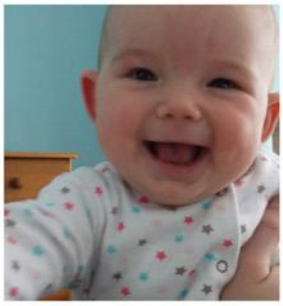
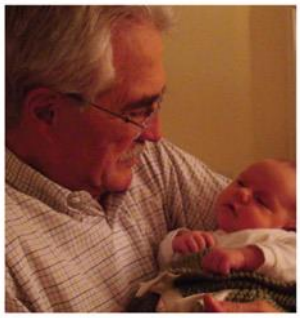
Safely delivered:

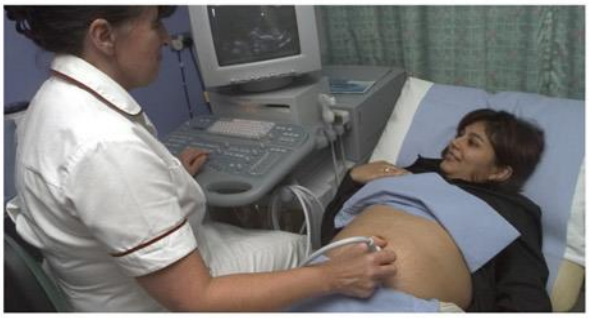
a national survey of women's experience of maternity care 2014









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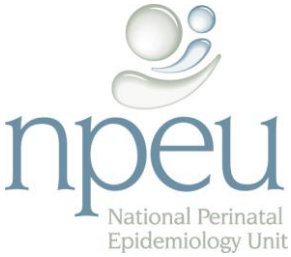

Safely delivered:

a national survey of women's experience of maternity care 2014

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Executive Summary

Maternity services are changing as is the population of women and families served. There is thus a continuing need to collect evidence regarding the views and experiences of women who have recently given birth. As maternity services are restructured and evolve, the information from this study provides a picture of current practice and point of comparison with the past and for the future.

The survey was carried out in 2014 using similar methods to those employed by the NPEU in 2006 and 2010. A random sample of 10,000 women giving birth in England over a two week period were selected by the Office for National Statistics from birth registration records. Women whose babies had died and new mothers less than 16 years of age were not included. The usable response rate was 47%, with responses from 4571 women. A total of 16% of respondents came from Black and Minority Ethnic (BME) groups, 24% had been born outside the UK and 13% were single parents. An online version of the questionnaire was made available to all participants; only 8% of those responding used this method of return.

Data were analysed and are presented separately for women for whom this was a first birth and for women who had previously given birth. Multivariate analyses, with adjustment for potential confounders, were carried out in relation to 24 selected outcomes contributing to quality of care.

Key findings

Key findings are presented to provide a picture of current maternity care from pregnancy through to postnatal care and the early months at home. These will also allow easy comparison with other and earlier surveys and with the care standards provided arising from policy, national and professional guidelines.

Care in pregnancy

- Most women (85%) had realised they were pregnant by six weeks' gestation and for three out of four women (76%) their pregnancy was planned.
- Almost all women (96%) had contacted a health professional about their pregnancy by the time they were 12 weeks pregnant and 91% had attended a booking appointment.
- Most women (66%) first contacted their general practitioner or family doctor.
- The median number of antenatal checks was 8 for women who had previously given birth and 9 for women having their first baby.
- Midwives were the health professional most commonly seen by pregnant women with 95% seeing a midwife one or more times antenatally. A total of 58% of women had all their antenatal care from midwives, rather than a combination of midwives and doctors. This was more common in women who had not given birth before.
- A total of 68% of women reported having a 'named midwife' who was responsible for providing all or most of their care during pregnancy and after birth, with contact details.
- There was evidence of limited continuity in antenatal care, with 35% of women seeing the same midwife every time and 44% seeing just one or two midwives over the course of their pregnancy. However, 1 in 5 (19%) saw five or more different midwives.
- Four-fifths of women (81%) reported that they had been screened for Down's syndrome; however, some women (17%) did not want the screening. Very few women were not offered the tests (1%).
- Dating and anomaly ultrasound scans were reported by 95% and 99% of women respectively.
- A majority, but not all women realised that the 20 week scan was to check for abnormalities (78%). Most (90%) were reassured, some (47%) liked knowing the sex of their baby and a quarter (24%) felt it was important for their partner to see the baby.
- NHS antenatal education was offered to 65% of women, with many more first-time mothers (84%) being offered classes or workshops than women who had previously given birth (45%). Less than a third of women attended NHS antenatal education sessions (31%). A minority of women attended non-NHS antenatal classes for which they paid (14%).
- When pregnant, only a third of women reported being specifically told about the NHS Information for Parents website (31%). Overall 76% of women used online websites for information about pregnancy and childbirth, more commonly first-time mothers. A wide range of sites was used including NHS sites which were listed by 73% of women.
- Some women had long-term health problems and others had problems arising in the course of their pregnancy and received additional care: of these 89% attended a specialist antenatal clinic;

47% attended a pregnancy day assessment unit and 31% had overnight stays in hospital that were separate from induction or a planned caesarean section procedure.

- Overall during their pregnancy more than 75% of women indicated that staff always treated them well, with respect and kindness and talked to them in a way they could understand.
- Almost all women (82%) were asked about their current emotional and mental health around the time of booking in pregnancy. A similar proportion (84%) were asked about past mental health problems and family history.
- Overall, a quarter of women (25%) were aware of all 4 options for place of birth: at home, in a free-standing midwifery unit, in an alongside midwifery unit, or in a unit where the team included obstetricians. A further 40% were aware of 2 or 3 options and 33% had one choice only.
- Most women (70%) felt they had been given enough information to decide where to have their baby and most (60%) made their choice in early pregnancy.

Care during labour and birth

- Most women gave birth in the NHS trust where they received their antenatal care (87%).
- Of the 77% of women who contacted a midwife or the hospital in early labour, most (84%) felt they had appropriate advice and support.
- Of the women who laboured, this started naturally for 60%. Nearly half (45%) of the women who were induced felt they had a choice about the induction.
- Other choices were evident in the experience of the women who laboured: moving around and choosing positions that were comfortable (52% most of the time); choosing where to give birth (5% of normal deliveries on the floor, 12% in a pool) and what position (19% squatting, kneeling or standing).
- Nearly half (46%) had continuous electronic fetal monitoring for all or part of their labour.
- A quarter of women who laboured reported having pethidine or a similar analgesic for pain relief (25%) and slightly more (29%) had epidural or spinal anaesthesia.
- The majority had the pain relief they wanted (63%) and slightly more (74%) received this when they wanted. A third to a quarter of labouring women did not have this experience.
- The vast majority of women (96%) gave birth in hospital with either midwife-led (50%) or consultant care (45%).
- The majority of women (59%) had a normal vaginal birth, a quarter had a caesarean (26%), and small proportions had vaginal birth which involved the use of forceps (9%) or ventouse (6%).
- 39% of caesareans were planned before labour, 7% planned but carried out after labour started and 54% followed unforeseen problems after labour had started.

- A total of 9% of women having a caesarean wished their baby to be born this way, but for only 1.4% was this the sole reason.
- 26% of women who had a vaginal birth reported having an episiotomy and 7% had a 3rd or 4th degree tear.
- Most women were helped to hold their baby shortly after the birth (89%), to have skin-to-skin contact (85%) and many put their baby to the breast (74%) at this time.
- Very few labouring women had one midwife caring for them through labour (16%). A quarter (26%) had four or more midwives providing care.
- A high proportion of women (85%) reported not having previously met any of the midwives caring for them during labour and birth.
- Over half the women (59%) reported that their baby was delivered by a midwife and 42% by a doctor (more than one option could be ticked).
- Perceptions of the quality of midwifery labour care were high, reflected in always being talked to in a way women could understand (90%) and always being treated with respect (89%) and kindness (89%).
- Perceptions of the care from medical staff were similarly positive: doctors talked to them in a way they could understand (84%), treated them with respect (88%) and with kindness (86%).
- Both groups of staff were slightly less likely to be always reported as listening to women (82%).
- Two-thirds of women (67%) reported always being involved in decisions about their labour and birth care, more commonly women for whom this was their first birth.
- Most women and their partners were not left alone at a time when it worried them either in labour or afterwards (79%). However, 13% reported that this happened during labour and 8% that they were left alone and worried shortly after the birth.
- Less than half of the women and partners who were left alone and worried were told this would happen (42%) or given an explanation (45%).
- Nearly half of women (44%) reported that their recent labour and birth was better than they had expected, a quarter (26%) that it was worse and nearly a third (31%) that it had gone more or less as anticipated.

Care during the postnatal period

- Postnatal hospital stays were quite short, with women having their first baby staying in hospital for an average of 2.6 days (median 2 days) and women who had previously given birth staying for an average of 1.8 days (median 1 day).

- Women's views varied about their stay: for 68% this was 'about right', for some (12%) it was 'too short' and others (15%) it was 'too long'.
- Many women felt that hospital postnatal staff always talked to them in a way they could understand (79%), with respect (76%) and kindness (75%). They were more critical of this aspect of their care than of the other phases of care, with fewer women always feeling listened to (68%) or treated as an individual (71%).
- After discharge home most, but not all women (77%) had the name and telephone number of a 'named midwife' or health visitor they could contact.
- 97% of women were visited by a midwife at home: on average women saw a midwife 3.1 times (median 3), with no difference between first-time and more experienced mothers.
- 40% of women had not met any of the midwives who made home visits before and 33% saw three or more different midwives.
- Most women (71%) thought that there were sufficient postnatal home visits, although a quarter (23%) would have liked more visits, more commonly first-time mothers.
- During the first few days after birth 82% of women exclusively or partially breast-fed their babies; by the time the infants were three or more months old, the comparable figure was 49%.
- More than a quarter (27%) of women would have liked more help with feeding their baby.
- Most women always had confidence in the staff caring for them after discharge (69%), but for some women this was only sometimes (27%) and a few (4%) not at all.
- Women's health varied shortly after the birth, but by the time the baby was three months or more, most (89%) were well. Almost all women (90%) had a postnatal check by their family doctor. Of those who did not, the majority (60%) had not been offered this.
- Since the birth of their baby almost all women (90%) had been asked about their own emotional and mental health by a health professional. Of those self-identifying with a mental health problem after the birth, 63% had received support and 49% had received treatment to date.

Fathers and Partners

- High proportions of fathers and partners were involved in pregnancy, labour and birth. A total of 68% were present for one or more antenatal checks, over 80% for the early dating and later anomaly scans, 82% during labour and 87% during the birth.
- More than a third of fathers and partners directly sought out information about pregnancy (43%) and birth (41%).

- Midwifery and medical staff communicated well with around 80% or more of fathers and partners during pregnancy and labour and birth.
- In the early months many new fathers and partners were directly involved in infant care a great deal: changing nappies (67%), helping when the baby cries (72%), bathing the baby (61%) and playing with the baby (82%), all of which were more common when the woman had given birth for the first time.
- Since the birth well over half of fathers (62%) had looked after the baby a great deal when the mother was out or at work.
- A total of 66% of fathers and partners had been able to take paid paternity or parental leave, with a median of 10 days (2 working weeks) being taken.

The overall experience of maternity care

- Most women felt they were definitely given information about choices regarding their maternity care (71%) and others only to some extent (25%).
- Most women felt definitely involved in making decisions about their own care (72%), and that they were given enough information (73%) and at the right time to decide (71%).
- When asked overarching questions about pregnancy, labour and birth and the postnatal period, women were positive about their care. More were satisfied about pregnancy care (88%), labour and birth care (89%) and slightly fewer about postnatal care (77%). More primiparous women than multiparous women were dissatisfied with their postnatal care.

The experience of different groups of women

- Women from Black and Minority Ethnic (BME) groups and BME women born outside the UK were significantly later in accessing care.
- There were also significant differences in the way that care was experienced by BME women, with poorer staff communication and feelings about not being treated with respect.
- Single women were also more likely to access care later, less likely to feel involved in decisions about their care, more likely to feel left alone and worried during their labour and birth care, and were less satisfied overall, although more likely to have been seen by a midwife for longer in the postnatal period.
- Few differences were evident for women living in the most disadvantaged areas after adjustment for other demographic factors: they were more likely to feel involved in decisions about their antenatal care and less likely to see a midwife after the baby had reached two weeks of age.

Change over time

Antenatal care

In comparison with the earlier surveys in 2006 and 2010, reported as 'Recorded Delivery' and 'Delivered with Care', in 2014:

- Women accessed antenatal care earlier, booked for their maternity care earlier and there was greater uptake of antenatal screening.
- Use of texting to communicate with their midwife had increased, although face to face checks predominate for almost all women.
- The median number of antenatal checks in 2006 was 10 appointments for first-time mothers and 9 for women who had previously given birth compared with 9 and 8 respectively in 2014.
- Relatively low proportions of women attended NHS antenatal education sessions, as in 2006 and 2010.

Labour and birth care

- Greater proportions of women were aware of the midwifery options for place of birth, care at home and in midwifery units.
- Fewer women reported being delivered by midwives.
- The use of interventions varied over time: more women were induced and the proportion of women having a normal vaginal birth decreased.
- Based on the surveys, the caesarean section rate has increased to over a quarter of women giving birth this way, and the rate for vaginal birth after a caesarean (VBAC) decreased.

Postnatal care

- The delivery of postnatal care has changed over the last decade: the length of hospital stay is shorter, even for women having a caesarean section birth; postnatal home visits were fewer in number and women were less likely to know the midwife or midwives who visited them.
- More women saw a midwife after their baby had reached two weeks of age, perhaps reflecting a recognition of the support needs of some women.
- The numbers of women reporting no home visits has increased from none identified in 2006 to 1% in 2010 and 3% in 2014.

Changes in perceptions of care

- Quite high levels of satisfaction with pregnancy and labour and birth care changed little over time, while this decreased slightly in relation to postnatal care.

- Almost all women felt that they were treated with respect by midwives and doctors at all the time points, although the extent of this declined over time.
- More women always had confidence and trust in the staff caring for them during labour and birth over the four years to 2014, although this did not change in relation to postnatal care.
- Information giving improved across the 2010 and 2014 surveys.

Conclusion

Earlier access to pregnancy care, high uptake of screening, greater awareness of options for care and active seeking of information about pregnancy and birth mark women's recent experience of antenatal care as evidenced in the survey. Response rates have declined and the 47% response rate must be acknowledged as possibly impacting on generalisability to the wider population. A relatively high level of intervention during labour and birth is reflected in the proportions of women experiencing induction, continuous electronic fetal monitoring and caesarean section birth. Postnatal care for most women involved short hospital stays and some home visits, although as with other phases of care, continuity was mostly limited to a minority.

Most women were positive about most of their maternity care and seem to have experienced greater involvement in decisions made about their care and better information-giving in recent years. Health professionals' awareness and concern about women's mental health during pregnancy and following birth are evident in the high proportions of women being asked about their emotional wellbeing.

Differences between the different phases of maternity care, between women with varying clinical needs and between women with different individual and other characteristics emphasise a need to respond to the individual, and at the same time create services which meet the needs of the whole population of child-bearing women and their families.

1. The context of 'Safely delivered'

As maternity services change over time it is critical to document the views of women with recent experience of maternity care, at national and local level. Following on from a survey carried out two decades ago[1], working with the Office for National Statistics (ONS), the National Perinatal Epidemiology Unit (NPEU) has been involved in a series of national population-based maternity surveys in 2006[2], 2010[3] and most recently in 2014 with this report.

The Care Quality Commission was responsible for a trust-based maternity survey in 2013 and like the maternity service review carried out in 2007 by the Healthcare Commission[4], this showed substantial variation in women's experience of care[5].

As with other areas of care, maternity services are evolving and the information from the study will enable comparison with findings from the earlier research carried out in 2006 and 2010. At the same time it will provide a benchmark of current practice and a baseline for measuring change in the future. It will also enable comparison of the experience of care between different groups of women and exploration of the variation in views and the impact of the care provided. Such a study will inform policy in maternity care, support implementation and change and provide a further point of comparison for local surveys of user views and experiences in individual trusts.

Obtaining information about women's views and experiences is important for several reasons:

- All health care is about more than the clinical aspects of treatment. Good care meets the needs of people as individuals, including their needs for choice, information, support and reassurance.
- Women and their partners' reactions to care around the time of birth may affect the way they care for themselves and their baby, influencing relationships with caregivers and the care system as a whole. Many women and their partners are in touch with services at this time and pregnancy and childbirth represent a window of opportunity for positive intervention.
- Some aspects of care can be assessed only by asking women, or are more practical to get this way. Women are best able to say whether they knew the caregivers who looked after them at different stages of care and are better placed to say whether they received sufficient information, whether

[1] Garcia et al. First Class Delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.
[2] Redshaw et al. Recorded Delivery: a national survey of women's experience of maternity care 2006. Oxford: NPEU, 2007.
[3] Redshaw et al. Delivered with Care: a national survey of women's experience of maternity care 2010. Oxford: NPEU, 2010.
[4] Healthcare Commission. Towards Better Births: a review of maternity services in England. London: Healthcare Commission, 2008.
[5] Care Quality Commission. National findings from the 2013 survey of women's experiences of maternity care. London: CQC, 2013.

they were able to understand what was said to them, if they were treated kindly and with respect, and to describe the quality of the facilities and services they received.

The over-arching research questions this survey aimed to address were:

1) What is current practice in the provision of maternity care in England? This includes clinical aspects of care and aspects of service provision and organisation associated with that care.
2) What are the key areas of concern for women receiving contemporary maternity care in England?
3) Does the experience of women from potentially vulnerable groups differ from that of other women and in what ways?
4) Have women's experiences and perceptions of care changed over recent years?

2. Methods and Sample

The methods employed were similar to those used in earlier maternity surveys on women's experience of care in terms of the type of instrument, sampling and survey management.

2.1 The survey instrument

The 2014 survey of recent mothers used a similar format to that employed in 2006 for 'Recorded Delivery' and in 2010 for 'Delivered with Care'. The twenty-six page questionnaire took women through their pregnancy, labour and birth and postnatal care and allowed them to describe the care they had received. Structured question formats were largely used, however, it was possible for women to make open text responses providing clarification on specific points and also to express their views about the different phases of care in their own words if they wished.

The questionnaire used for the 2010 national survey of recent mothers formed the basis of the 2014 survey to enable comparison (See Appendix A). However, some questions were added and minor adjustments made to other questions to ensure that it reflected current issues of interest, such as: maternal mental health, involvement in decisions about care, use of antenatal day assessment and specialist clinics, advice at the start of labour, satisfaction with labour and birth, the mother-infant relationship and infant outcomes.

No pilot study was undertaken as the survey was of similar length, structure and content, and used a large proportion of questions from the 2006 and 2010 surveys. The draft questionnaire was reviewed

and commented on by staff at the Department of Health, the Care Quality Commission and NCT, but no further stakeholder consultation was carried out as this had been done for earlier surveys.

