Left to your own devices:
The postnatal care experiences of 1260 first-time mothers
Authors’ contributions
Mary Newburn and Vanita Bhavnani designed the questionnaire, drawing on the earlier NCT postnatal care survey carried out by Debbie Singh and Mary Newburn. Vanita piloted the questionnaire and was responsible for data entry, statistical analysis and selection of open-ended responses to illustrate key themes and issues. Mary and Vanita planned the report together and shared the analysis and report writing, drawing on Mary’s experience with the NCT and knowledge of maternity policy.
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Executive summary

Women’s feedback and accounts of their experiences indicate widely varying standards of postnatal care. Around half of the first-time mothers indicate that they had high quality care that was responsive to their needs, provided by thoughtful staff who were empathetic and encouraging. Most first-time mothers felt that midwives were always or mostly kind and understanding (80%) and treated them with respect (83%).

In contrast, around one in eight were highly critical of their care, reporting insensitivity, inconsistent advice, inadequate assessments and care, lack of emotional support and/or too few home visits. Women who had had a caesarean birth were least satisfied with the level of care they received.

Four out of ten (42%) felt there were not enough midwives to provide them with the care they needed on the hospital postnatal ward. There was considerable variation in the number of community-based postnatal care contacts women had. Some women had no contact appointment or home visit with either a midwife or a maternity support worker (MSW), while others said they had 10 or more contacts (5 or more midwife contacts, plus 5 or more MSW contacts).

Three in ten were critical that healthcare staff did not take account of their personal needs and preferences, and the same proportion felt unable to discuss things with healthcare staff that were worrying them. One in four women were highly critical of the level of help and support they received with feeding their baby, and two thirds of breastfeeding mothers who introduced supplements of formula during the first week said they were given conflicting infant feeding advice.

Overall, there appears to have been very limited improvement in postnatal care during the last decade, despite record spending on the NHS and publication of a NICE guideline setting out standards for the Routine postnatal care of women and their babies.

NHS boards and trusts need to address routine postnatal care to ensure that all women have:

- an individual postnatal care plan,
- a named care coordinator whom they can contact at any time,
- regular home visits according to need,
- opportunities to get to know their carers,
- a high and consistent standard of emotional support, physical care and information to address their own health and wellbeing and their baby’s needs, particularly support with baby feeding.

This study replicates the NCT postnatal care survey carried out in 1999/2000. It also responds to recent policy developments and the NICE recommendations for postnatal care. The 1999/2000 survey found that half of all mothers wanted more emotional support from staff during the first 10 days after giving birth. Other key findings were that one in two women said they were not given enough help, support and consistent information about feeding their baby. Care and support was considered particularly poor in the first three days when many women were still in hospital and in the period 11-30 days after birth when midwifery care has come to an end for most women. The NCT called for more emphasis on meeting women’s needs for kindness, listening and help to adjust to the demands of new motherhood.
This follow-up survey involved 1536 women, who were mainly NCT members (95%). The analysis and results focus on 1260 first-time mothers, who made up a large majority of the respondents (83%). The questionnaire was available online from October 2009 to early January 2010 for women who had given birth within the previous 12 months. It was advertised through a range of NCT publications and a hard copy of the questionnaire was also inserted into the 2009 winter edition of NCT’s members’ magazine ‘NewGen’.

The women taking part are older, less diverse in terms of ethnic background, and more likely to have degree level education than average. The survey is not therefore representative of all childbearing women in the UK, and the results are not directly generalisable. However, the sample is large and the women are highly articulate about their experiences.

A large majority of first-time mothers gave birth in a hospital labour ward (86%); small but significant proportions used a birth centre (9%) or had a home birth (5%). Just under half had a spontaneous vaginal birth (48%), 26% gave birth with forceps or ventouse, and 26% had a caesarean. There were higher than average rates of breastfeeding, including exclusive breastfeeding rates (87% in the first 24 hours after birth, 76% in days 2-7 and 72% during the period 8-30 days after birth).

Key findings:

The emotional support, care and information needs of first-time mothers

Emotional support
- In the first 24 hours after birth less than half of the first-time mothers (41%) felt that they received all the emotional support they needed from healthcare staff.
- A third of women felt they got little or no emotional support in the first month after birth.

Physical care
- 56% of first-time mothers felt that they had received all the physical care they needed in the first 24 hours after birth.
- One in five said they got little or none of the physical care they needed, throughout the first month after birth.

Women’s health information
- Only 45% of first-time mothers felt that they had received all the information and advice they needed about their baby’s health.
- A quarter of first-time mothers said they got little or none of the information and advice they needed at that time.

Babies’ health information
- During the first week after birth, 52% of the first-time mothers said they got all the information and advice they needed about their baby’s health.
- Consistently during the first month after birth, around one in seven women said they had received little or none of the information they needed about their baby’s health.

Women who had operative births
- First-time mothers who had operative births (forceps/ventouse or a caesarean) consistently reported a bigger gap between their needs and what was provided in terms of emotional support, physical care and information about their own and their baby’s health compared with women who had a spontaneous vaginal birth.
- The biggest reported care gaps related to women who had had a caesarean birth. 43% of them reported that little or none of their emotional support needs were met in the first 24 hours. The trend continued throughout the first 30 days.
- Women who had unplanned caesarean births were more likely to feel that their needs for physical care were not met in the period 8-30 days after giving birth (28%) compared with women who had planned caesarean births (19%).

