structured questions and to make longer written comments if they wished. Questions about clinical aspects of care were included, as previously, to provide a background to women's experiences, to enable effective interpretation and because national statistics about maternity care do not cover all topics of interest.[45]

1.1 Questionnaire development

The objective was to develop and pilot a postal questionnaire to measure women's experiences and views of their maternity care. An experienced project team and a project management group with representatives from the Department of Health and the Healthcare Commission were set up. An expert stakeholder group, including representatives of professional bodies and user groups, was also formed to advise on topics to be covered by the survey (Appendix B).

The data collection instruments developed for the 1995 national survey of recent mothers and the local audits that followed, were the starting point for the development of the 2006 survey. As aspects of maternity care have changed since 1995 it was also important to ensure that the questionnaire was developed to reflect current issues of interest. These included:

- The views of women having a home birth
- Women delivering or planning to deliver in different types of unit
- Women's experiences of transfer from one clinical setting to another
- Compliance with recommendations made in the NICE guidelines on antenatal and postnatal care for the healthy woman, in relation to contact with health professionals, interventions, contact and the need for individualised care. Also with the principles emphasised in the draft NICE guideline on intrapartum care.

1.2 Cognitive interviews

The first draft of the questionnaire was tested in a series of cognitive interviews with mothers of young babies. Interviewees were asked to complete the questionnaire in the presence of a researcher and comment on the comprehensibility of the instructions, the relevance of the topics covered and whether any issues had been omitted. Women's recall of their maternity care and the general acceptability of the questionnaire were also explored. Interviewees were recruited via community groups and personal contacts.

The key findings from the cognitive interviews were:

- General approval for the appearance, style and layout – some suggestions to improve formatting.
- General comments that length was manageable.
- Need for women to be able to express variation in care. This is difficult to do when questions ask about "midwives" or "staff".
- Some difficulties with questions about "choice". Women recognise that choice is often constrained by individual factors and circumstances so feel uncomfortable answering simple questions about "choice".

In the light of these comments, a number of changes were made to the questionnaire.

1.3 Changes to the survey instrument

A range of strategies were used in designing the questionnaire that could help to maximise response rates[46 47]. While maintaining and adding to the range of topics covered, consistency was improved and duplication reduced

45 Department of Health. NHS Maternity Statistics, England: 2003-04. Statistical Bulletin 2005/10. London: Department of Health, 2005.

46 Edwards P, Roberts I, Clarke M, DiGuiseppi C, Pratap S, Wentz R, et al. Methods to increase response rates to postal questionnaires. Cochrane Database of Methodology Rev. 2003;(4).

47 Dillon D. Mail and internet surveys: the tailored design method. New York: Wiley, 2000.

through selection, combining questions, altering response format and page layout. The overarching themes of the 1995 survey[48] relating to access, continuity, choice and kindness and respect were still in clear evidence. Separate questions concerning women's perceptions of medical and midwifery staff were developed and used throughout. Changes included more detail about antenatal hospital admissions and screening, experience of and treatment for minor problems in pregnancy, antenatal education, women's own prior concerns about labour and birth, the labour and postnatal ward environments, advice and help about care of the baby, some additional symptoms relating to postnatal health and wellbeing, and more detailed questions on ethnicity and country of birth. Aspects no longer addressed included whether women held their own pregnancy notes, use of a birth plan and a listing of all the staff present at delivery.

Fewer details were requested about women's experience of having a baby cared for in a neonatal unit as it was felt that the experiences of this group could be better explored in a more focused study. The full scope of the questionnaire used in the main study is shown in Appendix A. (Copies can be obtained from the NPEU.)

With these changes in content and in some question formats, the A4 size questionnaire was reduced in length (from 43 printed pages to 27 pages). It was reproduced using colour in a limited number of tones and had a cover with a series of small photographs illustrating the target group of pregnant women, mothers, babies and partners.

The few changes that were made following the pilot study involved only minor adjustments to format and question order that aimed to improve flow and reduce ambiguity. The overall questionnaire design and colour scheme for the pilot and main surveys was the same, and the cover of the main study questionnaire was modified to include a photograph of a mother and baby from an ethnic minority group.

The final questionnaire used with the main study sample has formed the basis for an instrument developed for use in local NHS Trust-based surveys which will inform each Trust of the views and experiences of their local population, help them to identify areas of their service which require improvement, to set goals for improving the service and to monitor progress towards these goals.