Additional data on respondents and non-respondents were provided by the ONS. This included marital status, the small area based measure Index of Multiple Deprivation (IMD) quintile, maternal and paternal country of birth, and maternal and paternal age by category.

2.2 Sample

A random sample of 10,000 women aged 16 years and over, who had their baby in a two week period at the beginning of January 2014 in England were selected for the survey by ONS from birth registrations. Checks were made by ONS for notification of any baby deaths in the months following birth registration and replacements made for the survey sample. Thus the views expressed are based on the care associated with births during early 2014.

2.3 Data collection

The survey mailing was managed by ONS and a questionnaire was sent to each woman selected, along with an invitation letter, an information leaflet and a sheet with information in 19 different languages and a Freephone contact number. Women were offered three methods of response: a postal questionnaire which could be completed and returned to the NPEU, an online option which involved using a link from the NPEU website, a unique reference number and an individual password, or to complete the survey with an interviewer, using a Languageline interpreter if that was appropriate. The questionnaires, each identifiable only by a unique reference number, were returned by post to NPEU and logged. Online return information was sent to NPEU on a weekly basis. Checks were made at NPEU and details of all questionnaire returns sent to ONS to prevent inappropriate reminders being mailed. The initial mail out took place in April 2014. A reminder letter was sent out after two weeks, a further questionnaire after 4 weeks and then after 8 weeks, if no response had been received.

Ethical approval for the study was obtained from the NRES committee for Yorkshire and The Humber – Humber Bridge (REC reference 14/YH/0065) on 28 February 2014, with an amendment passed by the same committee on 12 May 2014.

2.4 Survey response

The breakdown of returns is as follows:

10,002 questionnaires mailed out
216 returned as undelivered
4197 unique postal completed returns
380 online completed returns
121 blank questionnaire returns / do not wish to participate phone calls
4571 completed returns (postal and online, excluding duplicates)

A response rate of 48% was achieved, with a usable response rate 47%. A total of 8% of responses were completed online. Comparison with 2006 and 2010 patterns of return shows a decline in response to postal surveys, with no increase in online responses from 2010 to 2014. This is a common finding reported for maternity surveys[6] [7] using both shorter and longer survey instruments. The decline in response rates to surveys of this type may relate to the ever-increasing number of surveys that people are sent and increasing time pressure.

2.5 Analysis

Analyses were undertaken using Stata 13.1 and SPSS 19.0. Data are presented for the whole group of respondents and separately for women for whom this was a first birth (primiparous women) and those who had given birth previously (multiparous women). A small number of women did not provide data on parity and so the totals for primiparous and multiparous women do not sum to that for all women. Selected comparisons are made with earlier survey findings, particularly looking at women's experience of care. Descriptive statistics, including means, medians and proportions were calculated and proportions compared using Chi-squared tests or Chi-squared test for trend as appropriate. Statistical significance for univariate analyses was set at p <0.01. (* indicates p <0.01 in tables and figures).

Preliminary regression analyses on selected outcomes for particular groups were undertaken to adjust for some of the factors that could have contributed to the observed differences between groups reported from the univariate analyses. The outcomes investigated included access to antenatal and postnatal care and women's perceptions of care during pregnancy, labour and delivery and the postnatal period. Adjustment was mainly for demographic factors including maternal age, ethnicity

[6] Care Quality Commission. Women's experiences of maternity care in England: key findings from the 2010 NHS trust survey. London: CQC, 2010.
[7] Care Quality Commission. National findings from the 2013 survey of women's experiences of maternity care. London. CQC, 2013.

and partner status as well as parity and type of delivery (more details are given in Appendix B). Specific regression analyses focused on:

1. Black and Minority Ethnic (BME) women compared with White women;
2. BME women born outside the UK compared with White women born in the UK;
3. Single women compared with women living with partners;
4. Women living in the most disadvantaged areas, using an area based measure, the Index of Multiple Deprivation (IMD), compared with women in less disadvantaged areas;

2.6 The women who responded

Summary data describing the characteristics of the respondents and non-respondents are presented in Appendix C. A comparison of the age, parity and ethnicity of women responding to surveys in 2006, 2010 and 2014 is also shown in Appendix D.

The women who responded to the 2014 survey were equally likely to have given birth previously (50.1%) or for this to have been the first baby to which they had given birth (49.9%). Data on parity from the Hospital Episode Statistics (HES) for 2012—13 suggest that 40% of women giving birth at that time were primiparous, however, for 28% of women in 2012—13 HES, data on parity status at the time of giving birth was unknown[8]. The proportion of women who were primiparous in survey returns to NPEU in 2010 was 50.4% and 48% for the CQC survey in 2013[9].

As with other surveys, women from some groups were less likely to respond[10] [11] [12]. Those responding were more likely to be older, to be married, to be living in the least deprived areas and to be born in the United Kingdom. A total of 13.2% of respondents were living as single parents at the time of the survey, 81.3% were white and 79.2% were born in the UK. The women born outside the UK came from many parts of the world, principally Poland (141), India (83) and Pakistan (68).

[8] Health and Social Care Information Centre. Hospital Episode Statistics. NHS Maternity Statistics – England, 2012-13. Table 3.i. 2013. Available at http://www.hscic.gov.uk/article/2021/WebsiteSearch?productid=13418&q=births+parity&sort=Relevance&size=10&page=1&area=both#top.

[9] Care Quality Commission. National NHS patient survey programme. Survey of women's experiences of maternity services 2013. Full national results with 2010 comparisons. Available at: http://www.cqc.org.uk/content/maternity-services-survey-2013.

[10] Garcia et al. First Class Delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.

[11] Redshaw et al. Recorded Delivery: a national survey of women's experience of maternity care, 2006. Oxford: NPEU, 2007.

[12] Healthcare Commission. Towards Better Births: a review of maternity services in England. London: Healthcare Commission, 2008.

Almost all respondents had singleton births (98.3%). A small proportion (6.7%) took place before 37 weeks' gestation.

There were no significant differences between the women who completed the postal and online surveys in terms of age, marital status and IMD. More online respondents lived in London than in other regions and more women who were born outside the UK responded online.

The findings are presented in the seven sections which follow, starting with antenatal care.

3. Antenatal Care

The NHS provides a universal service for maternity care as an integral component of care for women, children and their families, from pregnancy to the early months at home with their baby. It is recognised that pregnancy is a key time during which there is a particular need for care and monitoring and, at the same time, an opportunity to maximise the possibility of positive outcomes for women and babies. Much of the survey focused on services and experience of care during this time.

3.1 Pregnancy awareness

The survey provides evidence about the initiation of care, the health professionals involved, and the nature of the care provided, focusing on both physical and mental health and emotional wellbeing at this time. Evidence is provided by the survey on women's first awareness of pregnancy and earliest contact with the maternity service which are so critical in the timing and initiation of effective pregnancy care. Almost all women recognised very early on that they were pregnant and a home pregnancy test confirmed this for 94% of women. Very few had their pregnancy confirmed by a midwife (3.3%) and slightly more women who had not previously given birth saw a doctor for confirmation (15% compared with 11%).

A few women took considerably longer to become aware of their pregnancy (Table 1).

Table 1. Mean number of weeks' gestation when women first realised they were pregnant

Number of weeks *(n)*	**Mean**	**S.D.**	**Median**	**Range**	
Primiparous *(2,192)*	5.1	3.9	4	1	41
Multiparous *(2,196)*	5.2	3.5	4	1	42
All women *(4,525)*	5.2	3.8	4	1	42

Most had realised that they were pregnant by 6 weeks' gestation (85%) and a further 12% between 6 and 12 weeks, with only a small proportion (3.3%) not recognising the pregnancy until after this time. No differences were evident by parity.

Around three-quarters of women indicated that their pregnancy was planned (76% overall) with no significant difference by parity, with 62% reporting that they were overjoyed about the pregnancy, 20% pleased, and 17% with mixed or negative feelings. In the Avon Longitudinal Study of Parents and Children[13], quite a high proportion of women (71%) reported intentionally conceiving. However, fewer reported a planned pregnancy in the Millennium Cohort Study sample (58%)[14], suggesting that the way in which the question is asked and interpreted may have been different. In this survey, planned pregnancy was associated with older age, living in a less deprived area, and Asian or White ethnicity.

3.2 Access to antenatal maternity care

The first health professional most women saw about their pregnancy care was their general practitioner or family doctor (Table 2). However, while in 2010 this was more than three-quarters of women (77%), by 2014 this had reduced to two-thirds (66%), with the proportions seeing a midwife first significantly increasing from 20% in 2010 to 29% in 2014. As previously, this was more common among women who had previously given birth than in first-time mothers (36% compared with 23%). White women in their twenties were significantly more likely to see a midwife first compared to other women.

Table 2. Health professional first seen about pregnancy care

Health professional *(n)**	**Primiparous women**		**Multiparous women**		**All women**	
	No.	%	No.	**%**	No.	%
GP/family doctor *(3,002)*	1,564	71.4	1338	61.0	3,002	66.4
Midwife *(1,319)*	503	23.0	784	35.8	1,319	29.2
Other *(200)*	123	5.6	70	3.2	200	4.4

p<0.01 difference by parity*

Women were asked if the pregnancy was a result of treatment for infertility and for 5.7% this was the case (8.6% of the first-time mothers and 2.7% of women who had previously given birth). Among this group, women were significantly more likely to see a health professional other than their family doctor

[13] Farrow et al. Prolonged use of oral contraception before a planned pregnancy is associated with a decreased risk of delayed conception. *Hum Reprod*. 2002, 17:2754-61.

[14] Dex and Joshi. Children of the 21st century: From birth to nine months. Bristol: Policy Press, 2005.

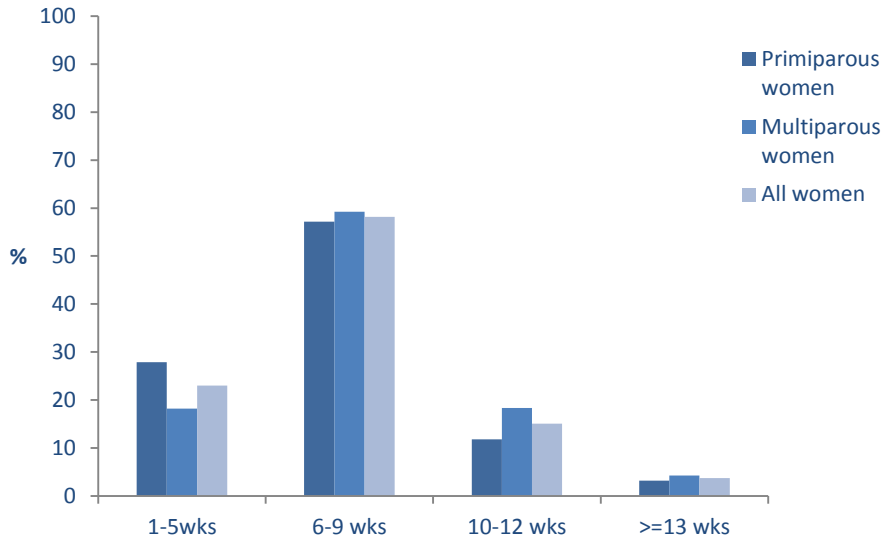
or midwife first (34.8% compared to 2.7%). This was also the case in 2010 but the difference was smaller although still highly significant (22.6% compared to 1.9%).

The timing of first contact varied. First-time mothers' contact with a health professional about care in pregnancy took place quite early (median 7 weeks) and only slightly later for women who had previously given birth (median 8 weeks) (Table 3). There were significant associations with timing of the first contact. This was significantly earlier for first-time mothers and those in less deprived quintiles and later for younger women, women who left school at 16 years or less and those identifying as Black or Black British. A total of 96% of women had seen a health professional by 12 weeks' gestation (Figure 1).

Table 3. Number of weeks pregnant when first saw a health professional about care

Number of weeks *(n)*	**Mean**	**95% confidence interval**	**Median**	**Range**	
Primiparous women *(2,172)*	7.1	7.0, 7.2	7	0	40
Multiparous women *(2,179)*	7.8	7.6, 7.9	8	0	36
All women *(4,489)*	7.5	7.4, 7.6	8	0	39

Figure 1.Timing of first contact with health professional (weeks' gestation)



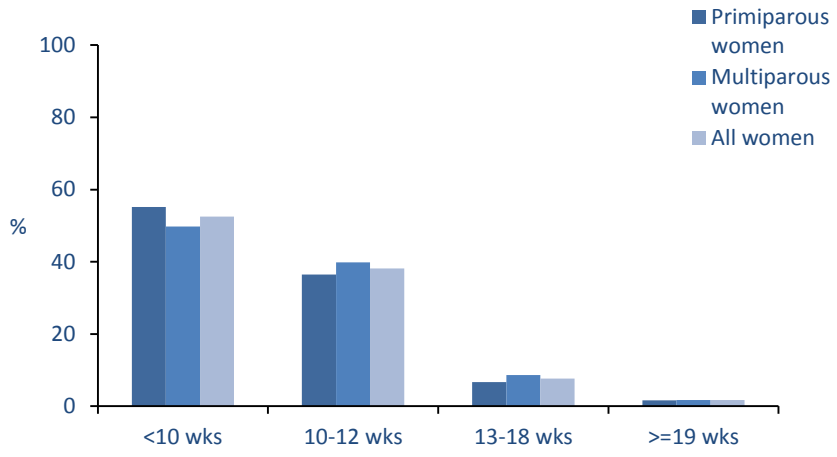
Relatively few women were aware that they could go straight to a midwife, rather than to a GP or family doctor as first point of contact for their pregnancy care (34%), though this was more than the 28% in 2010. Women who had previously given birth were significantly more aware of this possibility (43% of multiparous women compared with 26% of primiparous women). No significant differences were found by age, ethnicity or IMD, but women leaving school at or below 16 years were significantly

more aware of being able to go straight to a midwife (41% compared to 33% in more educated women).

The 'booking' appointment at which women have their history taken, usually by a midwife, and are given their pregnancy notes, is an important marker in planning care. Women who had previously given birth were significantly later in booking (Figure 2) as were those who were living in more deprived areas.

According to NICE, over half of first-time mothers (55%) and half of women who had previously given birth (50%) had attended a booking appointment by 9 completed weeks' gestation[15]. Most women had booked by 12 weeks (91%). Small proportions of women booked between 13 and 18 weeks (8%), or even later (2%).

Figure 2.Timing of 'booking' appointment (weeks' gestation).



3.3 Antenatal checks

Antenatal checks are a key part of care in pregnancy and almost all women (98%) had these, very few had no check-ups (1%) and a few were uncertain about the number (1%). The median number of check-ups for women giving birth for the first time was 9 and 8 for women who had previously given birth, with a median of 8 check-ups overall (Table 4). Data on outliers reporting very high numbers of antenatal checks were associated with serious maternal or feto-maternal history and health problems. NICE antenatal care guidelines[15] suggest that in an uncomplicated pregnancy, there should be 7 appointments for multiparous women and 10 appointments for primiparous women.

[15] National Institute for Clinical Excellence. Antenatal Care: routine care for the healthy pregnant woman. London: NICE, 2008.

Table 4. Number of antenatal check-ups

Number of antenatal check-ups *(n)*	Mean	95% confidence interval	Median	Range
Primiparous women *(2,106)*	10.1	9.9, 10.4	9	1 70
Multiparous women *(2,084)*	9.5	9.2, 9.7	8	1 60
All women *(4,306)*	9.8	9.6, 10.0	9	1 70

Antenatal care is provided by different professional groups in a range of locations (Figure 3, Table 5). Hospital clinics and GP surgeries were used by at least 60% of all women. Home, Children's Centres and local clinics were used less but by at least a fifth of women. When looking at the locations for *all* the appointments women reported (Table 5) just over a third were carried out at the GP surgery (38%) where midwife clinics are commonly run, less than a third in hospital clinics (31%) and smaller proportions at home (6%) or in local clinics (14%). Women also reported having appointments in specialist clinics and maternity units or birth centres. 'Other' places also included a leisure centre and private clinics.

Figure 3. Proportion of women having one or more antenatal checks in different locations *(*parity differences)*

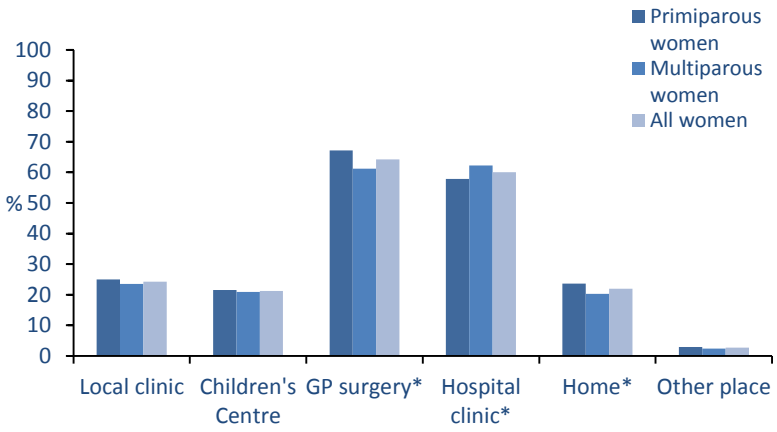


Table 5. Locations for all antenatal appointments reported

Location	No.	%
Local clinic	5,843	13.9
Children's Centre	4,317	10.2
GP surgery	16,009	38.0
Hospital clinic	13,159	31.2
Home	2,302	5.5
Other location	544	1.3
Total	42,174	100.0

While some women only attended one location for antenatal care (GP surgery 13%, hospital 6%, local clinic 4%, Children's Centre 2%, home 0.4% and smaller proportions at specialist clinics, birth centres and private clinics), many attended more than one type of clinic for antenatal checks. Among individual women, over a third (41%) had three or more appointments at a hospital clinic and most (51%) had at least three checks at the GP surgery. Fewer had checks at home (0.6% had three or more), slightly more (20%) had at least three appointments at a local clinic. Overall, a quarter of women (27%) only attended at one location, nearly half at two locations (46%), a fifth at three locations (21%) and a small proportion at four or more locations (5%). With this kind of variation, continuity of carer during the antenatal period may be difficult to organise and maintain.

Not unexpectedly, midwives were the health professionals that pregnant women most commonly saw, with almost all women (95%) seeing a midwife one or more times (Table 6). Just under a third saw an obstetrician at least once (31%), with a smaller proportion having at least one check with their GP (15%). However, there were differences by parity with women who had not previously given birth being more likely to see their GP and less likely to see an obstetrician. With regard to antenatal care being provided entirely by midwives, over half of the women responding (58%) had care of this type and it was significantly more common for women who were first-time mothers (61% compared with 55%).

Table 6. Health professionals seen by women for antenatal checks

Health professional	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Midwife*	2,133	96.7	2,101	94.8	4,350	95.2
GP/family doctor*	368	16.7	273	12.3	664	14.5
Obstetrician/hospital doctor*	575	26.1	785	35.4	1,396	30.5
Other health professional	53	2.4	66	3.0	122	2.7

**Difference by parity p<0.01 More than one response is possible*

Many women are clearly moving between healthcare providers and so effective communication with women and between the health professionals providing antenatal care at the different sites is critical.