Place of birth
- Among women who had a spontaneous vaginal birth, those who gave birth in hospital consistently reported a bigger gap between their need for emotional support, physical care and information about their own health in the first 24 hrs after birth compared with women who gave birth in a birth centre or at home.
- The biggest care gap related to their need for emotional support. 57% of those who gave birth in hospital reported that they did not get all the emotional support they needed in the first 24 hours compared with 43% of women who gave birth in a birth centre and 24% of women who gave birth at home.

Breast and bottle feeding
- A large majority of women exclusively breastfed their baby, though the decline, particularly during the first week, (first 24hours: 87%; 2-7 days: 76%; 8-30 days: 72%) indicates a lack of adequate support.
- Reports of conflicting information and advice were less common than in our 1999/2000 survey but still a concern for around half of the first-time mothers responding (52%).
- A positive finding is that four out of five women were encouraged to have skin to skin contact in the first hour after birth (79%).
- Less than a third of women reported that their partners were encouraged to have skin to skin contact in the first 24 hours after birth.

Help and support for baby feeding
- Less than half of first-time mothers felt they got all the help and support they needed with feeding their baby in the first 24 hours after birth (45%) with similar rates at 2-7 days and 8-30 days after birth.
- Three out of ten women said they got little or none of the help and support they needed in the first 24 hours after birth (30%) and after the first week (30%). In the period 2-7 days fewer women were critical (25%) though there remained a significant gap between need and provision.
- Among first-time mothers who were breastfeeding, those supplementing breastfeeding with formula feeding during the first week after birth were more likely to say that they lacked all the help and support they needed compared with those breastfeeding exclusively (21% vs. 41% received little or no support).
- Women who were formula feeding from birth were less likely to feel they had all the help and support they needed compared to women who were exclusively breastfeeding (first 24 hours, little or no support: 46%; 2-7 days: 24%; days 8-30: 43%).
- Around half of the first-time mothers used NCT’s formal breastfeeding support services: 29% contacted a local breastfeeding counsellor for support and information and 26% called the NCT Breastfeeding Line.
Consistency of advice and information
- 52% of first-time mothers felt they had not received consistent information and advice in relation to feeding in the first month after birth.

Baby feeding after an operative birth
- Around a quarter of first-time mothers who had an operative birth said they were not encouraged to have skin to skin contact with their baby in the 24 hours after birth (forceps/ventouse: 24%; caesarean: 29%) compared with 14% of women who had a spontaneous birth.
- First-time mothers who had had a caesarean birth felt less well supported with feeding (32%), compared with those who had a spontaneous birth (26%) or an assisted delivery (29%), during all three phases of care.

Place of birth
- Less than half of the first-time mothers who had a spontaneous birth in hospital (46%) felt they received all the help and support they needed in relation to feeding their baby in the first 24 hours after birth, compared with those who gave birth in a birth centre (55%) or at home (60%).

Have NICE recommendations for postnatal care been implemented?
A written care plan
- A negligible percentage of first-time mothers said that they had been involved in drawing up a postnatal care plan, as recommended by NICE (4%).

Kindness and respect
- Most first-time mothers felt that midwives were always or mostly kind and understanding (80%) and treated them with respect (83%).
- One in five women who had an assisted birth (19%) and almost a third of women who had a caesarean (30%) felt that midwives were only kind and understanding some of the time or never compared with 15% of women who had spontaneous births.
- 16% of women who had forceps or ventouse and 28% of those who had a caesarean felt they were treated with respect some of the time or never compared with 11% of women who had spontaneous births.

Communication and involvement in decisions
- First-time mothers felt health professionals were more likely to involve them in decisions about their baby's care (81%) than to create opportunities for them to discuss things that were worrying them (73%) or aspects of the woman’s own health (76%).
- Women who had operative (forceps, ventouse and caesarean) births were less positive about all dimensions of communication and involvement.
Structural and organisational aspects of care

Perceived level of midwifery staffing
- 42% of women who had given birth in hospital felt that there were sometimes or never enough midwives to provide them with the level of support they needed compared with 23% who had had their baby in a birth centre and 8% who had had a home birth.
- First-time mothers who had had an operative birth were less satisfied; 47% who had had an assisted birth and 48% who had a caesarean reported that there were sometimes or never enough midwives to provide them with the level of support they needed compared to 32% of women who had a spontaneous birth.

Continuity of care
- Most women (71%) felt it was important to be seen by the same midwife throughout their postnatal care.
- Yet, 51% reported that three or more midwives provided them with care after discharge from the maternity unit or birth at home.
- A third of women (33%) had five or more contacts with a midwife after leaving the maternity unit, or after a home birth.
- 98% of women had had at least one contact with a health visitor; mostly including a home visit (90%).

Length of contact time with health care staff
- Around half of women spent up to 30 minutes with a midwife for the first three contacts.
- Most women were satisfied with the amount of time they spent with various healthcare staff (with midwives: 83%; with maternity support workers: 77%; with the health visitor 84%).
- Women who had consultations with midwives lasting longer than 15 minutes felt more satisfied with the length of the consultation than if visits were shorter and better able to discuss things that were worrying them.
Introduction

Around three quarters of a million women give birth each year in the United Kingdom (UK). First-time mothers and fathers often have very limited experience of the physical and emotional demands of their new roles and can find learning new skills and adjusting to new responsibilities quite a challenge. The reality of the early days and weeks can be quite different from their expectations, and support, guidance and encouragement can make a big difference to how they feel. The postnatal period marks an important transition in parents’ lives when their roles, their day to day opportunities and their sense of self changes. The quality of postnatal care provided to women and families in the first days and weeks after birth can have a significant impact on their experience.