1.4 Ethics approval

Multi-centre Research Ethics (MREC) approval for the study was obtained from the Trent MREC on 15 March 2006. Approval for the revised version of the questionnaire for the main study was obtained from the same MREC on 4 May 2006.

1.5 Pilot study

The aim of the pilot study was to pilot the recruitment process and reliability of the data and to produce a version of the questionnaire which met the following quality criteria: evidence that it covered topics of importance to women as shown by their willingness to respond and complete the survey, evidence that it had been adequately tested, its relevance to policy priorities and evidence of validity and reliability.

2. The sample

The samples of women selected for the pilot and main studies were identified by staff at the Office for National Statistics (ONS), using birth registrations within two specific weeks: 2nd-8th January (pilot) and 4th-10th March 2006 (main). The same method of sampling was used as had been employed in 1995, to enable direct comparison. Random samples of 400 women for the pilot survey and 4800 women for the main survey aged 16 years and over who had their baby in a one week period in England were selected. The sampling was stratified on the basis of births in different geographical areas (Government Office Regions, GORs) and no sub-groups were over-sampled. In the week prior to mailing for each sample, checks on infant deaths were made by ONS and any women whose baby had died were excluded and replacements selected. A total of 17 replacements were made.

2.1 Sample size

For the pilot survey a sample size of 400 women was taken as it would allow us to estimate a response rate of 70% with 95% confidence intervals from 65% to 74%. If the observed response rate was 60%, then we could be confident that the response rate for the main survey would be between 55% and 65%. The initial sample size for the main survey was 4000 women. This was based on a predicted response rate of 65%, giving a projected sample size of 2600 returned questionnaires.

48 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

Justification for sample size

Using a sample size of 2600 would enable us to estimate the following proportions with the stated precision (95% confidence intervals):

50% (48%, 52%)

25% (23.2%, 26.8%)

10% (8.5%, 11.5%)

2% (1.4%, 2.6%)

As an example, in the 1995 national survey 50% of women said that one midwife remained with them throughout their labour. The proposed sample size will enable us to estimate this proportion with 95% confidence intervals from 48% to 52%. When comparing the 1995 and 2006 surveys, the proposed sample size would have in excess of 90% power to detect an absolute difference in this outcome of 5%.

During the pilot survey of 400 women, a lower response rate was achieved than anticipated, and at the time decisions needed to be made about the number of questionnaires to send out in the main survey, the response rate was 55%, though the final rate was 60%. To ensure 2600 questionnaires were returned in the main survey we increased the number of women sampled to 4800.

2.2 Pilot survey

In the last week in March 2006, when the babies of women selected for participation in the pilot survey were twelve weeks old, numbered questionnaires were sent by post from ONS to the identified sample of 400 women. Each participant was sent a questionnaire, a letter of invitation from the Deputy Registrar General on General Register Office headed notepaper, an information leaflet about the study, a leaflet in eighteen languages other than English giving details of how to get help with the questionnaire in different languages, and a post-paid return envelope. Women who did not return the questionnaire within two weeks received a letter reminding them of the survey. A second reminder letter, a further copy of the questionnaire and a post-paid return envelope were sent out after four weeks if no response had been received within that time period. No further attempts at contact were made. ONS were regularly sent lists of the questionnaires returned to prevent inappropriate reminders being sent.

Women were given the opportunity to participate in the survey by contacting the research team and completing the questionnaire over the telephone. They could also participate, with the help of a Languageline interpreter, in a three-way telephone call with a researcher, using their own language.

2.3 Main survey

The same procedure was followed with the main study sample of 4800 women whose babies were born 4th-10th March 2006. The first mailing for the main survey took place at the beginning of June 2006.

2.4 Data collection and data entry

Questionnaires were returned by women to the National Perinatal Epidemiology Unit, where each was logged using a bar code system. The back sheet of the questionnaire was used by some women to self-identify as being willing to participate in other studies of maternity care. The sheets containing this information were removed and stored separately at NPEU. The questionnaires, without any identifiers, were then sent for data entry. The accuracy of data entry was verified on a random 10% of responses.

2.5 Data analysis

Descriptive statistics, including means, medians and proportions were calculated using Chi-squared tests and means compared using t-tests. P values of less than 5% were regarded as statistically significant. Descriptive data are presented for the whole group of respondents and separately for women who had given birth previously (multiparous) and those for whom this was a first birth (primiparous). A total of 116 women did not provide information about parity and the tables show different totals for primiparous women, multiparous women and all women. Care at different stages is described and comparisons are made with the data collected in the 1995 Audit Commission survey[49]. Four sub-group analyses were also carried out and a regression analysis was undertaken to adjust for some of the important differences between the groups in relation to a number of selected outcomes.