Women were asked if they had a 'named midwife' with contact details during pregnancy. This is a midwife who is responsible for providing all or most of a woman's antenatal and postnatal care and co-ordinating care should they themselves not be available. Just over two-thirds (68%) reported having the name and contact details of such a midwife, a small proportion were unsure (8%) and a

quarter (24%) indicated that did not have a 'named midwife'.[16] There was no significant difference by parity. However, women aged less than 16 years and older than 40 years were more likely to have a named midwife; women from BME groups and those living in more deprived areas were less likely to report this.

It is important that women have a health professional they feel able to talk to about their individual concerns. This may be the midwife who has been allocated to care for them as a named midwife or another professional they see. Women were also asked if they had a health professional they could talk to about personal or sensitive issues during their pregnancy. Approaching half of women (46%) reported always having such a relationship with a health professional, just over a third (35%) indicated that they had this to some extent, while 18% of women reported not having this at all. No differences were evident by parity or maternal age, but women from BME groups were significantly less likely to report always having such a relationship.

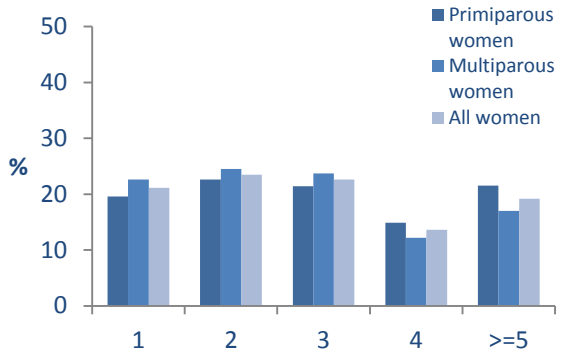
Several questions were asked that to some extent would reflect continuity of care during the antenatal period. Women were asked if they saw a midwife for their antenatal checks, and whether they saw the same one each time. Around a third (35%) reported that they saw the same midwife every time, a similar proportion that they would have liked to have seen the same midwife (32%) and a third did not see the same midwife, but did not mind (32%). It was more common for women who saw different midwives but would have liked to see the same one to be first-time mothers (35% compared with 28%). These figures are similar to those produced by the Care Quality Commission in their 2013 survey[17].

A question was also asked about the number of midwives who had looked after them during their pregnancy. A total of 44% of women saw only one or two midwives, however 19% of women saw five or more different midwives (Figure 4) with a significant difference by parity. Women seeing more midwives were more likely to be first-time mothers and women with complex pregnancies. Women with long-term health problems were no more likely to see more midwives than those without such problems.

[16] Department of Health. NHS pledges more support for women with postnatal depression. 2012. Available at: https://www.gov.uk/government/news/nhs-pledges-more-support-for-women-with-postnatal-depression

[17] Care Quality Commission. National findings from the 2013 survey of women's experiences of maternity care. London: CQC, 2013.

Figure 4. Number of midwives providing individual women with antenatal care



3.4 Antenatal screening and scans

An important part of antenatal care is the screening that is carried out at this time. Women were asked about some of the tests they may have had and if the tests were explained to them.

In relation to screening for Down's syndrome, four-fifths of women (81%) reported that they had been screened with a blood test or a nuchal scan or both methods of testing. Some women (17%) reported not wishing to have the tests and not doing so (Table 7). A higher proportion of women had these tests in 2014 than in 2010 when 76% had this type of screening.

Table 7. Proportions of women having screening for Down's syndrome

Screening tests for Down's syndrome	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Blood test and nuchal scan	1,048	47.9	1,090	49.5	2,190	48.4
Blood test only	652	29.8	572	26.0	1,276	28.2
Nuchal scan only	95	4.3	84	3.8	181	4.0
Did not want tests	347	15.9	415	18.9	784	17.3
Not offered tests	21	1.0	21	1.0	44	1.0
Don't know/cannot remember	26	1.2	19	0.9	46	1.0

Very small proportions of women reported not being offered the tests at all, or did not know or were unable to remember being offered the tests. There were small but statistically significant differences by parity, with primiparous women less likely to have the combined nuchal test and less likely to decline screening. Similarly, young women and those from BME groups were also less likely to have the combined nuchal test but more likely to report that screening was not offered. Most women felt

that the reasons for screening had been clearly explained (95%), with no differences between women who had previously given birth and those who had not.

Routine pregnancy care involves at least two ultrasound scans. As with screening for Down's syndrome, women were asked if screening had taken place and if they were given explanations about the procedure. A large proportion of pregnant women had a dating scan early on in pregnancy (95%) and almost all (99%) reported having an anomaly or '20 week' scan (Table 8). No differences were found between women having their first baby and those who had given birth before in the proportions being screened.

Table 8. Women having dating and anomaly ultrasound scans

Scans	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Dating scan at about 8—14 weeks	2,075	95.3	2,079	95.3	4,270	95.1
Anomaly scan at about 20 weeks	2,138	99.1	2,149	99.2	4,411	99.1

Almost all women felt that they had received explanations about both the dating and anomaly scans (95% and 97%), with little difference by parity.

In this survey women were also asked about the 20 week anomaly scan, what they thought it was for and how they felt about the scan (Tables 9 and 10). Most women reported that the scan was to check the baby's growth (84%) and to check for abnormalities (78%). Some women also reported that it was to check the placenta (51%) and to calculate the due date (27%). Over 90% of women reported being reassured by the scan, nearly half (47%) liked knowing the sex of their baby, a third (37%) reported that they got to know their baby better, and a quarter (24%) reported that it was important for their partner to see the baby. These last two aspects of ultrasound scans appeared to be particularly important for first-time mothers and their partners.

Table 9. Women's perceptions of the '20 week' or 'anomaly' scan

Function of 20 week scan	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
To calculate due date	563	26.0	621	28.5	1,220	27.3
To check on placenta	1,090	50.2	1,137	52.0	2,292	51.1
To check on my baby's growth	1,810	83.1	1,862	84.8	3,779	83.9
To check for abnormalities	1,714	78.6	1,716	78.3	3,513	78.4

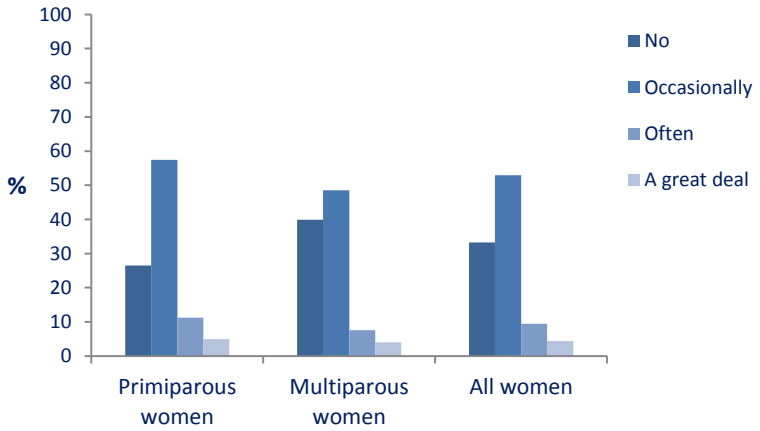
Table 10. Women's feelings about the '20 week' or 'anomaly' scan

Feelings about 20 week scan	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
It was reassuring to have a scan	1,990	91.0	1,984	90.3	4,075	90.3
I got to know my baby better	874	40.3	698	32.1	1,630	36.5
It was important for my partner	613	28.3	435	20.0	1,085	24.3
I liked knowing the sex of my baby	1,028	47.4	990	45.4	2,087	46.6

Women were also asked about the total number of ultrasound scans that they had during their pregnancy. A total of 10 women reported having no scans at all. Of those who had scans, women had on average 3.9 scans each (median 3 scans). Those women having higher numbers of scans were more likely to be older, to have pregnancies about which there was concern and to have received treatment for infertility.

Women have concerns about their baby as well as their own health during pregnancy. They were asked if during their pregnancy they had worried about their baby's movement. Overall, a third (33%) did not worry at all and just over half (53%) worried occasionally and a small proportion worried often or a great deal (14%) (Figure 5), with first-time mothers worrying significantly more. They were also asked, if they were worried, whether they had contacted a health professional. Of those who were worried at all, 58% contacted a health professional and those who worried more were more likely to do so. Women who had pre-existing health problems were slightly more likely to be anxious, and those with pregnancy related problems significantly more likely to be anxious; both groups were significantly more likely to contact a health professional than women who were well.

Figure 5. Worried about the baby's movement during pregnancy



3.5 Antenatal information and education

Women can obtain information about pregnancy and childbirth from a range of sources, including formal contacts with health professionals and informal interactions with other women: antenatal appointments, drop-in sessions, parent education groups and websites can all provide information. Different sources may suit different women and several questions were asked about what sources they used.

Women were asked if they had been given information about the NHS Information for Parents website. Nearly a third reported being given the information (31%), a similar proportion had not been told about the website (32%) and slightly more were uncertain about being told (37%). More first-time mothers reported being given this information than women who had given birth before (37% compared with 25%). Women aged 20—29 years were more likely to report being informed about the website. There was no significant difference by ethnicity or IMD.

Women were also asked if they used online websites for information about pregnancy and birth and most (76%) reported doing so. A range of websites were used and nearly three-quarters (73%) of the women in the study reported using a variety of NHS websites for information about pregnancy and birth. Many women used other websites for information about pregnancy and birth which provided information, discussion forums and opportunities for signing up for product information and samples (Table 11).

Table 11. Websites used by women during pregnancy

Sites*	n	%
NHS	2,529	73.4
Babycentre	888	25.8
Bounty	331	9.6
Google	132	3.8
Mumsnet	111	3.2
Netmums	93	2.7
Emma's diary	83	2.4
NCT	68	2.0
Birth centre	24	0.7
What to expect when you're expecting	21	0.6
Others	162	4.7

**Multiple responses possible*

There were significant effects of parity, age, ethnicity and IMD on the use of such websites. Use was significantly higher for first-time mothers than experienced mothers (85% compared with 67%), among mothers in their 30s compared to younger and older women (79% of women aged 30—34 years, compared with 58% in mothers aged 16—19 years and 73% in women aged 45 years and over), higher among White women than women from BME groups (78% compared with 70%) and higher among those women living in less deprived areas (83% in the least deprived quintile compared with 64% in the most deprived quintile).

Antenatal education classes can be an important source of information and support. Approximately two-thirds of women (65%) were offered classes or workshops, although the offer was more commonly made to first-time mothers (84%) than to women who had previously given birth (45%) (Table 12).

Table 12. Women offered and attending antenatal classes or workshops

Antenatal classes/workshops*	**Primiparous women**		**Multiparous women**		**All women**	
	No.	%	No.	%	No.	%
Not offered	359	16.4	1,173	53.5	1,576	35.0
Offered	1,831	83.6	1,019	46.5	2,930	65.0
Attended	1,122	51.6	181	8.6	1,349	30.6

**Difference by parity p < 0.01*

Some women did not want NHS classes: 20% of primiparous mothers and 39% of multiparous women declined. It seems that slightly fewer women were offered NHS antenatal education sessions in 2014 compared with 2010 (69%).

There was significant variation by demographic factors. The younger women were, the more likely they were to have been offered classes (73% of those aged 19 or less, compared with 56% of those of 40 or more years of age). Asian and Black women were less likely to be offered classes than White women (56% and 47% compared with 65%). There was also significant variation by IMD with women in the most and least deprived quintiles being least likely to have been offered classes.

Significantly fewer women with previous birth experiences attended such education sessions (9% of multiparous women compared with 52% of first-time mothers).

A minority of women attended non-NHS antenatal classes for which they paid (14%) and this was more common for women who had not given birth previously (23% compared with 4%). This compares with

12% in 2010. Women were significantly less likely to pay for antenatal classes if they were young, from a BME group, less educated and in the most deprived quintile.

3.6 Women with more complex pregnancies

Women with more complex pregnancies may be managed in different ways, with specialist clinics, day assessment units and admissions to hospital. Women were asked several questions about the different types of care they might have received during their pregnancy.

A total of 10% of women reported having a long-term health problem which had made the pregnancy difficult or complicated, most commonly diabetes, asthma, thyroid problems and back pain. Of these, 89% reported receiving additional or specialist care for this reason.

Women were also asked about specific pregnancy-related problems affecting them or their baby. A total of 27% reported positively on this point, most commonly for threatened preterm birth, concern about the position of the placenta, and maternal blood pressure. Of these women, 89% received specialist or additional care.

Women were also asked if they attended a specialist antenatal clinic because of their health or a specific pregnancy problem (29%). This was more common among those women who had previously given birth compared with those who were first-time mothers (33% compared with 24%).

When there is concern about women's health or that of their baby, day assessment units are a way of providing additional care that does not involve overnight stays. Women were asked if they had attended a pregnancy day assessment unit at any time during their pregnancy but before they went into labour. Just over a third of women reported doing so (36%), with this being more common for first-time mothers than women who had previously given birth (39% compared with 34%). The mean number of attendances for those who were assessed in this way was 2.4 (median 2 visits, range 1 to 30) for both primiparous and multiparous women.

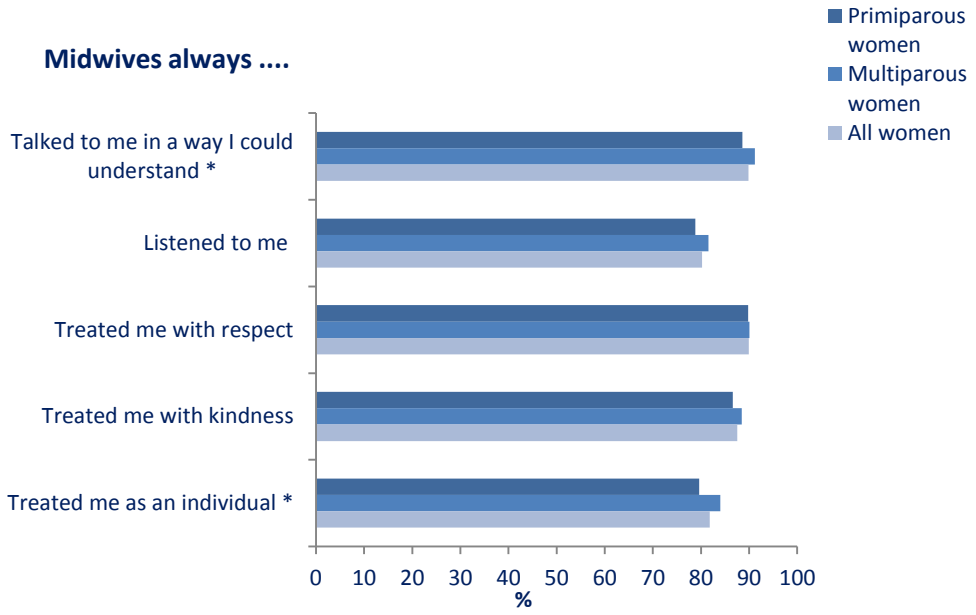
Women were also asked about admission to hospital and overnight stays for observation or treatment during their pregnancy that was separate from labour, a planned caesarean, or any induction of labour procedures. They were specifically asked about any overnight antenatal stays in hospital and the reasons for these. A total of 20% of women had overnight stays of this kind for reasons which included bleeding, hyperemesis, high blood pressure, suspected pre-eclampsia, and suspected preterm labour. Mean number of admissions for those having overnight stays was 2 (median 1), mean length of stay was 3 nights (median 2). There was no significant difference by parity, ethnicity or education, but women in the most disadvantaged quintile were significantly more likely to be admitted (23%

compared to 16% in the least deprived quintile). Also, women aged 45 years or over had fewer admissions but of longer duration.

3.7 Perceptions of antenatal care

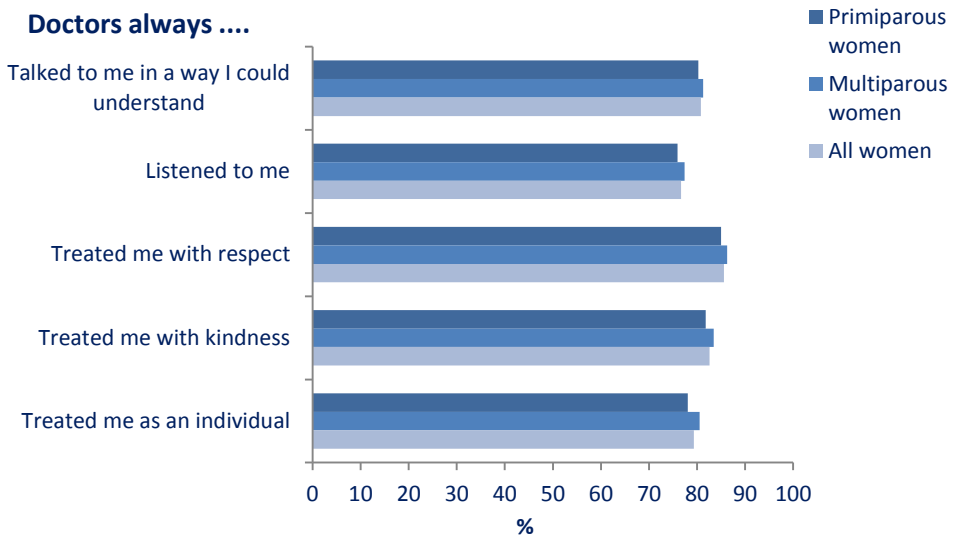
A question about how women viewed interpersonal aspects of their care involved statements about the care received. The broad statements about care from midwives have large proportions of women making a positive response (80% or more) (Figure 6a). Women were most likely to report always being talked to in a way they could understand (90%), always being treated with respect (90%) and with kindness (88%) by midwifery staff. They were less likely to always feel listened to (80%) or treated as an individual (82%). First-time mothers were more critical about some of these aspects of care.

Figure 6a. Women's perceptions of midwifery care during their pregnancy *(*parity differences)*



A slightly less positive response came in relation to women's perceptions of the interpersonal care they received from medical staff, with slightly fewer always feeling talked to in a way they could understand (81%) and always feeling listened to (77%) (Fig 6b). However, it must be emphasised that more than three-quarters of women always felt treated well in all respects. No differences were evident by parity.

Figure 6b. Women's perceptions of medical care during their pregnancy



3.8 Antenatal mental health and wellbeing

There is considerable concern about women's mental health both during pregnancy and afterwards[18] and recent guidance[19] makes recommendations for primary and secondary care services in supporting the effective identification and treatment of women's mental health problems in pregnancy and afterwards. It is suggested that at a woman's first contact with primary care or at her booking appointment and during the early postnatal period there is a general discussion about a woman's mental health and wellbeing, with specific questions being asked in relation to depression and anxiety.

In the 2014 survey women were asked whether, around the time of booking for their pregnancy care, they had been asked about their emotional and mental health. A total of 82% of women had been asked: of these 11% were asked by their GP or family doctor, 89% by a midwife, 5% by a hospital doctor and a small proportion by someone else (multiple responses were possible). They were also specifically asked whether staff enquired about past mental health problems and any family history, with 84% of women responding that they had been asked. Similar proportions of the different staff groups asked this question as had asked about their current mental health.