This report presents the findings of a survey carried out with a self selected group of women, mainly NCT members, who had had a baby between September 2008 and December 2009. The main body of results focuses on the postnatal care experiences of first-time mothers including their perceptions of the quality of support and information provided in the first month following birth.

The results will be used to inform the development of NCT information and services as well as lobbying and campaigning work.

1.1 Policy background

Across the UK, several major policy initiatives in the last decade have aimed to improve the quality of NHS maternity care, ensuring that services are safe and supportive, and meet the individual needs of women and babies. In England, the maternity standard of the National Service Framework emphasised the need for postnatal care which identifies and responds in a systematic way to women’s physical, psychological, emotional and social needs. Recommendations included extending the duration of postnatal midwifery care, with midwifery support being offered for at least one month after discharge from hospital and up to three months depending on individual need.

Maternity Matters the National Service Framework implementation plan for England, contained a series of national guarantees on choice within maternity services and highlighted the importance of both personalised care and continuity of the care-giver throughout pregnancy and into the postnatal period. The plan said women would have a choice about how and where to access postnatal care and a coordinated pathway of care encompassing their medical and social needs and those of their babies including perinatal mental health services and neonatal intensive care where needed.

The National Service Framework for Wales included three standards for maternity services and emphasised the importance of maternity services that are accessible, well co-ordinated and delivered in partnership with women and their families. Specific recommendations were made in relation to postnatal care including the identification of a lead professional responsible for assessing individual needs and co-ordinating postnatal care of all babies and women; the provision of appropriate support for women to initiate and sustain breastfeeding; and access to services from midwives, health visitors and other professionals and to specialised support services according to need.

The Framework for maternity services in Scotland included five principles related to postnatal care. It highlighted the importance of supporting women and their partners...
through a ‘confident and effective transition to parenthood’ particularly in the postnatal period. Recommendations included provision of appropriate care and assessment of women and their babies from birth up to the 6 week postnatal check, promotion of support to sustain breastfeeding, and planned effective care in the community.14,16

Another key driver for the development of postnatal care is the clinical care guideline, commissioned by the National Institute for Health and Clinical Excellence (NICE).17 This is based on a review of evidence and addresses the management of care for women and their babies during the first 6–8 weeks after birth. The review says: ‘Postnatal care is pre-eminently about the provision of a supportive environment in which a woman, her baby and the wider family can begin their new life together. It is not the management of a condition or an acute situation’.18 The guideline makes recommendations for the care of women and their babies and identifies priorities for implementation. The NCT contributed to the development of the guideline by having a nominated member, postnatal leader, Cathy Neale, on the guideline development group, by providing details of relevant research literature and submitting critical comments during the consultation phase. Written within a conceptual framework which places the woman and her baby at the centre of care, it emphasises that all postnatal care should be delivered in partnership with the woman and be individualised to meet the needs of each mother–infant dyad.17 Guidance is provided on the following aspects of care:

- Planning the content and delivery of care in the first 24 hours, 2–7 days and up to 8 weeks after birth using an individualised care plan and a co-ordinating health professional responsible for ensuring the right care is received at the right time.
- Maternal health, including guidance on the signs and symptoms of major maternal physical morbidity and commonly experienced morbidity.
- Infant feeding, including appropriate support and advice for women commencing breastfeeding or formula feeding and additional support for women following caesarean.
- Maintaining infant health, including the provision of information and advice to parents to enable them to assess their baby’s general condition and identify signs and symptoms of common health problems.

Evaluation of services is essential in order to establish the extent to which policy objectives and specific clinical guidelines have been achieved in practice.19 Understanding women’s experiences and views about care is an essential component of developing high quality services.20 This knowledge should help to identify priorities for further service developments and shape future policy.21

1.2 Research literature

The importance of support for women and their families during the postnatal period is increasingly recognised in research literature. Following birth women need time to recover physically and emotionally, and to develop a relationship with their baby. Learning to feed and soothe their baby involves gaining confidence and acquiring practical skills.22 The transition to motherhood has been found to be a time of profound change often involving a sense of loss, isolation and fatigue.2 Experiences, feelings and behaviour during pregnancy, after birth and in the early months of motherhood can be affected by a number of factors which interact together. These include socio-economic factors and relative deprivation, the mother’s orientation to her baby and her partner, family support and her previous experience of motherhood, clinical complexities, interventions and infant illness.23 The professional care and encouragement a woman
receives during labour, in hospital wards, and at home affect her health and well-being; and access to support from peers can also be protective. Despite the significance of the postnatal period, evidence suggests that postnatal care is under-valued and under-resourced. Repeatedly, studies have found that more women are dissatisfied with the care that they receive after their baby’s birth than at any other phase in the maternity care pathway. The large national survey of women who had given birth in England and Wales conducted by the Audit commission in 1997 reported that many women’s expectations of the help and support differed from what they experienced. Poor staffing levels, absence of needed facilities, inadequate food, poor cleanliness and hygiene, conflicting advice and limited availability of support were of particular concern.

Two more recent England-wide surveys have also reported clear shortcomings in postnatal care. One found that women tended to be more critical of their postnatal care than care received during pregnancy or labour and birthing. During the hospital stay, only half of women felt they were treated as individuals by staff, with one in ten reporting that they were never or rarely treated this way. The Healthcare Commission survey found that just under half of women were not given the information and explanations they needed and more than a third felt that they had not always been treated with kindness and understanding.