49 Garcia J, Redshaw M, Fitzsimons B, Keene J. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

ONS were asked to produce simple aggregate statistics of the women who did not respond, including their age, marital status, country of birth, Index of Multiple Deprivation categorisation[50] (based on grouping into quintiles), socio-economic classification (available on 10% of the sample), to enable comparison of the responders and non-responders and to allow the results of the survey to be interpreted appropriately.

Three questions asked for open text responses about women's views of care: about what else was needed during labour and birth, what they would change about postnatal care in hospital and a last 'Is there anything else you would like to tell us?' question. A total of 70% of women in the main survey answered one or more of these open-ended questions: 33% about labour and birth, 41% about postnatal care and 40% the last question. The characteristics of those responding to the last question are reported:

- more first time mothers responded (42% compared with 38%)
- more women who had instrumental births (44% compared with 37%)
- fewer women who self-identified themselves as BME (32% compared with 41%)
- fewer women who were born outside the UK (36% compared with 41%)

Preliminary analysis of 500 responses to this question indicated that 19% were positive, 47% were negative, 29% had a mixture of negative and positive elements and 5% were neutral. The open text responses have not been analysed systematically and have been used to illustrate specific points in the report.

3. The women who participated

3.1 Response

The response rates for the pilot and main surveys are shown below.

Table 1 *Responses for pilot and main surveys*

	Pilot survey	Main survey
Questionnaires sent out	400	4800
Returned undelivered	3	73
Returned blank	8	105
Returned completed	238	2966
Usable response rate (%)	59.9	62.7

Six women were excluded from the analyses of the main survey as their response was clearly about an earlier pregnancy. A further 20 responses were received after the cut-off date for data entry (fifteen completed), four of which were from Black and Minority Ethnic women (BME).

The age of the babies at the time of the survey varied depending on how quickly women completed and returned the questionnaire. The mean age of infants on questionnaire return was 15.5 weeks (median 15, range 13-28 weeks).

Table 2 *Telephone enquiries in response to the survey*

Enquiry	%	(n)
Had reminder, but no questionnaire	41.9	(36)
Needing interpreter	12.8	(11)
Queries about eligibility e.g. care elsewhere / independent midwife	9.3	(8)
Interpretation of questions	3.5	(3)
Already sent it back / will send soon	15.1	(13)
Don't want to take part	9.3	(8)
Can't complete e.g. woman away	4.7	(4)
New address	2.3	(2)
General advice re. pregnancy	1.2	(1)

50 Office of the Deputy Prime Minister. The English Indices of Deprivation 2004 (revised). London: Office of the Deputy Prime Minister, 2004.

3.2 Telephone enquiries

The Freephone helpline received 86 calls in response to the main survey. Eleven (12.8%) of these were women who needed advice or help in their own language. Three questionnaires were completed on the phone with the help of an interpreter.

3.3 Comparing responders and non-responders (main survey)

Summary data on responders and non-responders to the main survey, provided by ONS, are shown in Table 3.

Table 3 *Summary of respondent and non-respondent characteristics in the main survey*

	Responders n=2966* %	Non-responders n=1865 %
Government Office Region		
North East	4.9	4.9
North West	13.5	14.6
Yorkshire and Humber	10.3	11.3
East Midlands	9.1	8.1
West Midlands	11.0	10.2
Eastern	10.9	10.3
London	12.5	19.0
South East	17.8	13.6
South West	10.0	7.8
Sex of infant		
Male	52.2	51.8
Female	47.8	48.2
Marital status		
Married	62.5	51.5
Joint registration (same address)	27.7	27.9
Joint registration (different address)	5.8	11.6
Sole registration	3.9	9.1
Country of birth		
UK	83.8	69.5
Not UK	16.2	30.5
Age 16-19	4.7	10.2
20-24	16.0	22.5
25-29	24.9	27.6
30-34	32.0	23.0
35-39	19.3	14.0
40+	3.1	2.7
Index of Multiple Deprivation *Quintile (range of scores)*		
1 (0.61-8.35) (least deprived)	20.4	11.8
2 (8.36-13.72)	18.7	12.3
3 (13.73-21.15)	21.1	15.9
4 (21.16-34.22)	19.5	22.4
5 (34.23-80.65) (most deprived)	20.3	37.6
Mother's NSSEC (SOC 2000) *(10% of sample coded by ONS)*	**n=306**	**n=186**
Managerial and professional occupations	37.9	23.1
Intermediate occupations	13.1	14.5
Small employers and own account workers	2.3	3.2
Lower supervisory and technical occupations	1.6	1.1
Semi routine and routine occupations	14.7	11.8
Never worked and long term unemployed	0.0	0.0
Full time students	1.6	3.2
Occupation not stated or inadequately described	10.8	23.1
Not classified for other reasons	18.0	19.9

* Respondents who completed the questionnaire about an earlier pregnancy and birth are included here.