A total of 946 women (21%) self-identified as having a mental health problem during their pregnancy for which a third were offered treatment (36%). They were also asked about the details of any help or treatment. The most common forms of treatment mentioned were medication, counselling and

[18] Knight et al. Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012. Oxford, NPEU: 2014.
[19] National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance. Available at: https://www.nice.org.uk/guidance/cg192

cognitive behaviour therapy. Women were also specifically asked about anxiety and depression: 13% of women reported suffering from anxiety during pregnancy and 7% from depression. There was no significant difference in anxiety by parity but depression was somewhat more common among multiparous women (6.0% in primiparous women, 7.9% in multiparous women, *p=0.015*).

3.9 Choice and place of birth

Timely and appropriate information is needed in order to help women make informed choices about their options for care and the way that they use maternity services. Early and easy contact with health professionals providing maternity care and accessible written and online information can help women in making their individual choices about where, when and by whom care will be provided. Several survey questions were asked which reflect this aspect of care.

Women were asked about what options they were aware of when planning where to give birth (Figure 7). Over half were aware of the option of giving birth at home (59%), fewer felt they had the choice of a freestanding midwifery-led unit (MLU) or birth centre separate from the hospital (42%), around two-thirds were aware of midwifery-led units within hospitals (69%) and a similar proportion (65%) reported a consultant-led hospital maternity unit as an option. Significant differences were evident in relation to parity between women's awareness of home birth and both types of midwifery-led unit as options for place of birth, with women who had not previously given birth more likely to report all the midwife-led options.

Figure 7. Proportions of women aware of options for place of birth *(*parity differences)*

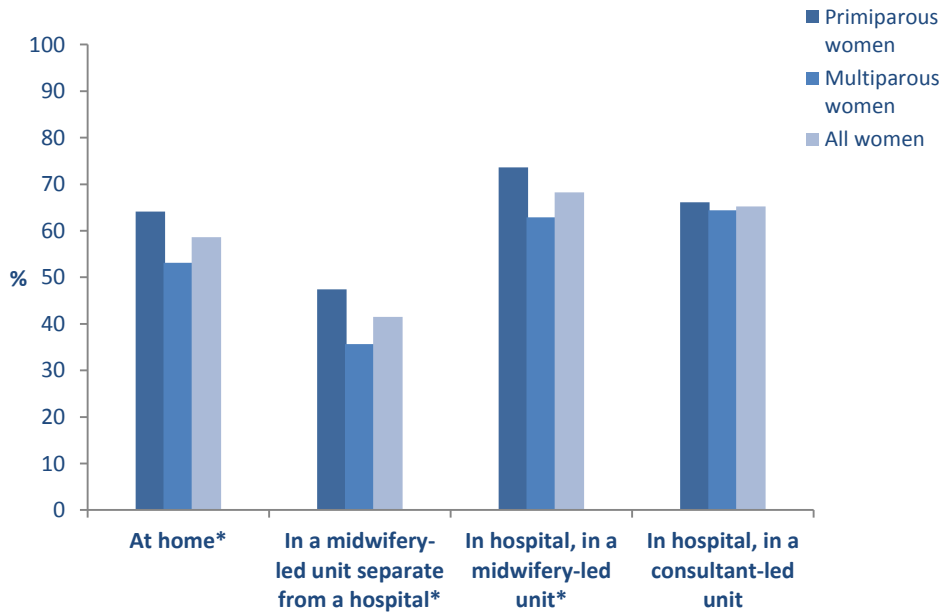


Table 13. Number of options for place of birth of which women were aware

Number of options*	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
1	587	26.7	832	38.0	1,478	32.7
2	423	19.2	435	19.9	881	19.5
3	515	23.4	390	17.8	921	20.4
4	640	29.1	476	21.8	1,138	25.2
No choice	36	1.6	56	2.6	97	2.2

** Difference by parity p < 0.01*

Not all options are available to all women and on average women reported 2.3 (median 2) options. Overall, a quarter of women (25%) were aware of having all four options, fewer had two (19%) or three options (20%) and a third of women reported only being aware of one option (33%) for place of birth (Table 13). Women who had not previously given birth were significantly less likely to report having had only one option (27% compared with 38%) and more likely to report being aware of three or four options.

Women were also asked if they had been given enough information by either a midwife or a doctor to help them decide where to have their baby. A large proportion of women felt they were given enough information (70%) to help with their decision, with more first-time mothers reporting this (73% compared with 68%). One in ten women (10%) did not have enough information and some women, reported that they did not need this information (20%).

In the 2013 survey by the CQC, 55% of women reported definitely having enough information and a further 29% agreed to some extent[20]. As women's choices for planned place of birth may be influenced by the availability of epidural anaesthesia, in the survey they were also asked if they were aware that epidurals for pain relief were only available in hospitals with a 24-hour epidural service. More than half of the respondents (57%) were not aware of this issue.

Choices about place of birth could be made at different times by individual women. When asked about timing of the decision about place of birth some women (18% of the sample) reported that they did not have a choice. However, most made their choice in early pregnancy (60%), fewer did so during

[20] Care Quality Commission. National NHS patient survey programme. Survey of women's experiences of maternity services 2013. Full national results with 2010 comparisons**.** Available at: http://www.cqc.org.uk/content/maternity-services-survey-2013.

mid or late pregnancy (20%) and only a small proportion made the decision at the start of labour (2%) (Table 14).

Table 14. Women's timing in relation to choosing place of birth

Timing*	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Early pregnancy	1,271	57.8	1,392	63.42	2,731	60.4
Mid-pregnancy	343	15.6	194	8.84	556	12.3
Late pregnancy	191	8.7	123	5.6	324	7.2
Start of labour	40	1.8	42	1.91	85	1.9
Had no choice	356	16.2	444	20.2	824	18.2

** Difference by parity $p < 0.01$*

Women who had given birth before tended to make their choices earlier. Those who had no choice on this point were significantly more likely to be less educated women, from a BME group, and either less than 20 years or over 40 years of age, with a history of health problems or a more complex pregnancy.

4. Care during labour and birth

Women were asked about their care during labour and birth. This included questions about early labour, interventions, and details of the staff caring for them and perceptions of that care. Clinical aspects of care on which data were collected included monitoring, methods of pain relief and induction, position for birth, type of delivery, episiotomy, perineal damage and repair.

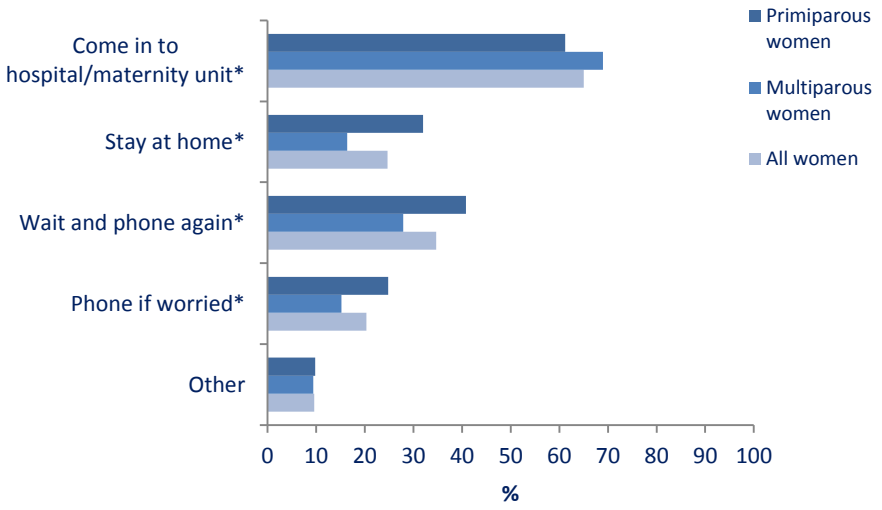
4.1 Care in early labour

Women were asked if they had been in labour prior to the birth, as opposed to having a planned caesarean section prior to labour. Most women had a labour (85%) and were able to answer several questions about their care at this time. Specifically, they were asked if at the start of labour they had contacted a midwife or the hospital and if they had received appropriate advice and support. Of the 77% of women who did contact a midwife or the hospital, most (84%) felt they had received

appropriate advice and support. However, 16% did not feel they were given the advice and support needed at this time. The figures from the 2013 CQC survey were very similar[21].

A question was also asked about what women were advised to do after contacting the maternity service. Most (60%) were told to come into the hospital or maternity unit. First-time mothers were more likely to be told to stay at home, to wait and phone again, or to phone again if they were worried (Figure 8).

Figure 8. Responses to women in early labour contacting a midwife or the hospital *(*parity differences)*



4.2 Interventions

During labour and birth women may experience a wide range of interventions, particularly when the labour is long and there are concerns about the health of the woman and her baby.

Induction of labour

For most women who laboured, this started naturally (59%), with little difference by parity. A quarter of women in both groups were given one or more membrane sweeps (28% of primiparous women and 26% of multiparous women); however, more first-time mothers had a vaginal gel or pessary (24% compared with 18%), a drip to induce labour (18% compared with 11%) or an amniotomy (17% compared with 15%). Of the women who had their labour induced, 45% felt that they did have a choice in the matter, with multiparous women more likely to report having a choice (68% compared to 63% of primiparous women).

[21] Care Quality Commission. National NHS patient survey programme. Survey of women's experiences of maternity services 2013. Full national results with 2010 comparisons. Available at: http://www.cqc.org.uk/content/maternity-services-survey-2013.

Overall, a third of women who laboured had their labour augmented, 38% by amniotomy, 32% by having a drip set up. First-time mothers were significantly more likely to have these interventions than mothers who had previously given birth.

Monitoring

Of the women who laboured, 5% reported no monitoring at all, 11% had only occasional checks by pinard and 29% reported that a sonicaid was used. The most common form of monitoring during labour was by using a belt around the abdomen continuously and this was experienced by 46**%** of women for some or all of their labour. Continuous monitoring was more often used with women who had not previously given birth. A relatively small proportion of all labours (13%) involved continuous monitoring with a scalp clip attached to the baby's head.

Pain relief

A range of methods were reported to have been used for pain relief during labour. Most women who laboured used natural methods such as breathing and massage at some time (57%) and a higher proportion used gas and air (entonox) (80%). Nearly a third used water or a birthing pool (31%). A quarter of women who laboured reported having pethidine or a similar analgesic for pain relief (25%) and slightly more (29%) reported having an epidural. No information is available about the type of epidural anaesthesia. First-time mothers were more likely to use all types of pain relief but particularly pethidine and epidurals. Overall, less than 2% of women did not indicate using any methods of pain relief, a higher proportion in multiparous women than primiparous women.

Women were also asked if they had received the pain relief they wanted and when they wanted. Nearly two-thirds (63%) definitely received the type of pain relief they wanted, for a quarter (28%) this was only to some extent and a small proportion (9%) did not get the pain relief they wanted. With regard to timing, three-quarters of women (74%) received pain relief in what they perceived to be a timely way.

Place of birth

For birth, half of the respondents reported delivering in a midwife-led unit in hospital (50%), with a substantial proportion (45%) reporting having consultant-led care and smaller proportions having care in a midwife-led unit or birth centre separate from hospital (3.6%). A total of 1% of women reported giving birth outside hospital or birth centre.

Women were asked whether the place where they had given birth was in the area or trust where they had received antenatal care and for almost all women (87%) this was the case. The 13% of women

crossing trust boundaries were slightly more likely to give birth in a consultant-led unit (48% compared with 45%).

Mode of birth

Most women had a vaginal birth (59%); however, over a third of women (41%) had an instrumental delivery of some kind, including just over a quarter (26%) who had a caesarean birth (Table 15). Women who were first-time mothers were more likely to have an instrumental vaginal birth (25% compared with 5%) or a caesarean (28%) compared with women who had given birth before (25%). Overall, 27.7% of women gave birth sitting or lying with their legs in supports or stirrups.

Comparisons with previous maternity surveys would suggest that the caesarean rate is gradually rising among maternity survey respondents: 22.3% in 2006, 24.8% in 2010 survey, having been 17% in 1995 Audit Commission Survey[22].

The most recent data from the Hospital Episode System (2012—13) suggests that 25% of women were delivered by caesarean at that time[23]. This is comparable to data presented here.

Table 15. Mode of delivery

Type of delivery*	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Normal (vaginal)	1,035	47.4	1,536	70.4	2,636	58.7
Forceps	314	14.4	62	2.8	392	8.7
Ventouse	228	10.4	37	1.7	273	6.1
Caesarean section	607	27.8	547	25.1	1,187	26.4

** Difference by parity p < 0.01*

Just over half of caesarean sections were as a consequence of unforeseen problems in labour (54%). However, a substantial proportion were planned and carried out before labour (39%) and a smaller proportion planned but carried out after labour had started (7%) (Table 16). A clear relationship with parity is evident, with women giving birth for the first time being considerably more likely to have a caesarean following unforeseen problems in labour (74% compared with 54%). More than one reason could be given for a caesarean. The most common were fetal distress (28%), failure to progress (28%), previous caesarean (27%), breech presentation (16%), and concern about the mother's health (16%).

[22] Garcia et al. First class delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.
[23] Health and Social Care Information Centre 2013, available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=13418&q=birth+parity&sort=Relevance&size=10&page=1&area=both#top Table 1d)

A total of 9% of women having a caesarean indicated that they had wished their baby to be born this way, but for only 1.4% was this the sole reason for the section.

Table 16. Proportion of women experiencing different types of caesarean section.

Type of caesarean*	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Planned and carried out before labour started	110	20.3	280	60.9	397	38.7
Planned, but carried out after labour started	29	5.5	41	8.9	73	7.1
Due to unforeseen problem during labour	402	74.3	139	30.2	557	54.2

** Difference by parity p<0.01*

Women who had previously delivered by caesarean were significantly more likely to do so again (71% compared to 13% in other multiparous women) and it was also significantly more likely to be a planned caesarean rather than due to unforeseen problems in labour (68% compared to 38% in other multiparous women).

Women who had a caesarean birth were also asked if other methods of delivery had been tried. This was most likely for women where unforeseen problems had arisen during labour and attempts to deliver the baby were reported using ventouse (9%) and forceps (10%) for this group of women.

Of those women who had a caesarean birth, almost all (93%) received epidural or spinal anaesthesia and for almost all of the 7% of women having a general anaesthetic, this was associated with a caesarean following unforeseen problems arising during labour.

Perineal trauma

Perineal trauma and repair are important aspects of labour and childbirth that affect women in the short and longer term. In intervening to assist with the birth of the baby an episiotomy may be performed. The overall rate for this intervention as reported for the women who had vaginal births was 26% (4% reported being unsure). A small number of women who went on to have a caesarean had also been given an episiotomy. For instrumental births it was used relatively routinely (90% for forceps and 79% for ventouse). Minor tears not requiring stitches were reported by 11% of women. However, tears that needed stitches were reported by a larger proportion of women (44%), with a further 7% having a serious third or fourth degree tear. Serious tears were most common in women having a forceps delivery (15%).

Cord clamping

All women were asked about cord clamping and when this had taken place. For 61% the cord was clamped and cut immediately after the birth. For 39% of women this took place after a minute or more. A delay was more common among women having a normal vaginal birth, and for women who had given birth previously.

Transfers during labour

Some women who plan to give birth in one location are transferred during labour for medical reasons or for access to an epidural anaesthetic service. A total of 11% of women reported that they were transferred, although some of these transfers were from an alongside midwifery unit to an obstetric unit in the same hospital. A total of 5% of women (half of all transfers) were between hospitals, between birth centre and hospital or between home and hospital, travelling an average distance of 12 miles (median 8 miles), with one travelling 200 miles, in possible preterm labour.

Women were also asked about the reasons for transfer. Of those who had been transferred, 39% indicated that staff were concerned about the baby, 38% about slow progress of labour, 19% of women wished to have an epidural for pain relief, and for 18% there were concerns about the woman's own health. Transfers were much more common among first-time mothers (16% compared to 6% in women who had given birth before), particularly where there was slow progress in labour or the woman wished to have an epidural.

4.3 Choice in labour and birth

Women had some choice about place of birth, as described in section 3.9 and questions were also asked about other aspects of choice and autonomy during labour and birth. Nearly two-thirds of the women (65%) who experienced some form of induction felt they had a choice about whether or not their labour would be induced.

More than half of those who had a labour reported that they had been able to move around and choose the position that made them most comfortable most of the time (52%) and a further proportion (29%) were able to do so some of the time.

Women were asked about where and in what position they gave birth reflecting both choice and needs. Of women having a vaginal birth, most gave birth on a bed (82%), with women who had instrumental vaginal births being more likely to have done so. Of those who had a normal vaginal birth, a small proportion gave birth on a mat or mattress on the floor (4%), in a pool (12%), and some (2%) used a birthing stool or other furniture allowing an upright posture.

During the birth itself, a total of 19% of women who had a vaginal birth adopted a position which allowed them to give birth squatting, kneeling or standing, some were sitting without support (15%) and a few more (21%) gave birth sitting with legs supported by midwife or partner. A total of 16% gave birth while lying flat and a small proportion on their side (7%). Women who needed instrumental assistance nearly always gave birth sitting or lying with their legs supported by supports or stirrups (93% of forceps and 88% of ventouse deliveries).

Half of the women having a caesarean (52%) felt they were definitely involved in the decision-making around their caesarean birth, particularly where the procedure was planned. Where the caesarean followed unforeseen problems during labour, women were less likely to say they were involved, nevertheless more than two-thirds (72%) felt that they were involved at least to some extent in the decisions made.

Women were asked if at any time during labour and birth they had felt pressure from a health professional to have a particular procedure or type of birth. Few women (7%) reported feeling pressure to have their baby in a consultant-led unit, to have an epidural for pain relief (4%) or to have a caesarean birth (6%); slightly more (13%) felt pressure to have continuous fetal monitoring, to give birth on a bed (10%) or, excluding those who had a planned caesarean, to have their labour induced (9%).

4.4 The baby and early contact

A small proportion of babies were preterm, being born before 37 weeks' gestation (6.7%), and a similar proportion (7.5%) were born weighing less than 2,500 grams. For some of these babies care in specialist facilities would have been planned prior to birth.

Most of the infants delivered by caesarean section were term infants (90%), with some (7%) born between 33 and 36 weeks and a very small proportion born earlier than this (3%).

A total of 1.6% of the respondents had given birth to more than one baby, 72 to twins and 1 to triplets.