NCT has also previously conducted a survey of members’ experiences of postnatal care in the first month after birth. Based on care during 1999 and 2000, the study of 960 women found that needs for emotional support and information were frequently not met. Half of all mothers wanted more emotional support from staff during the first 10 days after giving birth (51%), half also said they were not given enough help, support and consistent information about feeding their baby. In particular, at that time, the need-provision gap was widest during the first three days after birth and after day 10, when midwifery care usually comes to an end. These were also the times when there was the greatest reported lack of information, with 16% and 18% of women respectively saying they received little or none of the information they wanted.

1.3 Aims and objectives

The aim of the current study was to replicate aspects of the earlier NCT survey, in order to compare findings, and to explore the extent to which recent recommendations about the delivery of postnatal care had been implemented.

The key objectives of the study were to explore:

- women’s experiences of care and support during the first month after birth focusing on three time phases (first 24 hrs, 2-7 days and 8-30 days after birth) with particular reference to:
  - information, physical care and emotional support needs
  - support for baby feeding
  - perceptions of involvement in decision making;

- whether NICE recommendations for postnatal care, published in 2006, had been implemented, particularly the use of individualised postnatal care plans; and

- the consistency of care provided, including opportunities for a continuing relationship with a small number of carers.
In NCT’s earlier postnatal care survey, the periods investigated were: 1-3 days, 4-10 days and 11-30 days. We sought to make comparisons between feedback NCT received from women in 1999/2000 and in 2009/2010, and to evaluate women’s experiences of care in relation to the NICE recommendations. Two of the time periods selected for investigation in the current survey (first 24 hours, 2-7 days) relate directly to the periods identified in the NICE guideline on postnatal care. NICE identified the third relevant time period as ‘continuing through to 6-8 weeks’ after birth. The start of our third time period, 8-30 days, coincides with the start of the third time period identified by NICE but ends on day 30 to coincide with NCT’s earlier investigation period.

NICE postnatal care pathway

NICE adopted a care pathway approach providing recommendations on what should be included in postnatal care during the first 24 hours after birth, the first 2-7 days and the period from day 8 to around 6-8 weeks. The guideline states:

‘A clinical care pathway was designed to indicate the essential steps in the care of mother and baby after birth and the expected progress of both the woman and the newborn through the first six to eight weeks postpartum. Three key components of care provide the basic themes for the pathway. These are:

• maintaining maternal health,
• infant feeding, and
• maintaining infant health.

The pathway is divided into three ‘time bands’ which cover the postnatal period, and where necessary direction is given about when after birth particular care should be given. Recommendations for core care are indicated as are referral points for raised concern’ (p24).
2

Research methods

The study is based on a self-completion questionnaire comprising 31 closed questions and three open-ended questions. Women who said they had not received consistent information and advice in relation to feeding were asked to explain what had occurred. Also, at the end of the questionnaire, women were asked to explain what was ‘especially good or important’ about their postnatal care and what aspects of their care ‘were not good or could have been improved’. All of the free-text feedback women provided therefore relates to something they regarded as especially good or important or care which was not in their view of an adequate standard.

2.1 Questionnaire development and piloting

The survey was designed to replicate aspects of the NCT postnatal care survey carried out in 1999/2000 and to reflect the recommendations in the NICE postnatal care guideline. It was piloted online and on paper with 32 women who had given birth in the previous 12 months (September 2008 to September 2009). The aim of the pilot study was to ensure that the questionnaire covered topics that were relevant to women and was easy to complete. In response to feedback, amendments were made to the questionnaire to make it easier to navigate. No modifications to the wording of individual questions were suggested.

2.2 Data collection and data entry

The survey was conducted online using SurveyMonkey software from October 2009 until early January 2010. It was advertised through NCT publications. These included: eGen, an electronic newsletter, which has a readership of approximately 50,000 NCT members; NewGen, the hard-copy NCT members’ magazine, with a readership of 57,000; and Stepping Stones which has a readership of approximately 22,000 NCT members and non-members. A hard copy of the questionnaire was also inserted into the 2009 winter edition of NewGen. Women were encouraged to go online to complete the questionnaire or to complete the paper copy and submit by freepost. A total of 1540 responses were received of which 1097 were online and 443 were on paper. Data from the paper questionnaires were entered into SurveyMonkey. The accuracy of data entry of the paper questionnaires was verified on a random sample of 10%.

2.3 Data analysis

The questionnaire invited participation from people who had ‘had a baby within the last 12 months’. As a large majority of the respondents were first-time mothers (83%) we decided to focus the report on this group of women. In addition to having a large sample of first-time mothers, it is known that this group generally have greater needs than those who have previously given birth. Reports of care were analysed within different time periods (first 24 hours, 2-7days and 8-30 days) and comparisons were made with data collected in the 1999/2000 postnatal care survey.

¹ The survey was intended for women only, though this was not made completely explicit. Data for four men who responded has been excluded from the analysis.
Proportions were compared using Chi-squared tests and p values ≤0.05 were reported as statistically significant. Means were compared using Kruskal Wallis tests and Mann Whitney tests. A Bonferroni adjustment was made when running Mann Whitney tests to compare women’s experiences by different modes of birth (spontaneous, assisted and caesarean).