3.3 Characteristics of respondents

The characteristics of the respondents to the pilot and main surveys are summarised in Tables 4 and 5 below.

Table 4 *Characteristics of recent mothers who responded to the pilot and main surveys*

Maternal characteristics		Pilot survey n=238 % (n)		Main survey n=2960 % (n)	
Age	**16-19**	5.1	(12)	3.9	(115)
	20-24	15.7	(37)	15.4	(452)
	25-29	26.4	(62)	23.9	(702)
	30-34	29.4	(69)	32.7	(959)
	35-39	17.9	(42)	20.5	(601)
	40+	5.5	(13)	3.6	(105)
Age (mean, s.d.)		29.8	(6.1)	30.0	(5.7)
Ethnicity					
	White	86.1	(204)	87.4	(2551)
	Asian	8.0	(19)	6.9	(201)
	Black	4.6	(11)	3.6	(105)
	Mixed / Chinese / Other	1.3	(3)	2.1	(62)
Place of birth					
	UK	83.1	(192)	83.3	(2402)
	Outside UK	16.9	(39)	16.7	(480)
Age left FT education					
	<=16	30.2	(71)	28.3	(828)
	17-18	29.4	(69)	29.7	(869)
	19+	37.9	(89)	40.9	(1195)
	still in education	2.6	(6)	1.1	(33)
Current situation					
	In paid work	9.8	(23)	8.5	(250)
	On maternity leave	52.5	(124)	56.4	(1670)
	Looking after family	30.9	(73)	27.3	(807)
	In education	1.7	(4)	0.7	(20)
	Unemployed	3.8	(9)	4.7	(138)
	Unable to work	0.4	(1)	0.9	(27)
Physical or mental health problem		2.9	(7)	4.0	117)
Previous births					
	None	49.2	(117)	41.0	(1165)
	1 or more	50.8	(121)	59.0	(1679)
Previous caesarean		22.1	(27)	10.1	(298)

Table 5 *Characteristics of infants whose mothers responded to the pilot and main surveys*

Infant characteristics	Pilot (n=238) % (n)		Main (n=2960) % (n)	
Gestation at delivery				
<37 weeks	7.6	(18)	5.6	(163)
37+ weeks	90.8	(216)	94.4	(2479)
Birthweight				
<2500g	5.9	(14)	5.8	(170)
2500+g	94.1	(222)	95.2	(2758)

Among the respondents 4% of women indicated that they had a long-standing physical or mental health problem and for two-thirds (67%) this 'definitely' or 'to some extent' affected their day to day activities. A total of 3% of respondents indicated that they needed help in understanding English and of those women indicating that they had a language difficulty, this was more likely for the non-white participants (70% compared with 30%) women.

Comparison with the most recent national statistics for women giving birth in England and Wales[51] shows that the survey sample is older, with higher proportions of women aged 30-39 years, and that fewer survey respondents were born outside the UK.

3.4 Comparison with 1995

A comparison with the 1995 survey shows that the more recent sample of mothers is older, with higher proportions of women aged 35 years or older, and more ethnically diverse, with 12.6% of responders from BME groups compared with 8.1% in 1995.

Table 6 *Key characteristics of main sample responders in 2006 compared with the Audit Commission Survey responders in 1995*

Characteristics of respondents	Audit Commission Survey 1995 n=2406 %	National Maternity Survey 2006 n=2960 %
Age		
16-19	3.7	3.9
20-24	16.3	15.4
25-29	32.9	23.9
30-34	32.7	32.7
35-39	12.1	20.5
40+	2.4	3.6
Age (mean, s.d.)	28.9 (5.2)	30.0 (5.7)
Ethnicity	91.9	87.4
White	3.1	6.9
Asian	2.1	3.6
Black	2.9	2.1
Mixed / Chinese / Other		

51 Office for National Statistics. 2006 Birth statistics: Review of the Registrar General on births and patterns of family building in England and Wales, 2005. Series FM1 no.34. London: Office for National Statistics, 2006.

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