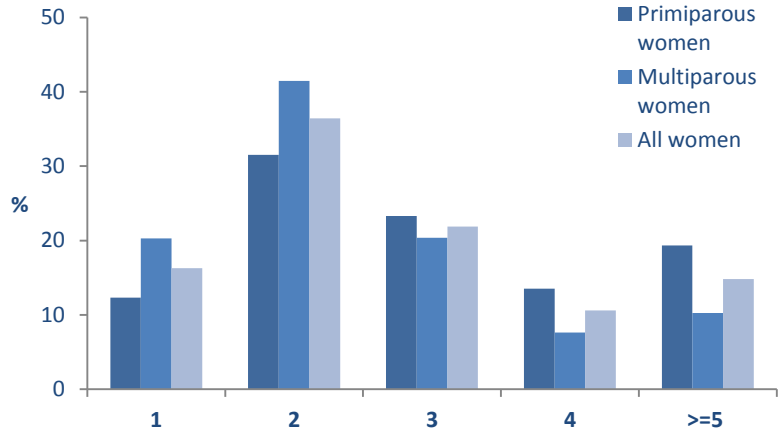
Contact with their infants soon after birth is thought to be reassuring and beneficial for women and their babies and supportive of successful breastfeeding. Women in the study were asked about holding their baby, having skin-to-skin contact and breastfeeding their baby shortly after the birth. Most women (89%) held their baby, had skin-to-skin contact (85%) and put their baby to the breast (74%) soon after the birth. First-time mothers were more likely to hold and have skin-to-skin contact with their baby than women who had previously given birth and were more likely to breastfeed at this time. Small proportions of women were not offered the possibility of these activities (2—5%), some

were not well enough and very small proportions did not wish to have this kind of contact. Women whose baby was admitted to a neonatal unit were much less likely to hold, have skin-to-skin contact or to breastfeed at this time.

4.5 The staff providing care during labour and birth

Concern about both continuity and the importance of 'one-to-one' care during labour[24] led to questions being included in the survey about the numbers of midwifery staff who had looked after women during their labour and birth (Figure 9) and about having previously met the midwives.

Figure 9. Number of midwives providing care during labour and birth



Relatively few labouring women had one midwife caring for them during labour (16%), a quarter had at least four midwives (26%) and 15% were cared for by five and more different midwives. Achieving continuity during labour care and providing one-to-one woman-midwife ratios can be difficult given the individual and variable nature of labour and birth. A majority (58%) of women having a normal vaginal birth had just one or two midwives. However, first-time mothers were significantly more likely to have greater numbers of midwives, as did women who had longer labours and those with more complex deliveries. Among women whose labours were 4 hours or less compared to 12 hours or more, 15% and 38% respectively were cared for by four or more midwives**.** Two-thirds of the women having a forceps delivery (67%), and slightly fewer with a ventouse delivery (60%), had three or four midwives caring for them over the course of their labour.

Women were also asked if they had met any of the midwives before they went into labour. While a very small proportion had previously met all the midwives providing care in labour (3%), more had met some of them (12%), however a high proportion (85%) said they had not met any of them before

[24] Hodnett et al. Continuous support for women during childbirth. *Cochrane Database Syst Rev*. 2013; 7:CD003766.

this point in time. First-time mothers were slightly less likely to have previously met any of the midwives caring for them during labour (13% compared with 16%). Women who delivered at home or in a birth centre were significantly more likely to have met at least some of the midwives previously.

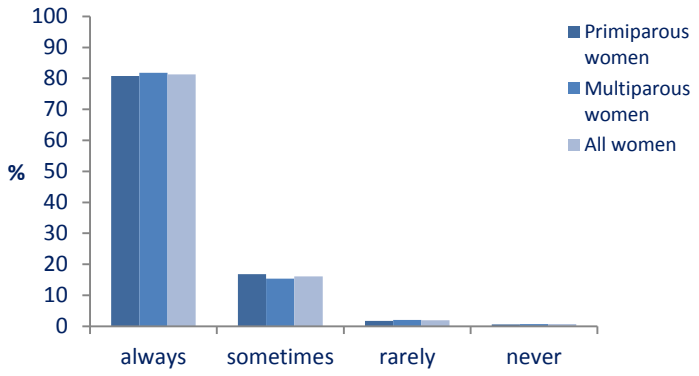
Over half of women (59%) reported that a midwife delivered their baby; 42% of deliveries were undertaken by a doctor, and for some women (4%) the responsibility was shared between other professional groups.

4.6 Perceptions of care during labour and birth

Women were asked a range of questions about the way in which they were cared for during their labour and birth: about trust and confidence, communication with staff, being treated with kindness and respect and about being left alone at a time when it worried them.

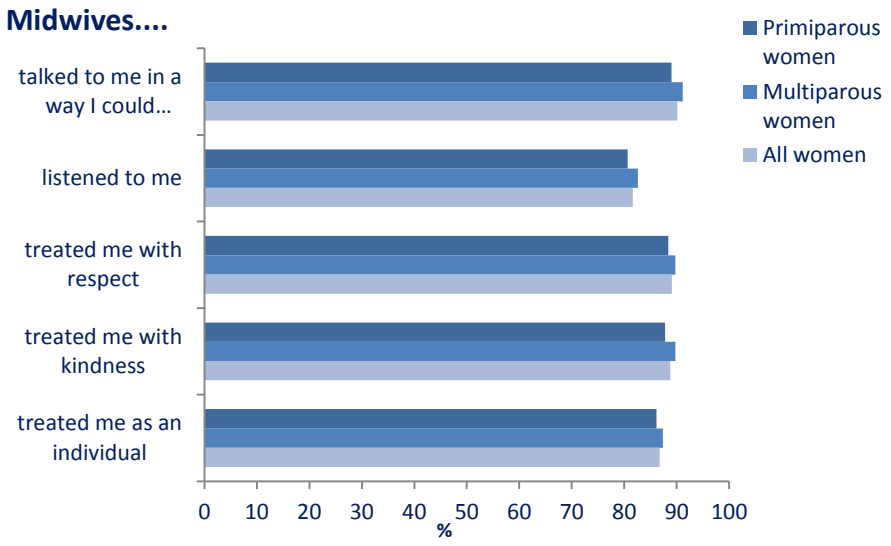
Having trust and confidence in the staff during labour and birth is critical to women's perceptions of care and may influence their choices and decisions in the future, as well as how they feel about themselves. Over 80% of women always felt they had confidence and trust in the staff caring for them at this time, a further 16% said they sometimes felt this and small proportions (3%) reported this as 'rarely' or 'never' (Figure 10). The proportions were similar for first-time mothers and women who had given birth previously.

Figure 10. Proportions of women having confidence and trust in the staff caring for them during labour and birth



Similar questions to those used about interpersonal aspects of interaction with midwifery and medical staff during pregnancy were asked about care during labour and birth. Almost all women reported that midwives talked to them in a way they could understand (90%), treated them with respect (89%) and with kindness (89%) and as an individual (87%) (Figure 11a). They were slightly less likely to say they were listened to by midwives (82%).

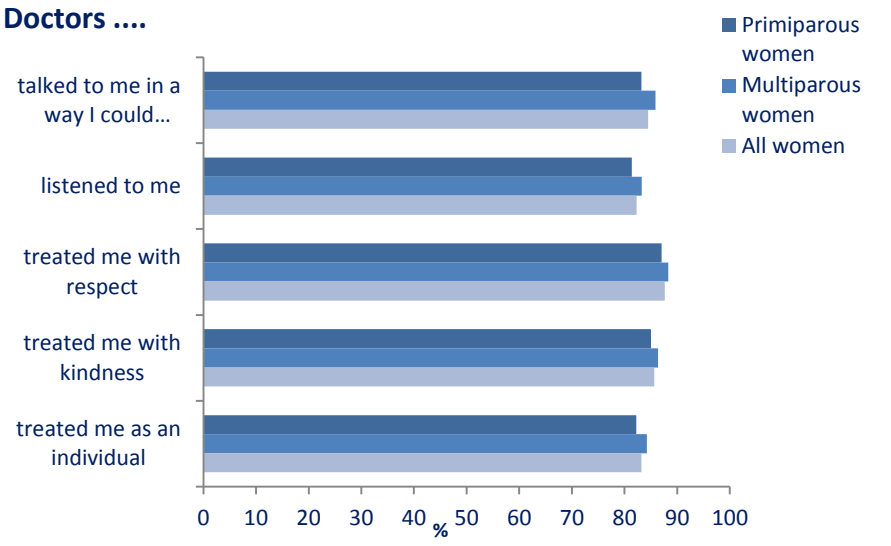
Figure 11a. Women's perceptions of midwifery care during labour and birth



Perceptions of interpersonal aspects of care in relation to the medical staff were similarly positive (Figure 11b), with many indicating that doctors talked to them in a way they could understand (84%), treated them with respect (88%) and with kindness (86%), and as with care provided by midwives, were least likely to report medical staff as always listening to women (82%).

Small proportions of women (1—3%) reported that for both groups of staff they were not treated well regarding all the aspects of care listed.

Figure 11b Women's perceptions of medical care during labour and birth



Support in labour is a critical aspect of the care provided. While being left alone in labour or shortly after the birth may allow women and their partners or birth companions to be together and have time

with their new baby, being left alone may also cause concern to women at what is an important time. Women were thus asked about labour and the time immediately after the birth and if they and/or their husband, partner or companion were left alone at a time when it had worried them.

While four out of five women were not left alone and worried at all, some were left alone at a time when it worried them during labour (13%) and a few were left alone and worried shortly after the birth (8%). First-time mothers were no more likely to report being left alone and worried than women who had previously given birth. An association was found with length of labour and being worried and left alone at this time, with women having longer labours being more likely to report this experience. However, for all types of vaginal birth the proportion reporting this was similar. In contrast, women having a planned caesarean were much less likely to report being left alone and worried (5%), while those having an unplanned caesarean were somewhat more likely to report this (23%) than women having a vaginal birth.

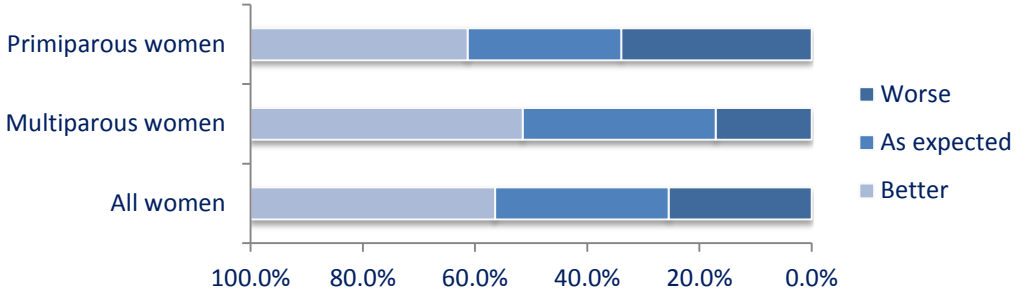
In 2014 those women who reported being left alone and worried were asked two additional questions: were they told this would happen and were they given an explanation. Less than half had been told they would be left alone (42%) and slightly more (45%) were given an explanation. Women who had not previously given birth were no more likely to say they were not told or given an explanation compared with women who had given birth previously.

Women were also asked about being involved in decisions about their labour and birth care. Most (67%) reported always being involved, a further proportion (25%) reported sometimes being involved and a few women reported not being involved at all (5%). Very few (1%) did not need or wish to be involved in decision-making at this time. Women having their first baby were less likely to say they were always involved in such decision-making. These figures are very similar to those reported from the 2013 CQC survey[25].

Women bring to labour and birth both expectations and experience, and parity is likely to make a difference. Towards the end of the survey section on labour and birth they were asked a general question about their labour and birth and whether things had gone better or worse than they had expected.

[25] Care Quality Commission. National NHS patient survey programme. Survey of women's experiences of maternity services 2013. Full national results with 2010 comparisons. Available at: http://www.cqc.org.uk/content/maternity-services-survey-2013.

Figure 12. Women's perceptions of their labour and birth in relation to their expectations



Around a third (31%) of women reported that labour and birth went more or less as expected, a quarter worse (26%) and just under half (44%) better than they had expected (Figure 12). However, significantly more women giving birth for the first time rated the experience as worse than expected (34% compared with 17% in women who had given birth before).

5. Postnatal Care

Postnatal care takes place in a number of locations, in hospital, at home and in primary care and is the area of perinatal care about which women are most critical. Guidance has aimed to identify the essential core of routine care that every women and her baby should receive in the first 6—8 weeks after birth, and to identify when additional care may be needed[26].

5.1 Care in hospital after the birth

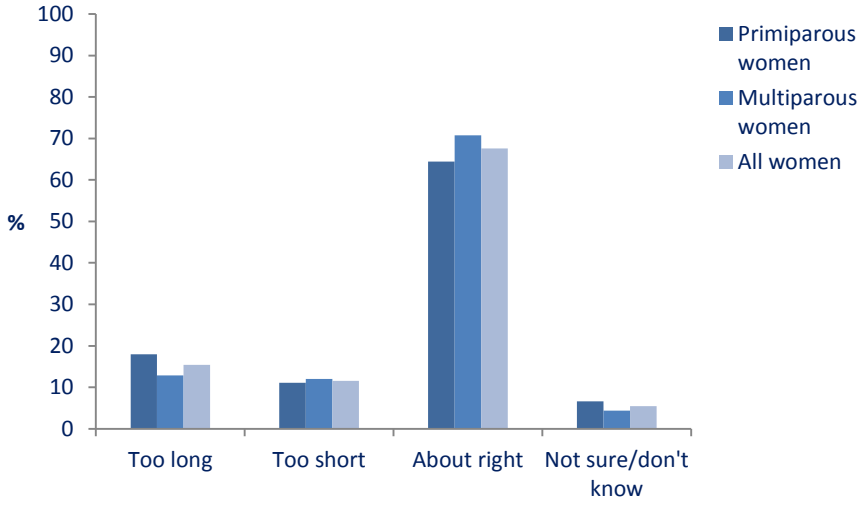
The postnatal period is one during which women recover from childbirth, establish infant feeding and begin to get to know their baby. For most women this starts in hospital. However, the length of time that women stay in hospital varies and it was generally shorter in 2014 than in 2010. On average in 2014 this was 2.2 days (median 1.5). Women having their first baby on average stayed for a slightly longer period (mean 2.6, median 2 days) compared with women who had previously given birth (mean 1.8, median 1 day). Not unexpectedly, women who had instrumental or operative deliveries had

[26] National Institute for Health and Care Excellence. Postnatal care. NICE clinical guideline 37. Available at: https://www.nice.org.uk/guidance/cg37/resources/guidance-postnatal-care-pdf

significantly longer postnatal stays in hospital, with a mean of 3.3 days for women who had caesarean births, compared with a mean of 1.6 days for women having a normal vaginal birth.

Women's views about their length of postnatal hospital stay varied (Figure 13).

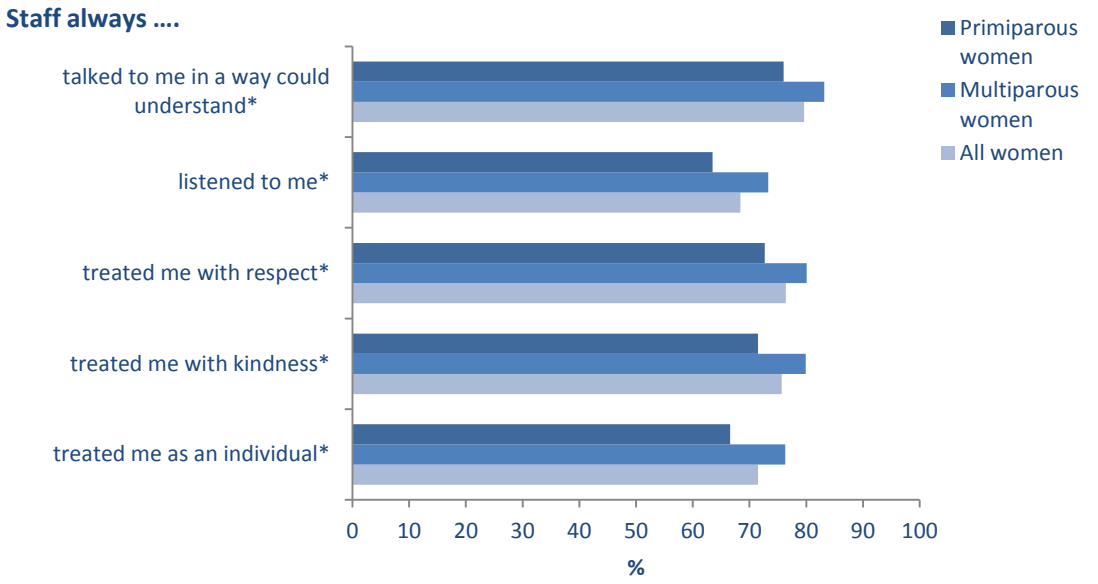
Figure 13. Women's views about the length of their postnatal hospital stay



Most (68%) found it 'about right', for some (12%) it was too short, slightly more women (15%) found it 'too long' and a small proportion (6%) were not sure. First-time mothers were significantly more likely to describe their stay as too long (18% compared with 13%) and women who had previously given birth more often described their stay as 'about right' (71% compared with 65%).

As with earlier sections of the survey, women were asked about the quality of interpersonal and communication aspects of their postnatal care. Most women felt that staff always talked to them in a way they could understand (79%), with respect (76%) and kindness (75%), 71% always felt treated as an individual and 68% always felt listened to (Figure 14). However, women were more critical of this aspect of their care than of other phases of maternity care, particularly in relation to always being listened to and treated as an individual. Very small proportions of women were completely negative on these aspects of care (1—5%), feeling that they were not treated well at all. Women having their first baby were more critical about their interpersonal care than those who had given birth previously, as was found with some aspects of their experience of antenatal and labour and birth care.

Figure 14. Women's perceptions of maternity unit or hospital unit staff postnatal care *(*parity differences)*



5.2 Postnatal care at home

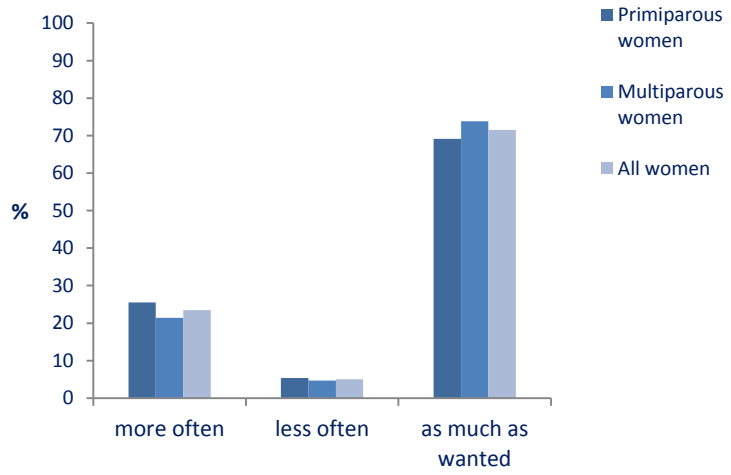
After discharge home around three-quarters of women (77%) had the name and telephone number of a 'named' midwife or health visitor they could contact, however a total of 17% indicated that they did not have this information and 6% were unsure, with no difference by parity. Nevertheless, 97% of women were visited at home by a midwife, with a few women visiting a midwife clinic (1.9%) and a very small proportion of women reported that they had not been offered a home visit at all (0.4%).