A total of 1321 respondents (86%) included feedback to one or more of the three open ended questions, including 1081 first-time mothers (86%). Eighty percent of comments received by first time mothers contained a mixture of positive and negative comments about postnatal care, 8% of comments were wholly positive and 12% were wholly negative. The open text responses submitted on-line have been used to illustrate women’s experiences of care indicated by the responses to closed format questions. Minor amendments have been made in some cases when feedback was not in complete sentences. With a few exceptions, such as feedback about NCT services and support, the open text comments have not been analysed systematically.
The sample

A total of 1536 self-selected women took part in the survey. The profile was not typical of all childbearing women in the UK. The results chapters focus on the experiences of first-time mothers only, unless otherwise stated. However in this chapter, where comparisons are made between the profile of the NCT sample with national statistics for childbearing women, details for all the women who responded are provided. This seemed appropriate as many of the national statistics are for all maternities or all women of childbearing age rather than first-time mothers.

3.1 Socio-demographic profile of respondents

A large majority of the sample were first-time mothers (83%, n=1260/1536) and most were NCT members (95%, n=1399/1476). Two thirds of those responding to the 1999/2000 survey were first-time mothers, so the proportion is considerably greater in the follow-up survey.\(^2\)

Comparison with the most recent national statistics for women giving birth in England and Wales\(^3\) shows that our survey sample is older with higher proportions of women aged over 30 (79%, n=1174/1479) and only 1% of women under 25 (see Table 1).

Table 1. Age profile of women in survey compared with age profile of women for all of live births for England and Wales

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<th>Age in years</th>
<th>% of first-time mothers in NCT survey (n=1211)</th>
<th>% of all mothers in NCT survey (n=1479)</th>
<th>% live births in England &amp; Wales 2008 (n=708,711)</th>
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<tbody>
<tr>
<td>Under 25</td>
<td>1</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>25-29</td>
<td>15</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>30-34</td>
<td>50</td>
<td>48</td>
<td>27</td>
</tr>
<tr>
<td>35-39</td>
<td>29</td>
<td>31</td>
<td>16</td>
</tr>
<tr>
<td>Over 40</td>
<td>5</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>


Ninety six percent of women classified themselves as White (see Table 2). Compared with census data collected in 2001,\(^3\) respondents from minority ethnic groups are under-represented in this survey.

Table 2. Ethnic background of mothers in survey compared with population profile 2001

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>% of first-time mothers in NCT survey (n=1206)</th>
<th>% of all mothers in NCT survey (n=1470)</th>
<th>% population in England &amp; Wales 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (English/Scottish/Welsh/Northern Irish/British, White Irish and White other)</td>
<td>95</td>
<td>96</td>
<td>92</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>5</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: http://www.statistics.gov.uk/cci/nugget.asp?id=273  NB ‘Other ethnic groups’ included Mixed White and Black Caribbean, Mixed White and Black African, Mixed White and Asian, Asian Indian, Chinese, Black Caribbean and Black African and other
Approximately 90% (n=1323/1476) of women reported having a higher education or postgraduate degree with the same proportion of first-time mothers 90% (n=1087/1209). This proportion is 4.5 times higher than the rate for mothers with dependent children in the UK (19%). Around 98% (n= 1447/1470) of women reported living with a partner either married, in a civil partnership or unmarried. This figure is higher than average; official statistics show that approximately 84% of babies are born to married or unmarried parents who are living together.

### 3.2 Place of birth

The majority of women (84%, n=1273) who responded to the survey gave birth to their baby in a hospital labour ward. Around 9% (n=137) gave birth in midwife-led unit/birth centre (see Figure 1). The rates for home birth (7% n=113) were higher than for the population as a whole (3%). Compared with NCT postnatal care survey carried out in 1999/2000, more births took place in birth centres and fewer in a hospital labour ward. The proportion of home births stayed the same (see Figure 2).

#### Figure 1. Place of birth – NCT 2009/10 survey

[Diagram showing hospital, midwife-led unit/birth centre, and home births]

#### Figure 2. Place of birth – NCT 1999/2000 survey

[Diagram showing hospital, midwife-led unit/birth centre, and home births]

Women who had previously given birth were more likely to have their baby in a midwife-led unit/birth centre or at home (30%) (see Table 3). The terms ‘birth centre’, ‘midwife-led unit’ and also ‘community maternity unit’ are used to refer to maternity units managed by
midwives. These can be ‘freestanding’, i.e. away from a hospital with an obstetric unit, or ‘alongside’, located on the same site as a hospital with an obstetric unit. In this report no distinction is made between freestanding and alongside midwife-led units/birth centres as women were not asked to provide information that would enable us to distinguish one setting from the other. The questionnaire used the phrase ‘midwife-led unit or birth centre’, however, in the following chapters the term ‘birth centre’ is used for simplicity. This term appears to be preferred by most new midwifery-led units in the UK.10

**Table 3. Place of birth**

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>First-time mothers (n=1250)</th>
<th>Other mothers (n=265)</th>
<th>All (1523)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital</td>
<td>86%</td>
<td>70%</td>
<td>84%</td>
</tr>
<tr>
<td>In a midwife led unit /birth centre</td>
<td>9%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>At home</td>
<td>5%</td>
<td>18%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Significant association (Chi square p≤0.01)

The Healthcare Commission reported that ‘the vast majority of births take place in obstetric units (93%). Of the remainder 3% take place in alongside maternity units, 2% in freestanding maternity units and 2% at home’.13 In the NCT sample, the proportion of women giving birth in a birth centre or at home was higher.

### 3.3 Mode of birth

Overall 53% of women had a spontaneous vaginal birth with the rate somewhat lower for women having their first baby (48%). More than half of first-time mothers had an operative birth (52%). This is higher than the proportion reported by the Healthcare Commission in Recorded Delivery (47%). However, the Healthcare Commission sample was younger with 42% aged under 30 years compared to 14% in the NCT sample.31 The proportion of first-time mothers having a caesarean section (26%) in this survey is broadly similar to the proportions for all women in 2009 for England (26%), Scotland (24%) and Wales (27%).40,41,42 The proportion of all women who had operative birth (47%) is slightly higher than the rate reported in the 1999/2000 survey (41%).32

**Table 4. Mode of birth**

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>First-time mothers (n=1255)</th>
<th>Other mothers (n=266)</th>
<th>All (1529)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous vaginal delivery</td>
<td>48%</td>
<td>81%</td>
<td>53%</td>
</tr>
<tr>
<td>Assisted delivery (forceps or ventouse)</td>
<td>26%</td>
<td>3%</td>
<td>22%</td>
</tr>
<tr>
<td>Caesarean</td>
<td>26%</td>
<td>16%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### 3.4 Duration of stay

One of the most dramatic changes in postnatal care in the UK in the past 30 years is the reduction in the length of time women spend in hospital following birth.43 In this survey, for those women who gave birth in hospital, the most common experience for first-time mothers was to stay in hospital for 1–2 days (44%); women who had had a baby before commonly stayed for less than 24 hours (40%) (see Table 5). Around one in seven first-time mothers (14%, n=173) stayed in the unit for 5 days or longer.

Hospital Episode Statistics for England indicate that overall 90% of women stay in hospital 0–3 days. This grouping of data is not directly comparable with the data collected here.44
A much higher proportion of first-time mothers who gave birth in a birth centre went home within 24 hours (40%) (see Table 6).

Table 6. Duration of stay in a birth centre

<table>
<thead>
<tr>
<th>Parity</th>
<th>First-time mothers (n=1074)</th>
<th>Other mothers (n=186)</th>
<th>All (n=1260)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 24 hours</td>
<td>15%</td>
<td>40%</td>
<td>18%</td>
</tr>
<tr>
<td>1-2 days</td>
<td>44%</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>3-4 days</td>
<td>27%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>5 days or more</td>
<td>14%</td>
<td>9%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Not unexpectedly, there were significant differences in duration of stay in hospital for women experiencing different modes of birth (see Table 7). Women who had an assisted delivery or a caesarean stayed longer in hospital than those who had a spontaneous birth (Mann Whitney p≤0.016).

Table 7. Duration of stay in hospital by mode of birth for all mothers

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>Spontaneous birth (n=428)</th>
<th>Assisted (forceps or ventouse) birth (n=312)</th>
<th>Caesarean birth (n=331)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 24 hours</td>
<td>27%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>1-2 days</td>
<td>48%</td>
<td>50%</td>
<td>32%</td>
</tr>
<tr>
<td>3-4 days</td>
<td>17%</td>
<td>23%</td>
<td>44%</td>
</tr>
<tr>
<td>5 days or more</td>
<td>8%</td>
<td>14%</td>
<td>24%</td>
</tr>
</tbody>
</table>

3.5 Summary

In summary, the survey is based on a group of women who were in touch with NCT. They are older, less diverse in terms of ethnic background, and more likely to have degree level education than the population as a whole. They are also more likely to use a birth centre or to have a home birth than average. The sample is not representative of all childbearing women in the UK and the results are therefore not generalisable. However, the sample is a large and articulate one. The women participating have provided detailed information about their experiences and attitudes. It is useful to be able to compare the postnatal care accounts of women from this socio-demographic cohort who had had a spontaneous birth with those who had had an operative birth. The disproportionately large numbers of women, including first-time mothers, giving birth at home or in a birth centre also make it possible to compare the postnatal care experiences of women in different maternity care settings, which is highly relevant to the current policy debates about place of birth, women’s informed decision-making, and the provision of woman-centred care.
First-time mothers’ experiences of support, care and information

This is the first of four results chapters. All findings reported relate to first-time mothers unless otherwise stated. The survey focused on women’s experiences and views about their postnatal care at their place of birth and after returning home.

NCT was concerned to know how well supported women felt in the days and weeks after the birth of their baby, and whether they felt they were given adequate clinical care, particularly if they had more complex needs. In our earlier survey, we had identified emotional support and information as being important elements of woman-centred postnatal care, and we reported a gap between women’s reported needs and the care being provided. In particular, women who had had an operative birth (assisted with forceps or ventouse or a caesarean section) generally had more complex needs and suffered more when care and support were lacking.

In this survey we look at women’s postnatal experiences again, a decade after our previous study. This chapter reports on aspects of postnatal care which replicate the 1999/2000 investigation. The first section addresses women’s emotional support needs and how well they felt that they were met. The second section addresses women’s physical care. The third section looks at information provided on the postnatal ward and afterwards, including advice and communication about women’s own health and recovery, and about their babies’ health and wellbeing.

These three aspects of care, the emotional the physical and the informational, are closely interwoven in practice, so it is neither possible nor meaningful to separate them out completely. Rather, this way of structuring the material seeks to demonstrate the complexity of the ‘work’ that women are doing in the early days after birth: the emotional processing of what has occurred and adjustment to the new sense of self, the physical changes of restitution, recovery and lactation, and getting to know and care for their baby, initially often away from their family in a busy postnatal ward. By focusing on different aspects of experience and need, the report begins to illustrate the multiple ways in which this work can be acknowledged, valued and assisted or, conversely, overlooked and undermined.

The fourth section of the chapter addresses the experiences of women who had had an operative birth, and compares the reported needs of women who had planned and unplanned caesarean births. The fifth section compares the experiences of women giving birth in different settings: in hospital, in a birth centre and at home. The final section of the chapter compares the 2009/10 findings with those of the 1999/2000 survey.