On average, women saw a midwife at home 3.1 times (median 3) with no difference between the numbers of visits to women with their first baby and those who had previously given birth. Contact with maternity support workers was variable and they were seen on average less than once (0.5 times) and most women did not see them at all (median 0). Combining the data on home visits by a midwife and visits by a maternity support worker, the mean number of postnatal home visits was 3.6 (median 3). Phone contact with either a midwife or maternity support worker can provide further support and information. This occurred on an average of only one occasion, but most women did not contact midwifery staff that way (median 0).

Questions that reflected continuity were also asked: the numbers of different midwives who visited and whether the women had met them before. A third of women saw three or more different midwives (32%), more than a third saw two midwives (40%) and a quarter (25%) saw just one midwife. A few women did not receive a home visit at all (3%). A total of 60% of women had previously met some or all of the midwives who visited, although 40% had met none of them before this time.

Women were asked about their views of the number of postnatal visits they had received. Most women thought they had sufficient home visits from midwives (Figure 15). Nearly a quarter (23%) would have liked visits more often, most were satisfied (71%) and a small proportion (5%) would have liked fewer visits. First-time mothers were significantly more likely to say they would have liked more visits (27% compared with 19%) and less likely to say they had received as many as they had wanted (68% compared with 75%).

Figure 15. Proportions of women with different views about how frequently they saw a midwife for postnatal home visits



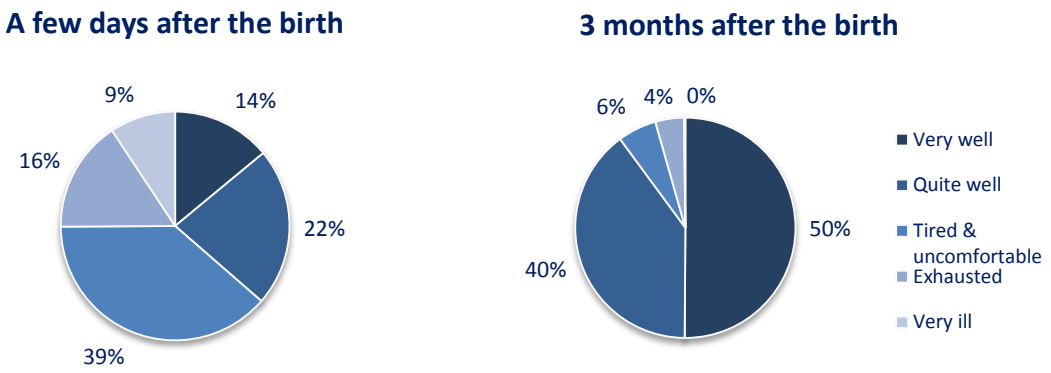
The timing of the last contact with a midwife or maternity support worker may reflect flexibility in the provision of postnatal help and support. On average, first-time mothers were seen up to 26 days (median 16) following the birth, which was slightly more than the 21 days for the experienced mothers (median 14 days), although contact for some women was considerably longer than this.

Women were asked if they had trust and confidence in the midwives they saw after going home. Over two-thirds of women (69%) always had trust in the midwives making postnatal visits and a further proportion (27%) sometimes did so. A small proportion (4%) reported rarely or never having trust and confidence in midwives making postnatal visits.

5.3 Health and wellbeing

Physical and mental health after childbirth are important aspects of maternal wellbeing in the perinatal period. The surveyed women were asked about their health and wellbeing in the first few days after the birth and then at the time of the survey.

Figure 16. Women's health shortly after the birth and at three months



Women's health varied considerably in the early days after the birth (Figure 16.) However, almost all women (89%) described themselves as very well or quite well at the time of the survey, three months after the birth. Nevertheless, some women were still experiencing the effects and consequences of childbirth and did not feel themselves to be in good health at this time.

Women were asked about the postnatal checks carried out by GPs or family doctors at 4—8 weeks following childbirth. A large proportion of women reported having these (90%), with little difference between first-time mothers and women who had previously given birth. Of those who did not have a check, a small proportion did not wish to do so (13%) or did not have one for other reasons (27%) including having a hospital check or their baby still being in hospital. However, some women (60%) reported that a postnatal check of their health had not been offered at all. In open text some reported that the check was difficult to arrange and it was more informal that they had anticipated.

Many women (48%) had talked to a health professional about what happened during their labour and birth. Of these, 23% had talked to a doctor or midwife present during the labour or birth; 47% to a doctor or midwife who was not present for the labour or birth; and 39% to their GP and 67% to their health visitor. Of those who had not talked over their labour and birth, a third (36%) would have liked to have done so. Higher proportions of women talked to health professionals after birth about their experiences following forceps delivery and unplanned caesarean delivery (58%) compared to women who had a normal delivery (45%). Similar patterns were apparent among women who had not talked to anyone but would have liked to have done so.

Several questions explicitly related to mental health. Women were asked if they had been asked questions about their emotional and mental health since having their baby. Almost 90% of women reported that they had been asked. Women who were multiparous, aged over 40 years or less than 20 years, or from a BME group were significantly less likely to have been asked about their mental

health. Three months after the birth, small proportions of women reported experiencing depression (3%) and anxiety (6%), although reports were higher at one month postpartum. If women reported that they had experienced a mental health problem since the birth of their baby, they were also asked about any support, advice and treatment they had received. Of those women self-identifying with a problem 63% had received support, 64% advice and 49% had received treatment. The treatment included medication, counselling and cognitive behaviour therapy.

5.4 Support for infant feeding

An important component of postnatal care in hospital and at home is the provision of support for infant feeding. However, in anticipation, pregnancy is a time when feeding is commonly discussed and plans are made for the method of infant feeding to be used. During their pregnancy just over two-thirds of women had planned to exclusively breastfeed (68%). This was more common among women who were first-time mothers (73% compared with 63% in multiparous women), although the same proportion of both groups (80%) reported that their midwife had discussed infant feeding with them during pregnancy.

Almost all women had tried to breastfeed their baby at least once (87%). During the first few days 60% of women reported feeding their baby breast milk exclusively, a further 22% used breast milk and formula milk. At the time of the survey when babies were more than three months old, the rate for exclusive breastfeeding was 34%, with a further 15% of mothers partially breastfeeding at this time. However, of the women who breastfed their baby, some (27%) did not do so for as long as they would have liked.

Women were also asked about the kind of help provided. While small proportions of women did not want advice, practical help or encouragement (2—4%) (Table 17), over 40% of women felt they were always given these and a further substantial proportion, 35—40% felt that they received these to some extent.

Women were asked about a range of possible sources of help and advice regarding infant feeding and could give multiple responses to the question (Figure 17). Some women reported not needing any help or advice at all, most often women who had given birth previously (16% compared with 3%).

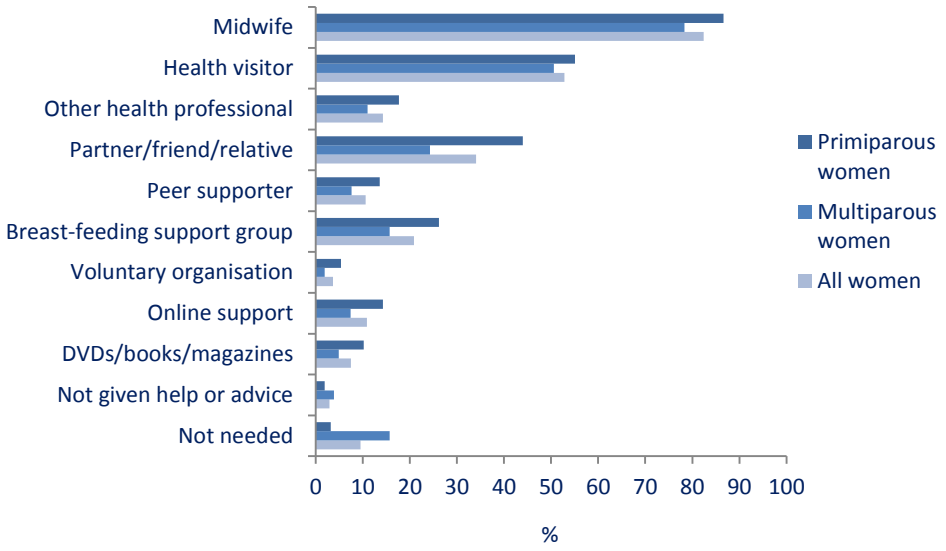
Table 17. Help with infant feeding from midwives and other health professionals providing care

	Primiparous women		Multiparous women		All women	
Consistent advice*	No.	%	No.	%	No.	%
yes, always	871	40.1	987	45.6	1,900	42.7
yes, generally	802	36.9	812	37.5	1,658	37.3
no	483	22.2	290	13.5	794	17.9
didn't want this	15	0.7	77	3.6	93	2.1
Practical help*						
yes, always	904	41.6	925	43.0	1,868	42.2
yes, generally	919	42.3	774	35.9	1,743	39.3
no	319	14.7	319	14.8	653	14.7
didn't want this	29	1.3	135	6.3	186	3.7
Active support/encouragement*						
yes, always	1,009	46.6	1,029	47.8	2,087	47.2
yes, generally	814	37.6	772	35.9	1,624	36.7
no	320	14.8	258	12.0	593	13.4
didn't want this	23	1.1	93	4.3	117	2.6

** Difference by parity p < 0.01*

All the women responding were most likely to ask health professionals for help and advice in relation to infant feeding. However, more than a quarter (27%) of women would have liked more help with feeding their baby.

Figure 17. Sources of advice, support and information about infant feeding in the postnatal period

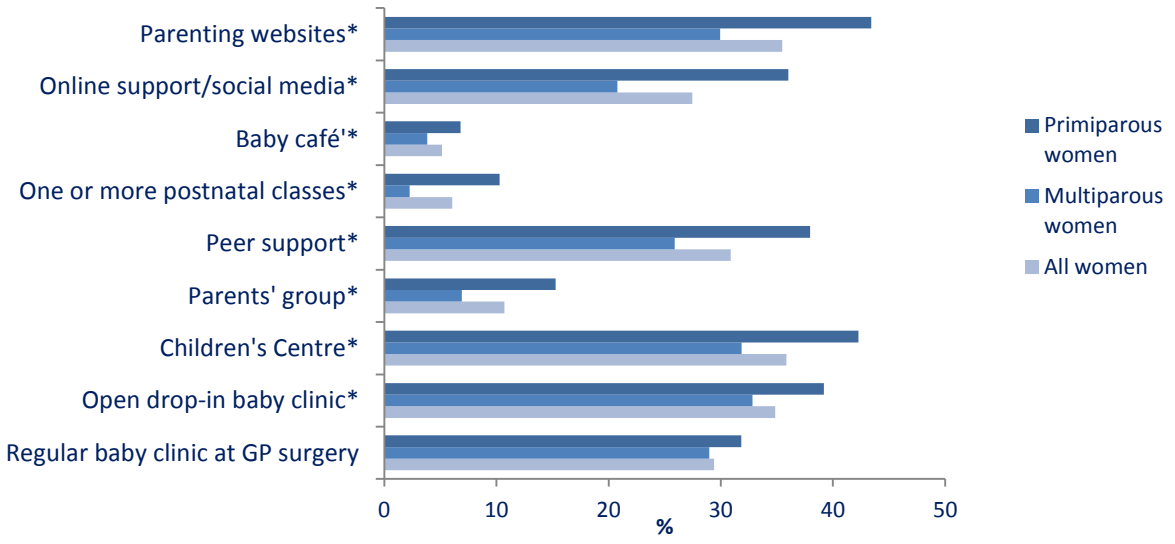


While health professionals were a key source of information, particularly for first-time mothers, at the same time this group were also more likely to use the diverse sources listed, including peer support (14% compared with 8% in multiparous women), voluntary organisations (5% compared with 2%), online support (14% compared with 7%), DVDs and written materials (10% compared with 5%), and breastfeeding support groups (26% compared with 16%), as well as family and friends (44% compared with 24%).

5.5 Sources of information and use of postnatal services

Women use a wide range of resources in the early months with a baby at home. Respondents were asked about their preferences for sources of advice, support and information in the broader context of continuing postnatal support and information, in addition to that available on infant feeding. Women were specifically asked about a range of different services that they had used (Figure 18), all of which were used more by first-time mothers. Women were able to use multiple responses in answering this question.

Figure 18. Proportions of women using different postnatal support services *(*parity differences)*



Apart from parenting websites, the services used most commonly were open drop-in baby clinics (36%) and Children's Centres (37%), which rely on NHS services. More than a third of women, particularly first-time mothers, used social media and online support as well as more direct peer support.

The kind of services women identified are sources of information and support about many topics, including infant care and development, breastfeeding and maternal health, in which women can engage directly with health professionals, user group postnatal supporters and with other women in a similar situation.

5.6 Babies needing specialist care

After birth, 13% of women had babies that needed specialist care and were admitted to a neonatal unit (NNU). Reasons for admission included preterm birth (33%), difficulties in breathing (31%), problems with feeding (13%), and for observation (27%). Other reasons for admission most commonly given were for infection, hypoglycaemia and jaundice, and less commonly conditions such as meconium aspiration and a range of congenital anomalies. Duration of stay in the NNU averaged 10.8 days (median 4 days) and varied from 0 to 150 days. A small proportion of women (2%) had babies who were still in an NNU at the time of the survey.

The neonatal unit is a complex and usually unfamiliar environment for parents. The need for contact with their baby and for information about their baby's care dominate their experience at this time. Women were asked a number of questions about their experience of neonatal care. Only around two-thirds of women (66%) reported that the equipment and procedures were always explained to them, 22% that this happened sometimes and 12% that this rarely or never happened. They were also asked if their baby's problems were discussed with them, with more (75%) reporting that this always occurred, 17% that this happened sometimes and 7% that this happened rarely or never.

Most mothers whose baby had been admitted to neonatal care had been able to touch their baby at birth (67%), a further proportion (25%) within a day later, and a small proportion were only able to do so after that. Holding their baby followed a similar pattern with two-thirds of women (62%) doing so at birth, 21% within a day later and 17% not being able to hold their baby until their baby was several days old or later.

A marker for NNUs in supporting the family concerns parents being able to stay overnight while their baby is in the NNU[27]. Thus women were asked if, during their baby's stay, they had stayed in the hospital overnight after they themselves had been discharged home. Nearly half the women (49%) had stayed overnight, with an average stay of 5.5 nights (median 4).

[27] Redshaw and Hamilton. Family centred care? Facilities, information and support for parents in UK neonatal units. *Arch Dis Child Fetal Neonat Ed* 2010; 94:F260-F264.

6. Father and Partner engagement

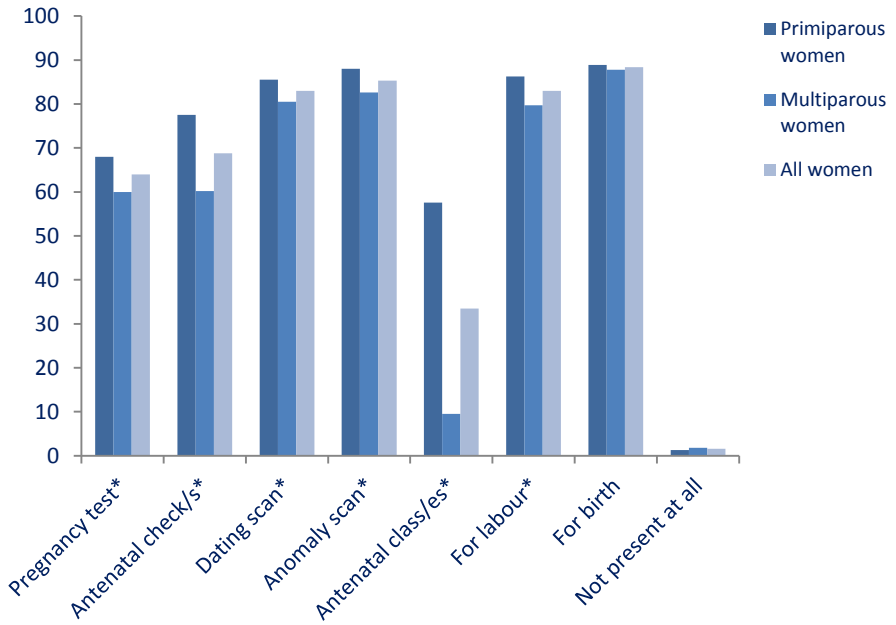
Fathers and partners have an important role in supporting women through pregnancy, birth and afterwards. In 2010 for the first time, a section about fathers and partners was included in the survey. A similar series of questions was used in 2014 covering reactions to the pregnancy, presence at key events during pregnancy, labour and birth, and involvement in caring for the baby afterwards.

6.1 During pregnancy, birth and afterwards

Most women reported that their partners were positive about the pregnancy when they found out (83%) and a small proportion had mixed feelings (14%). A further very small proportion was unhappy or had no particular feelings (3%) and a small number were altogether unaware of the pregnancy (0.2%). Most of the partners were men; however, 16 women (0.4%) reported having a same sex partner. A total of 13.2% of women were living as single parents at the time of the study, a quarter of whom (22.8%) shared accommodation with other family members.

Substantial proportions of partners were engaged in the pregnancy, labour and birth as reflected in their presence throughout pregnancy and childbirth (Figure 19).

Figure 19. Father or partner present for specific aspects of pregnancy and birth *(*parity differences)*



Over half (63%) were present when the pregnancy was confirmed and for one or more antenatal checks (68%) and a third for antenatal classes (33%). Almost all partners were present for the early dating scan (82%) and the anomaly or '20 week' scan (84%) when perhaps the direct evidence of the baby's presence and development is something that can be more obviously appreciated and shared. Involvement generally increased through the pregnancy, irrespective of parity, but higher proportions of partners were involved when this was the women's first baby.

Overall, for most women their partner was present for labour (82%) and for birth (87%). However, individual women may have a preference for having someone else rather than their partner present during labour and birth. For women from some ethnic groups this may also be more culturally appropriate. There were significant differences between some groups on this point: having a partner present during labour was most common for White women (85%) and less so for Asian women (75%) and Black women (60%). Similarly for birth, partner presence was greater for White women (90% compared with 79% for Asian women and 69% for Black women).

A question was specifically asked about partner involvement in accessing information about pregnancy and birth and in decision-making at this time. A third or more of partners were reported to have sought out information about pregnancy (43%) and about labour and birth (41%), and more than half participated in making decisions with regard to antenatal screening (56%) and those required during labour (50%). Significant differences by parity showed that on all these points, women who had not given birth before were more likely to have partners who were engaged in information-seeking.

Partners have a valuable support role to play during pregnancy, labour and birth, and after the baby is born. During labour particularly, they may function as advocates for their partner. Effective communication at this time is critical to a sense of wellbeing and, in a practical way, can enable women's needs to be better recognised. Responses to a structured survey question indicate that three-quarters or more of women reported that midwives and doctors communicated with their partners 'very well' or 'quite well' during pregnancy (84%). The most positive responses (91%) were about labour and birth, reflecting good communication with partners at this time, with fewer positive responses regarding communication in the postnatal period (79%).

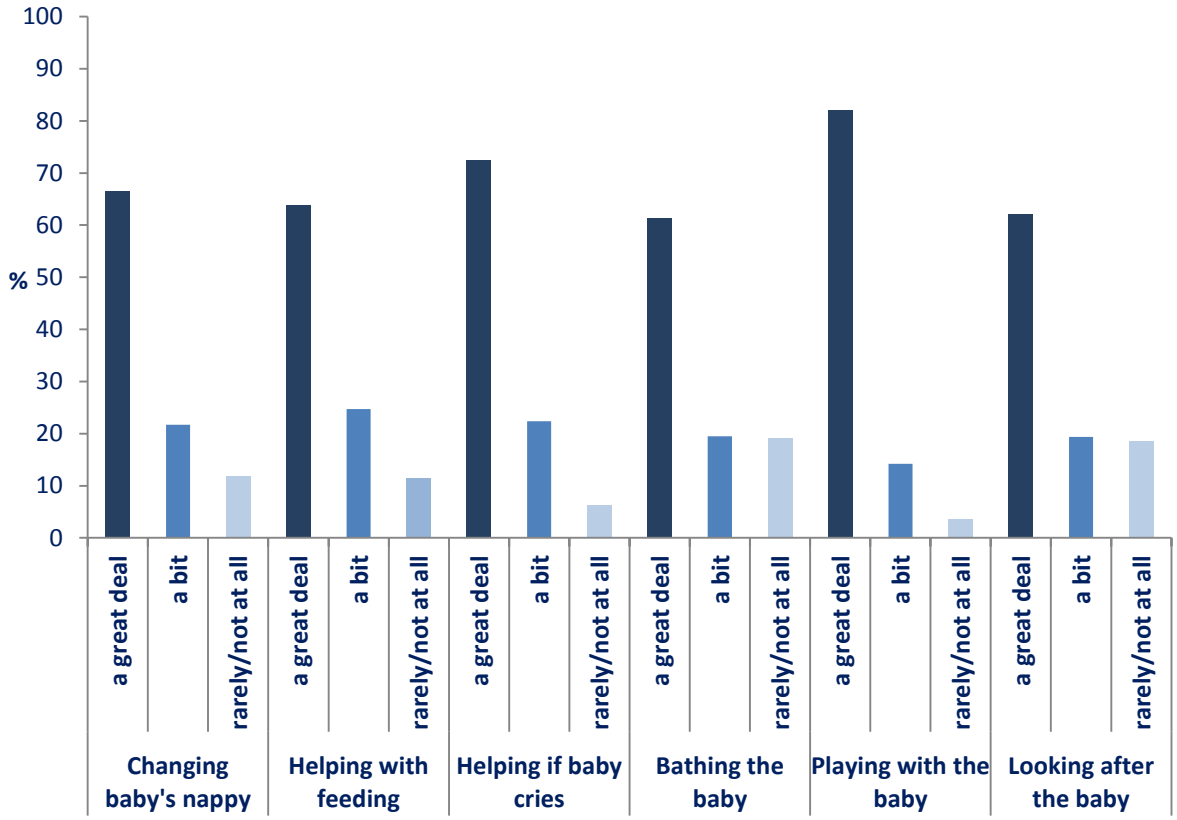
6.2 Involvement in infant care

Women were asked about father or partner involvement in infant care since the baby was born.

More than half of fathers and partners were involved a great deal in the direct care that comes with nappy changing (67%), comforting a crying baby (72%), play (82%) and helping or providing support with feeding (65%) (Figure 20). Many fathers and partners help with childcare and this is reflected in

looking after the baby when the baby's mother is out or at work: more than half overall (62%) were reported to do this 'a great deal', and 19% 'a bit'. Fathers and partners of first-time mothers were significantly more likely to be involved in all the listed aspects of care than those of mothers who had previously given birth.

Figure 20. Women's reports on father and partner involvement in caring for babies



The women in the study were also asked whether their partners had been able to take paid paternity or parental leave, and for how long. Two-thirds of women reported that their partners had taken paternity or parental leave (66%), for some this was not applicable (16%) because, for example, they were unemployed, in education or the women were single mothers. Nearly one in five (18%) reported that their partner was unable to take leave. For partners and fathers able to take paternity or parental leave the median was 10 days (2 working weeks) and ranged from 1 day to 20 weeks. There was no significant difference by parity.

7. Experience of maternity care overall

Some overarching questions relating to the experience of care in general, that is across different stages and aspects of care, were included near the end of the survey.

Table 18. Proportions of women given information and involved in decisions about their care

	Primiparous women		Multiparous women		All women	
	No.	%	No.	%	No.	%
Given information about choices for maternity care						
Yes	1,528	69.9	1,557	71.3	3,153	70.6
To some extent	556	25.5	525	24.1	1,106	24.8
No	101	4.6	101	4.6	208	4.7
Able to participate in decision-making about care						
Yes	1,528	70.1	1,607	73.8	3,196	71.7
To some extent	557	25.6	495	22.7	1,087	24.4
No	94	4.3	76	3.5	172	3.9
Given enough information to decide about care						
Yes	1,554	71.4	1,623	74.6	3,243	72.8
To some extent	517	23.7	468	21.5	1,014	22.8
No	108	5.0	85	3.9	196	4.4
Given information at the right time to decide about care*						
Yes	1,491	68.6	1,605	73.9	3,159	71.1
To some extent	567	26.1	466	21.5	1,067	24.0
No	116	5.3	100	4.6	219	4.9

*Difference by parity * p<0.01*

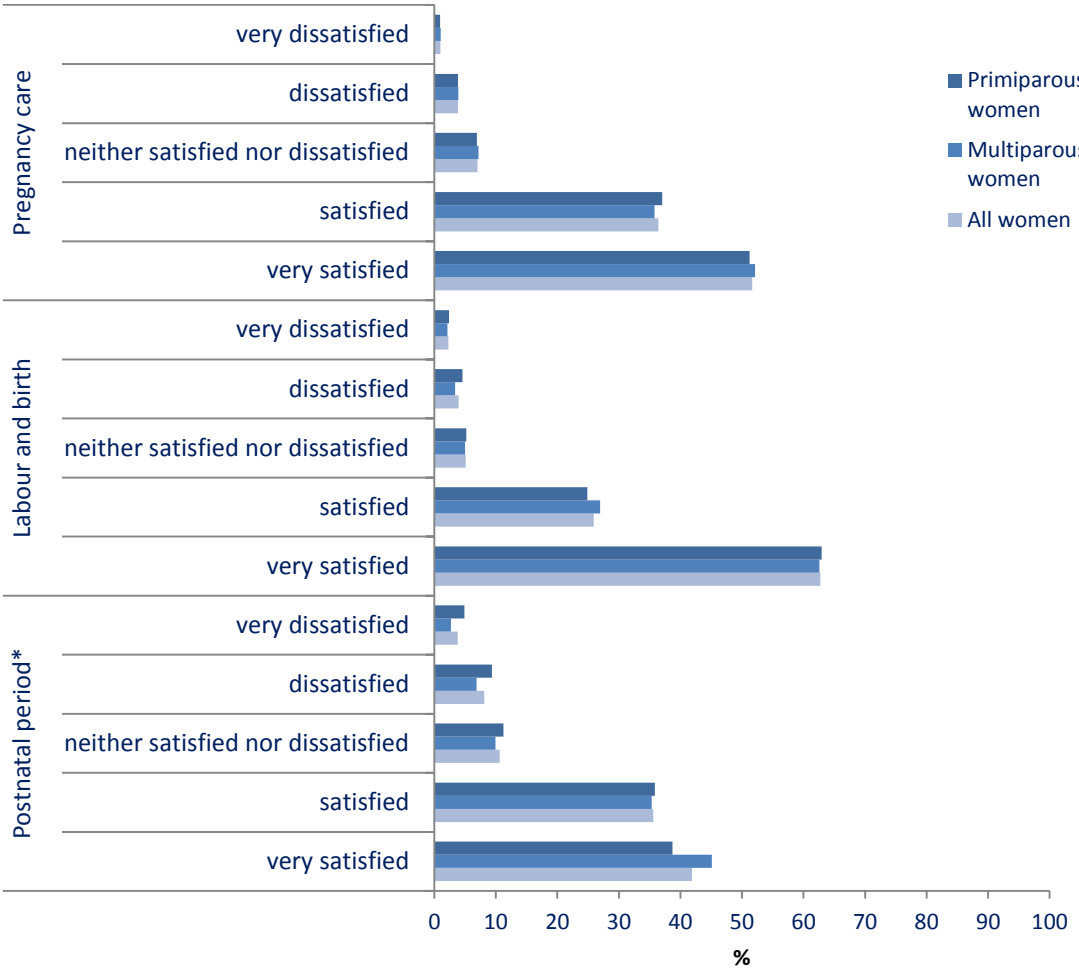
Women were asked about information-giving and access to information to support their decision-making and choices (Table 18). Many felt they were always given information about choices in maternity care, were given enough information to help them decide, and that the information was timely (over 70%), although for a further proportion (23—25%) this was only to some extent. Similar proportions of women felt that they were definitely involved in decision-making about their care (72%) and a further proportion to some extent (24%). Women who had previously given birth were more likely to feel that they were able to participate in decision-making about their care, were given enough information and at the right time to decide.

Relationships with health professionals during the perinatal period are particularly important in terms of women feeling able to access care. They were asked if overall they had been able to have or to build a trusting relationship with a health professional during their pregnancy, birth and afterwards. Just over half (56%) responded unequivocally and positively and a further third (32%) indicated that they

had been able to do this to some extent. Women who had previously given birth were more likely to report having such a trusting relationship.

A general question was asked about satisfaction with the maternity care that women received. Women were largely positive about their care during pregnancy, labour and birth and afterwards in the postnatal period (Figure 21).

Figure 21. Women's perception of pregnancy, labour and birth and postnatal care *(*parity difference)*



High rates of satisfaction with pregnancy care and with labour and birth were reported (88% and 89% satisfied or very satisfied). A slightly lower rate was reported for postnatal care (77% satisfied or very satisfied). Nevertheless, while some women were less positive about care in the postnatal period, only 12% were actually dissatisfied with this aspect of their care. First-time mothers were significantly more critical of this phase of care than women who had previously given birth (14% compared to 10% in women who had given birth before).

8. The experience of different groups of women

Specific groups of disadvantaged women may experience poorer care and outcomes. This was explored using multivariate analyses to adjust for potential confounding factors. A range of outcomes were selected with the aim of exploring the experience of specific groups of women in relation to accessing care and the quality of the maternity care received. The groups used in the logistic regression analyses were: BME women compared with White women; BME women born outside the UK compared with White women born in the UK; women living in areas with the most deprived quintile of deprivation (IMD) compared with women in the other four quintiles, and single women compared with women living with partners. The 24 selected outcomes and potential confounders are as outlined in Appendix B. All analyses were adjusted for parity and maternal age as well as each of the variables being investigated. Significant findings for the different groups after adjustment are shown with odds ratios and 95% confidence intervals in Tables 30-34.

8.1 Black and Minority Ethnic women

The findings (Table 19) show that for BME women the first antenatal contact was later, they were less likely to be offered antenatal classes, less likely to report always being involved in decisions about their antenatal care or that midwives were always respectful. Similarly, during labour and birth they were more likely to report that they were not always involved in decisions about their care and didn't always have confidence and trust in staff.

Table 19. Outcomes for Black and Minority Ethnic women

	OR	95% CI
First contact by 12 weeks	0.47	0.30, 0.72
Offered antenatal classes	0.78	0.63, 0.96
Always involved in decisions about antenatal care	0.70	0.57, 0.86
In pregnancy, midwives always respectful	0.69	0.51, 0.92
Always had trust and confidence in staff during labour and birth	0.72	0.57, 0.91
Always involved enough in decisions about care during labour and birth	0.74	0.61, 0.90
Duration of postnatal stay >3 days	1.38	1.07, 1.78
Staff always respectful during postnatal stay	0.63	0.51, 0.79
More postnatal contact with midwife needed	1.33	1.07, 1.65
Satisfied with postnatal care	0.75	0.60, 0.94
Given information about choices for maternity care	0.77	0.62, 0.94
Given enough information to help decide about care	0.75	0.61, 0.93

Compared with White women, BME women were more likely to have a longer duration of postnatal stay and to say that they were not always treated with respect by postnatal staff. After hospital

discharge they were more likely to indicate that they would have liked more postnatal midwifery contact. Overall women in the BME group were less likely to report being satisfied with postnatal care, less likely to say they were given enough information about the choices for maternity care or given enough information to help them decide about care.

8.2 Black and Minority Ethnic women born outside the UK

When compared with White women born in the UK, for Black and Minority Ethnic women born outside the UK (Table 20) the findings are generally similar to those reported in the previous table but with smaller numbers, fewer variables were statistically significant. BME women born outside the UK reported later initial and booking contact, less offer of antenatal classes, less awareness of all options for place of birth, and less involvement in decisions about antenatal care. However, last contact with a midwife was generally later.

Table 20. Outcomes for Black and Minority Ethnic women born outside the UK

	OR	95% CI
First contact by 12 weeks	0.29	0.19, 0.45
Booking by 12 weeks	0.44	0.22, 0.89
Offered antenatal classes	0.63	0.50, 0.80
Aware of 4 options for place of birth	0.63	0.48, 0.82
Always involved in decisions about antenatal care	0.65	0.52, 0.82
Last contact with midwife when baby aged >=15 days	1.32	1.03, 1.68

8.3 Single parents

The findings for women who were single parents (Table 21) were similar in some respects to those for BME women.

Table 21. Outcomes for women who are single parents

	OR	95% CI
First contact by 12 weeks	0.42	0.28, 0.63
Booking before 12 weeks	0.42	0.23, 0.77
Aware of 4 options for place of birth	0.54	0.42, 0.71
Always involved enough in decisions about antenatal care	0.72	0.58, 0.89
Always had trust and confidence in staff during labour and birth	0.68	0.54, 0.86
Always involved enough in decisions about care during labour and birth	0.81	0.66, 0.99
Left alone and worried during labour or shortly after birth	1.56	1.23, 1.98
Staff always respectful during postnatal stay	0.75	0.60, 0.94
Last contact with midwife when baby aged >=15 days	1.35	1.10, 1.66
Given enough information to help decide about care	0.77	0.62, 0.96
Satisfied with care during labour and birth	0.75	0.57, 0.99
Satisfied with postnatal care	0.76	0.61, 0.95

Single parents were significantly less likely to contact a health professional early or to have their booking visit by 12 weeks, and were less likely to be aware of all the options for place of birth. In both pregnancy and labour, single women were less likely to always be involved in decisions about their care, and in labour they were less likely to have trust and confidence in the staff, and more likely to report being left alone and worried either during labour or shortly after the birth. They were less likely to feel that staff were respectful towards them in the postnatal period, but the last contact with a midwife was more likely to be later.

Overall, single mothers were less likely to feel that they were given enough information to help them decide about their care, and less satisfied with care during labour, birth and in the postnatal period.

8.4 Women living in the most disadvantaged areas

After adjustment for potential confounders including BME, low education, and single parenthood, few variables were associated with IMD (Table 22). The women living in the most deprived areas were significantly more likely to always feel involved in decisions about antenatal care, and to have contact with the midwife for longer than two weeks after the birth. Although they did not see fewer midwives, they were more likely to have met at least some of them before.

Table 22. Outcomes for women in the most deprived quintile of the Index of Multiple Deprivation

	OR	95% CI
Always involved enough in decisions about antenatal care	1.21	1.00, 1.45
Last contact with midwife when baby aged >=15 days	0.83	0.70, 0.98

A range of issues are evident in the analyses carried out looking at different groups of women that are common to disadvantaged groups more generally. Differences in access to care, to information and in the way women experience interactions with staff, particularly in the postnatal period, reflect a need for care that focuses on the individual woman and her family at the same time as addressing the information needs of the child-bearing population more broadly, especially in relation to the choices available and involving women in decisions that affect them.

9. Change over time

In making comparisons with earlier surveys it is possible to see changes in both the care provided and women's views of that care. A few questions changed between the different surveys or were not used in all three. Response rates have changed over time, from 63% in 2006, to 55% in 2010 and 47% in 2014, a pattern found with other maternity surveys[28] [29] [30]. A comparison of respondent characteristics for the different surveys is shown in Appendix D. Change over time in key variables are shown in Tables 23—28.

9.1 Changes in accessing antenatal care

Earlier access to pregnancy care and greater uptake of antenatal ultrasound screening is evident in women's responses to the questions about care. Based on the responses to the different surveys from 2006 to the present, the proportion of women seeing a health professional by 12 weeks' gestation has increased over time (Table 23). A marked increase in booking for pregnancy care by 12 weeks is also evident, so that in 2014 nine out of ten women had done so. The proportion of women booking after 18 weeks has reduced steadily since 2006.

Table 23. Proportions of women reporting on key service aspects of antenatal care (%)

	2006	2010	2014
Contacted a health professional by 12 weeks' gestation*	93.5	90.1	96.2
Booked by 12 weeks*	78.2	85.8	90.6
Booked later than 18 weeks*	4.2	2.8	1.7
Offered screening for Down's syndrome*	88.0	99.7	99.0
Had dating scan*	86.3	89.8	95.1
Had anomaly or '20 week' scan*	96.6	98.5	99.1
Offered NHS antenatal classes*	71.5	68.5	65.0
Attended NHS antenatal classes*	36.7	40.2	30.6
Had midwife-only antenatal care *	48.5	55.8	58.3
Had overnight stay in hospital during pregnancy	21.1	18.4	19.6

** Significant difference by time period, $p < 0.01$*

Most contact with maternity care is direct, with women attending for antenatal checks. This form of contact has changed relatively little. However, the median number of antenatal checks in 2006 was 10 appointments for primiparous women and 9 for multiparous women compared with 9 and 8

[28] Garcia et al. First Class Delivery: a national survey of women's views of maternity care. London: Audit Commission, 1998.
[29] Healthcare Commission. Towards Better Births: a review of maternity services in England. London: Healthcare Commission, 2008.
[30] Care Quality Commission. National findings from the 2013 survey of women's experiences of maternity care. London: CQC, 2013.

respectively for these groups in 2014 (Table 24). While the use of texting has increased, with the proportion of women communicating with their midwife this way going up from 3% in 2006 to 23% in 2014, almost all (90%) still rely on the routine appointments to keep in touch. Midwife-only care has not increased significantly over recent years, although there was a marked change between 2006 and 2010. However, with the changing intrapartum care guidelines this may change further[31].

Table 24. Number of antenatal checks in 2006, 2010 and 2014

	n	Mean	Standard deviation	Median	95% Confidence interval
2006					
Primiparous women	*1165*	10.9	6.1	10	10.5, 11.2
Multiparous women	*1679*	10.2	6.0	9	10.0, 10.5
All women	*2960*	10.5	6.0	10	10.3, 10.7
2010					
Primiparous women	*2484*	10.0	5.1	9	9.8, 10.2
Multiparous women	*2486*	9.4	5.2	8	9.2, 9.6
All women	*5079*	9.7	5.2	9	9.5, 9.8
2014					
Primiparous women	*2105*	10.1	5.4	9	9.9, 10.3
Multiparous women	*2081*	9.5	5.4	8	9.2, 9.7
All women	*4302*	9.8	5.4	9	9.6, 9.9

More women are having first trimester dating scans (95% in 2014 compared with 90% in 2010 and 86% in 2006 and by 2014 almost all (99%) of women were having anomaly scans. Screening for Down's syndrome was also offered to almost all women (99%), an increase from 88% in 2006. This increase was across all ages groups.