Some of the results and discussion address the extent to which there were differences or similarities in the quality of care from women’s perspectives at different time periods during the first month after birth.

The three results chapters which follow address women’s experiences of breastfeeding and bottle feeding; the implementation of NICE recommendations for postnatal care; and structural and organisational aspects of care, including women’s perceptions of midwifery staffing levels and opportunities for women to have continuity of care and carer.

The quotes we have selected from the responses to the open-ended questions are accompanied by details of where the woman gave birth and whether her baby was born.
spontaneously or with assistance. This detail is provided as we recognise that some women are likely to need more care and support, and in some settings there may be a different philosophy of care, different organisation of midwives or different staffing levels, all of which may influence how midwives and other staff interact with women.

4.1 Emotional support

Women experience a range of emotions after giving birth. For some there is elation and a deep sense of awe and fulfilment. At the other extreme anything from numbness and exhaustion to traumatic flashbacks, anguish or regret. Often feelings of happiness and relief are mixed with tiredness and uncertainty. Any worries about their baby’s health or separation, if their baby is taken into special care, can be distressing. Physical discomfort, particularly if there is frequent or sustained pain, can be emotionally draining. Numerous studies have highlighted women’s need for kindness, positive acknowledgement and reassurance as they process what is happening and what it means for them.30,45,46

The NICE guideline on postnatal care acknowledges the importance of the affective aspects of care, encouraging health professionals to ask women how they are feeling at each postnatal contact. It recommends that women ‘should be asked about their emotional well-being’ and that both women and their partners should be encouraged to talk about ‘any changes in mood, emotional state and behaviour outside their normal pattern’.18

Women’s partners also need to feel valued and included in the days after birth. Having to leave the hospital after the birth and go home alone to an empty house is increasingly recognised as a low point for many fathers.5,47,48 If there is any kind of health crisis for their partner or their baby they can feel particularly fearful.47 Partners’ needs and preferences may be overlooked, particularly as they may be careful to conceal the extent of their feelings.

We asked women to what extent they got the emotional support they needed during the first month after birth. In the first 24 hours after birth less than half of the first-time mothers (41%) felt that they received all the emotional support they needed. As table 8 shows, approximately a third of women felt they got a little or no emotional support from healthcare staff during the first month after birth.

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours (n=1252)</th>
<th>2-7 days (n=1249)</th>
<th>8-30 days (n=1242)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all the emotional support needed</td>
<td>41%</td>
<td>41%</td>
<td>35%</td>
</tr>
<tr>
<td>Got some of the emotional support needed</td>
<td>25%</td>
<td>28%</td>
<td>34%</td>
</tr>
<tr>
<td>Got a little of the emotional support needed</td>
<td>17%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Did not get the emotional support needed</td>
<td>17%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Women who said that they got all the support that they needed tended to emphasise the importance of being reassured about their health and life with a new baby and the interest taken in their emotional and physical health.

*Although I saw several midwives I got to know each of them so felt very supported. I had two midwives at home whilst in labour and felt very safe, one of which kept in close*
contact with me for the first couple of weeks before I was discharged as there were some initial warning signs of postnatal depression so I felt very assured that if it did develop I was on the radar and had some great advice which helped me overcome my initial fear of becoming a parent. (Spontaneous home birth)

Our midwives were compassionate, had humour, were sensible but also incredibly flexible and made us feel we could handle this new life. I had fairly rough baby blues for a few weeks and they were just incredible. (Spontaneous hospital birth)

One woman in particular valued the extra support she was given when her baby was in a neonatal intensive care unit.

My postnatal care took place in two hospitals before we were allowed to come home. Day 1 was at [name] General Hospital and Days 2 to 17 were at the [second] Hospital. The staff at the latter were far superior to those at the first hospital. Yes, they were busy but they would always find time to talk to me and catch up with how baby was doing on the neonatal intensive care unit. They were interested in my physical and emotional well-being. They were pushed for bed space at one point but fought to allow us to remain on the postnatal ward so we could be close to our baby and they were willing to have baby room-in on the postnatal ward prior to our discharge to ensure we had the support we needed. It felt as if they cared – like a second family or another set of friends who were there when your own had gone home. Even when they were low staffed they didn’t take it out on the patients. (Spontaneous hospital birth)

Conversely, the comments of those who experienced a care gap show there was both a lack of midwifery time and a lack of sensitivity. It was not uncommon for women to report feeling isolated, needing to ask in order to be given attention.

I did not feel much emotional support as a first-time mother once I was on the ward in the hospital and once I was home. Every midwife or health visitor seemed to have their own opinion which often conflicted – not great for a stressed-out and emotional mum. (Spontaneous hospital birth)

In the postnatal ward, the midwives seemed very stretched and did not have enough time to really provide any ‘hand holding’ and reassurance. You were pretty much left to your own devices unless you had a troublesome baby or were very vocal in your demands. (Assisted hospital birth)

My stay in hospital was horrendous. The staff were rude and impatient and midwives seemed to treat me like a malingerer during my five days stay despite me having a c-section and my baby needing some time on the neonatal ward... My partner was regularly treated as a hindrance and spoken to rudely by staff. A depressing and isolating experience. (Caesarean birth)

Some women whose babies were unwell and cared for separately in a special care baby unit felt particularly unsupported emotionally during this time.

Greater understanding was needed about the emotional impact of having a baby taken to the special care baby unit (Assisted hospital birth).