9.2 Changes in labour and birth care

Care during labour and birth shows some variation and change over time (Table 25). For example, increasing numbers of women are aware of the midwifery options for place of birth, care at home, and in midwifery units separate from hospital. Other options, including consultant-led care in an obstetric unit and midwifery-led care in an alongside unit near to an obstetric unit (AMUs), were also listed. In 2010, 20% of women were aware of all four options for place of birth; the comparable figure in 2014 was 25% of women. However, these proportions are likely to reflect differences in local availability as the AMUs, which are increasing in number, are not available in all trusts[32].

[31] National Institute for Health and Care Excellence. Intrapartum care: care of healthy women and their babies during childbirth. Clinical Guideline no. 190. 2014. Available at guidance.nice.org.uk/cg190

[32] Rowe et al. Service configuration, unit characteristics and variation in intervention rates in a national sample of obstetric units in England: an exploratory analysis. *BMJ Open* 2014; 4:e005551.

Table 25. Proportion of women reporting on key service aspects of intrapartum care (%)

	2006 *(n=2,966)*	**2010** *(n=5,333)*	**2014** *(n=4,571)*
Aware of separate MLUs/birth centres*	10.0	32.8	41.6
Aware of home birth option*	37.3	65.5	58.6
Started labour naturally*	63.3	62.2	59.4
Continuous abdominal fetal monitoring (of labouring women)	40.4	44.7	46.3
Normal vaginal birth*	64.6	62.7	58.7
Caesarean section birth*	22.8	24.7	26.4
Vaginal birth after caesarean (VBAC)*	34.8	30.4	27.6
Midwife delivered the baby*	66.9	64.4	59.3
Gave birth standing, squatting or kneeling (of vaginal births)	14.7	13.9	15.3
Gave birth in water (of normal vaginal births)*	4.8	5.1	12.5
Labour and birth care provided by 1-2 midwives*	57.5	54.7	52.4
Had met all or some of the midwives before*	32.7	19.3	14.9
Left alone at a time when it worried woman/partner*	19.9	24.4	18.3

** Significant difference by time period, $p < 0.01$*

The use of interventions in labour varied over time. The proportion of women starting labour naturally has reduced, and the use of continuous fetal monitoring during labour has gradually increased, so that in 2014 under half of women (46%) experienced this for all or part of their labour. The proportion of normal vaginal births has declined, and the proportion of women giving birth in less conventional positions is relatively unchanged (15%); 12% of women who had a normal vaginal birth reported giving birth in a birthing pool in 2014.

The caesarean section rate based on the survey is slightly higher, and the rate for vaginal birth after caesarean section (VBAC) is lower than in 2006. Rates for forceps and ventouse are generally similar over the different surveys.

Over time the proportion of women whose babies were delivered by midwives has reduced and care during labour and birth, while mostly provided by midwives, has increasingly come from midwifery staff that women have not met previously. The proportion of women and partners left alone and worried during the labour and birth or afterwards varies across the survey time points, but has not increased overall.

9.3 Changes in postnatal care

While the content of postnatal care may have changed little, the delivery of postnatal care has changed over the sequence of surveys.

Duration of postnatal hospital stays have reduced slightly since 2006, from a median of 2 days for all women to 1.5 in 2014 (Table 26).

Table 26. Duration of postnatal hospital stay in 2006, 2010 and 2014

	n	Mean	Standard deviation	Median	95% Confidence interval
2006					
Primiparous women	*1165*	2.8	2.9	2	2.6, 2.9
Multiparous women	*1679*	1.9	2.1	1	1.8, 2.0
All women	*2960*	2.3	2.5	2	2.2, 2.4
2010					
Primiparous women	*2610*	2.4	2.7	2	2.3, 2.5
Multiparous women	*2603*	1.6	1.8	1	1.5, 1.7
All women	*5332*	2.0	2.3	1.4	1.9, 2.0
2014					
Primiparous women	*2205*	2.6	2.6	2	2.5, 2.7
Multiparous women	*2217*	1.8	2.7	1	1.7, 1.9
All women	*4570*	2.2	2.7	1.5	2.1, 2.3

In 2006 a total of 63% of women stayed 2 days or less, increasing to 70% in 2014, with 63% of primiparous women and 78% of multiparous women going home within two days. Median duration of stay for women who had a caesarean delivery decreased from 4 days in 2006 to 3 days in 2014 (range 1—40 days in 2006 and 1—30 days in 2014).

Table 27. Proportion of women reporting on key service aspects of postnatal care (%)

	2006 *(n=2,966)*	**2010** *(n=5,333)*	**2014** *(n=4,571)*
Postnatal stay 2 days or less*	63.2	68.0	70.0
More than 2 home visits by midwife*	90.5	75.9	62.3
Had 3 or more different midwives visit at home*	45.5	42.0	32.5
Had met midwife saw at home before*	77.5	67.3	59.6
Last PN contact at more than 15 days*	29.8	32.7	45.9
Had PN check	90.1	85.1	89.8

** Significant difference by time period, p < 0.01*

Fewer women in successive surveys knew the midwife who came to visit them postnatally (Table 27). The number of home visits was also lower in 2014, with a median of 3 visits compared with 4 in 2010. The timing of the last postnatal contact with a midwife increased from a median of 11 days in 1995[33] to 13 days in 2006 and 14 days in 2010 and 2014, ranging from one day to well over three months after the birth in 2014. Approaching half of the women responding in 2014 (46%) last saw their midwife after their baby was two weeks old. This may reflect more individualised care and flexibility

[33] Audit Commission. First Class Delivery: Improving maternity services in England and Wales. London: Audit Commission, 1997.

in response to need, in relation to maternal as well as infant health. However, it must be emphasised that while no women were identified as having no home visits at all in 2006, the proportion doing so in 2010 was 1% and 3% 2014.

Little difference was evident over time in the proportion of women having postnatal checks, but additional text written in the questionnaires suggests that many of these checks are now taking the form of a short chat, often about the baby, with little about a woman's physical health and no physical examination.

Sources of information and methods of communication have changed over the last decade with greater use of the mobile phone, texting and use of the internet. However, many women still expect and would like to see their midwife at home and to be able to communicate with them face to face as well as having easy access using other methods.

Shorter postnatal stays, fewer postnatal visits and a reduction in continuity have all contributed to the changing landscape of postnatal care.

9.4 Changes in perceptions of care

The way that women perceived selected aspects of their maternity care were compared across the different NPEU surveys.

Table 28. Proportion of women reporting on their perceptions of care during the different phases of maternity care (%)

Phase of care		**2006** *(n=2,966)*	**2010** *(n=5,333)*	**2014** *(n=4,571)*
Pregnancy	Treated with respect by midwives *	94.8	95.8	89.8
	Treated with respect by doctors*	94.6	95.8	85.6
	Satisfied with antenatal care*	86.4	87.5	88.1
Labour and birth	Treated with respect by midwives *	94.4	94.6	88.9
	Treated with respect by doctors*	94.1	93.8	87.6
	Always had confidence and trust in staff*	-	75.1	81.2
	Staff communicated well with woman during labour*	90.4	91.3	96.1
	Satisfied with labour and birth care*	86.5	86.7	88.6
Postnatal care	Treated with respect by postnatal staff in hospital*	89.2	91.0	76.3
	Postnatal stay too short	13.1	11.6	11.5
	Always had confidence and trust in midwives saw after going home	68.9	68.6	68.6
	Needed more postnatal contact with midwife after going home*	18.3	23.9	23.5
	Satisfied with postnatal care*	79.8	76.2	77.3
Overall	Enough information about choices for maternity care*	-	59.7	70.6
	Enough information to help decide about care at right time*	-	63.3	72.8

** Significant difference by time period, p < 0.01*

The possible answers to some structured questions varied slightly and so the responses were grouped to enable comparison (Table 28).

While almost all women feel that they were treated with respect by both midwives and doctors at all the time points, the extent to which this occurred appeared to have declined in relation to the care provided by both staff groups. There was an increase in the proportion of women always having confidence in the staff caring for them during labour and birth over the four years since the 2010 survey.

Postnatal care was the area where criticism was most marked, although views were rather similar in comparing responses at the different time points. Despite changes in the length of postnatal hospital stay, relatively few women indicated that their stay was too short and this did not differ over time. Only two-thirds of women in 2006, 2010 and 2014 indicated that they always had trust and confidence in the midwives they saw after being discharged home and, since 2010, once home, approaching a quarter of recent mothers would have liked to have seen a midwife more.

Satisfaction with all three phases of care differed little over time, with generally high levels of positive response being expressed, although as reported earlier in section 7, lower levels of overall satisfaction with postnatal care were evident.

In 2010 and 2014 additional over-arching questions were asked about women having enough information to make choices and decisions about their maternity care. Comparison of women's views between 2010 and 2014 show marked increases in the proportion of women feeling they had enough information to help them choose and to make decisions.

In summary, as far as the women responding to the surveys were concerned, their perceptions are largely positive across all three surveys. While over time they were more critical of staff attitudes and communication, they were at the same time more positive about information-giving and their involvement in care.

10. Conclusion

This report is based on data collection and analysis of items of current interest, particularly those relating to access, choice and information, health and wellbeing, the engagement of fathers and partners and the views of women receiving maternity care in 2014. Substantial numbers of women from various different sociodemographic groups completed the survey. However, the response rate of 47%, may affect generalisability to the wider population.

The findings provide a broad picture of women's recent experience of pregnancy and childbirth and their views of care provided at that time. The data are presented by parity and for all women, to facilitate an understanding of the way that previous experience of pregnancy, childbirth and early parenting may affect women's subsequent experiences. Where appropriate, further analyses have been carried out to explore some of the relationships between key factors and some findings are presented on the experiences of specific groups using multivariate methods.

Most women were positive about most of their maternity care and the role of their partners at this time. As this and previous national maternity surveys have shown, all women wish to be treated as individuals, with kindness and respect, by skilled staff in whom they have confidence and trust. The data presented reflect possible gaps in care and areas for improvement. Some concerns are evident in relation to communication, difficulties in educating and preparing women for their first birth, the frequency of labour and birth interventions, providing support for recent mothers and monitoring women's emotional health and wellbeing. Health professionals working with women and their families have a chance to support, inform and intervene more effectively. What is important is to try and get it right for all women, not just the majority and the survey findings indicate some areas where women's experience could be improved.

The wishes and experience of individual women, those from different groups and women with different clinical needs vary. While this large scale survey and descriptive analyses reflect the numbers of women responding in different ways, it is important to be aware of more than the numbers and to hold in mind the voices and experiences of the women who participated. Further analyses of this and the previous data sets based on women's experience of care are planned, including the qualitative data, which will facilitate a better understanding of the issues. The further analyses will be guided in part by the interests of stakeholder and user groups.

Listening to women's views, and understanding their different perspectives on this important life event, provides essential feedback on services, the way that maternity care works for women and their families, critical public health issues and what is really valued in the care that is received.

Appendix A. Scope of the survey questionnaire

Section A. **Dates and your baby**	Date and time of birth Singleton or multiple Gestation Birth weight
Section B. **Antenatal care**	Pregnancy confirmation Planned pregnancy and reactions Access to health professionals Information about choices The booking appointment Contact with health professionals Asked about emotional and mental health Support and treatment for mental health problems Timing and method of contact Tests and scans: explanations, offer, uptake and views Use of NHS Information for Parents and other websites Use of pregnancy day assessment unit Hospital stays Health problems during pregnancy Antenatal education offer and uptake Perceptions of care
Section C. **Labour and birth**	Prior worries about labour and birth Options for place of birth Place of birth Length of labour Induction Monitoring Methods of pain relief Transfers in labour Mode of delivery Timing and reasons for caesarean section Episiotomy and tears Contact with health professionals Continuity of carer Early contact with baby Presence of partner or companion Being left alone Perceptions of care and advice to others Open text about care in labour and delivery
Section D. **Babies born at home**	Planned birth at home Information for home birth Transfer Open text about home birth
Section E. **Care in a maternity unit after the birth**	Duration of stay Perceptions of care Open text about postnatal care
Section F. **Infant feeding**	Plans in pregnancy Feed type first few days and at the time of the survey (3 months) Support and advice from health professionals Other support with infant feeding Introduction of solids

Section G. **Babies needing specialist care**	If baby was cared for in a neonatal unit Reasons for admission Information about neonatal care Contact with baby Duration of stay If baby still in neonatal unit Overnight accommodation for parents
Section H. **Care at home after the birth**	Access to postnatal care and information Contact with different health professionals Age of baby at last contact with midwife Help and advice about baby care Perceptions of baby and current baby health problems Perceptions of care Sources of support Postnatal check Maternal health and wellbeing Support and treatment for mental health problems Talked over the labour and birth with health professional Satisfaction with care received Information about choices for care
Section J. **Father and partner involvement**	Reactions to the pregnancy Involvement during pregnancy, labour and birth Health professional communication Postnatal involvement with the baby Paternity/parental leave
Section K. **Previous pregnancies and childbirth**	Previous pregnancies Number of births Fetal or maternal health problems in previous 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 Help in understanding English Physical problem or disability Mental health problem or learning disability Open text about any aspect of maternity care

Appendix B. Experience of maternity care in disadvantaged groups

Selected outcomes and potential confounding factors used for adjustment in regression analyses

Service aspects: Antenatal care

1. Timing of first contact by 12 weeks
2. Timing of booking appointment by 12 weeks
3. Asked about emotional and mental health
4. Offered antenatal classes
5. Number of options aware of for place of birth: all 4 vs. fewer
6. Number of midwives that provided antenatal care >3 vs fewer *(additional adjustment for overnight AN stays for this outcome)*

Adjusted for parity, IMD, mother's age, single parenthood, age on leaving full-time education, BME, UK-born

Service aspects: Labour and birth care

1. Number of midwives that provided care during labour and birth: >=3 midwives vs. fewer *(Additional adjustment for duration of labour for this outcome)*
2. Left alone at a time when it worried during labour/the birth of your baby Yes vs No

Adjusted for parity, mother's age, and type of delivery

Service aspects: Postnatal care

1. Length of postnatal stay: >=3 days vs. fewer days
2. Number of postnatal contacts with midwife: 1—2 vs. more
3. Last PN contact: >=15 days vs. fewer

Adjusted for parity, mother's age, and type of delivery

Women's perceptions

1. Involved enough in decisions about antenatal care: always vs rest
2. Being treated with respect by midwives during antenatal care: most of the time vs. rest
3. Being treated with respect by doctors during antenatal care: most of the time vs. rest
4. Had confidence in staff providing care during labour and birth: always vs. rest
5. Involved enough in decisions about care during labour and birth: always vs rest
6. Being treated with respect by staff during postnatal stay: always vs. rest
7. Perception of postnatal stay as too short: yes vs. no
8. More postnatal contact with midwife needed: yes vs. no
9. Given information about your choices for maternity care: yes vs. rest
10. Given enough information to help you decide about your care: yes vs. rest
11. Satisfaction with care during pregnancy: very satisfied and satisfied vs. rest
12. Satisfaction with maternity care during labour and birth: very satisfied and satisfied vs. rest
13. Satisfaction with maternity care after birth: very satisfied and satisfied vs. rest

Adjusted for parity, IMD, mother's age, single parenthood, age on leaving full-time education, BME, UK-born

Appendix C. Summary of respondent and non-respondent characteristics

	Respondents		Non-respondents	
	No.	%	No.	%
Mother's age (years) *				
16-19	101	2.2	274	5.3
20-24	538	11.8	1122	21.5
25-29	1228	26.9	1547	29.6
30-34	1587	34.7	1363	26.1
35-39	874	19.1	717	13.7
40 and over	241	5.3	195	3.7
Total	4569	100	5218	100
Marital status *				
Married	2744	60.1	2389	45.8
Sole registration	139	3.0	400	7.7
Joint registration (same address)	1395	30.5	1649	31.6
Joint registration (different address)	291	6.4	780	14.9
Total	4569	100	5218	100
Index of multiple deprivation (quintile) *				
1 (most deprived)	894	19.6	1781	34.1
2	977	21.4	1256	24.1
3	935	20.5	886	17.0
4	865	18.9	711	13.6
5 (least deprived)	899	19.7	585	11.2
Total	4570	100	5219	100
Mother's socioeconomic position (NS-SEC) [1] *				
Large employers and higher managerial and administrative occupations	5	1.2	6	1.1
Higher professional occupations	30	7.2	15	2.8
Lower managerial, administrative and professional occupations	128	30.9	80	14.8
Intermediate occupations	73	17.6	79	14.6
Small employers and own account workers	12	2.9	14	2.6
Lower supervisory and technical occupations	10	2.4	17	3.1
Semi-routine occupations	45	10.9	62	11.5
Routine occupations	18	4.3	27	5.0
Students	5	1.2	19	3.5
Not stated or inadequately classified	9	2.2	37	6.9
Not classifiable for other reasons	79	19.1	184	34.1
Total	414	100	540	100

Appendix C continued

	Respondents		Non-respondents	
	No.	%	No.	%
Government Office Region (GOR) *				
North East	191	4.2	254	4.9
North West	589	12.9	733	14.0
Yorkshire & Humberside	434	9.5	527	10.1
East Midlands	383	8.4	397	7.6
West Midlands	426	9.3	595	11.4
East of England	524	11.5	540	10.3
London	780	17.1	1025	19.6
South East	793	17.3	754	14.4
South West	441	9.6	390	7.5
Unknown	10	0.0	4	0.0
Total	4571	100	5219	100
Born in the UK *				
No	1084	23.7	1,553	29.8
Yes	3485	76.3	3,665	70.2
Total	4569	100	5,218	100

** p < 0.01*

[1] *NS-SEC available for a 10% sample of respondents and non-respondents*

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010-technical-report

Appendix D. Comparison of respondent characteristics for 2006, 2010 and 2014 NPEU surveys

	2006		2010		2014	
	No.	%	No.	%	No.	%
Age group						
16-19	115	3.9	153	2.9	396	4.0
20-24	452	15.4	697	13.2	1723	17.2
25-29	702	23.9	1312	24.9	2838	28.4
30-34	959	32.7	1747	33.2	2992	29.9
35-39	601	20.5	1087	20.6	1610	16.1
40+	105	3.6	272	5.2	440	4.4
Total	2934	100	5268	100	9999	100
Parity						
primiparous	1165	41.0	2610	50.1	2206	49.9
multiparous	1679	59.0	2603	49.9	2217	50.1
Total	2844	100	5213	100	4423	100
Ethnicity						
White	2551	87.4	4487	85.7	3710	83.9
Mixed	41	1.4	99	1.9	87	2.0
Asian	201	6.9	386	7.4	442	10.0
Black	105	3.6	202	3.9	159	3.6
Chinese/other	21	0.7	63	1.2	23	0.5
Total	2919	100	5237	100	4421	100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