* A glossary of terms and abbreviations is provided in Appendix 1. Words and phrases included in the glossary are marked with an asterix.
Staff failed to carry out urgent tests on our baby which endangered his life. ...Panic ensued, the paediatricians were involved and he was whisked away to another hospital NICU* for stabilisation and emergency treatment. They didn’t bother with me after that. They did not give a damn about how it might feel to be stuck on a bed in the postnatal ward when your baby was gravely ill and you couldn’t be there for it. Where was the human kindness? (Assisted hospital birth)

Husbands’ and partners’ needs for emotional support were overlooked just as women’s were.

I had a haemorrhage immediately after birth and was taken into theatre for 2.5hrs. My husband was not supported ...he was left holding a baby in a sheet for 2 hours. During the whole experience I felt that no one was supporting me emotionally. (Spontaneous hospital birth)

In the absence of adequate care and support in hospital many women commented that they would have felt less isolated and scared if their partners had been allowed to stay overnight with them or if visiting hours were less rigid. Some felt flexibility in these areas would have been beneficial for their partner as well as providing much needed practical and emotional support for them.

Care in hospital after my caesarean was awful. There weren’t enough midwives available to support me during the night and I was upset, emotional and confused for the entire stay in hospital. I think partners should be permitted to stay during the first night after childbirth. (Caesarean birth)

The postnatal ward was too crowded with four women and their babies in one room. It was impossible to rest with all the noise and activity going on at all hours. Partners are not allowed to stay overnight and this is particularly hard for a new dad who has to leave his newborn and also hard on the mother who needs his support and assistance. (Spontaneous hospital birth)

My husband not being allowed up on the ward as I had my baby in the evening (was not good). It left me feeling very scared and lonely. (Assisted birth)

In contrast, women whose partners were able to stay over night felt that this contributed to the support available to them and their overall sense of well-being.

I gave birth in a midwife-led unit. I cannot speak highly enough of the support that I received. My partner was also able to stay as extra support. (Spontaneous birth centre birth)

(I was at) a midwife-led unit where mothers and their partners can stay. This is a wonderful service that should be available across the country. I will forever be grateful for their help. (Spontaneous birth centre birth)

Several women talked about having postnatal depression or feelings that indicated that they were experiencing psychological distress in the days after discharge from hospital. They felt that healthcare professionals were particularly bad at picking up on
this and providing support. There were instances where women had to raise these issues with staff in order to seek support and at times the response from staff was of a poor standard.

Support from midwives and health visitors in the first few weeks was particularly bad. I felt they were particularly bad at giving emotional support; they seemed to mainly concentrate on practical advice. When I explained that I felt I had some kind of psychological illness, the health visitor gave me a leaflet about “not shaking my baby” which seemed very insensitive. (Spontaneous hospital birth)

I didn’t feel my health post-birth was ever checked. I was struggling and worried that I had postnatal depression. I tried speaking to the health visitor who suggested I speak to my doctor. When I spoke to my doctor she suggested I speak to the health visitor. I just felt that no one wanted to get involved and I was just fobbed off. (Spontaneous hospital birth)

My health visitor was appalling and did not pick up on my postnatal depression...I sincerely believe that the lack of support I received from the health visitor contributed to me getting postnatal depression. (Spontaneous hospital birth)

I felt extremely low but was never asked about the emotional side of things so did not feel comfortable about talking about (my feelings). I feel emotional support is as important as all other aspects of postnatal care but somehow it was overlooked. (Caesarean birth)

4.2 Physical care

After a spontaneous vaginal birth, women may have some bruising or a perineal or labial tear. They may worry about the extent of their bleeding or about having their bowels open for the first time, but generally their physical care needs are more straightforward. If they are attended to early it is often possible to avoid problems developing. New mothers need plenty of rest, access to a clean toilet and bathroom and to be looked after with regular drinks and appetising food. Supportive attention in the early days is also important in order to avoid or minimise breast engorgement and nipple trauma (see Chapter 5).

Yet, studies have shown that emotional health problems are common after childbirth and woman often do not discuss the symptoms health professionals.\textsuperscript{49,50,51} Backache, perineal pain, feeding difficulties and depressed mood can persist, preventing women from being able to carry out everyday activities.\textsuperscript{51} Early identification and management is important for the sake of the mother and her family.\textsuperscript{11,23} The NICE guideline emphasises the need to ask women at each contact about both her physical and emotional wellbeing.\textsuperscript{18}

We asked women about the extent to which their physical care needs were met by healthcare staff. Slightly over half of first-time mothers felt that they had received all the physical care they needed in the first 24 hours after birth (56%). The proportion decreased from day 2 and decreased again after day 8 (see Table 9) Throughout the first month after birth, around one in five first-time mothers said they got little or none of the physical care they needed.
Women who reported positive experiences about their physical care often noted the importance of a holistic approach which addressed physical changes during recovery, the need to learn new practical skills in baby care, and the importance of rest and nourishing meals.

My postnatal care was exceptional. I had a surprise home birth (no time for the hospital) and the care I received from my midwives both during and after cannot be faulted. They were kind, caring, understanding, knowledgeable, consistent and helpful with regards to both baby and my health/recovery. (Spontaneous home birth)

The staff from the birth centre were friendly and extremely competent. There I received a good level of care and assistance physically and practically — e.g. with fundamental tasks such as how to put a nappy on! I was able to get a relaxed night with a hearty breakfast. (Spontaneous birth centre birth)

Some women felt that their community midwives were good at supporting and informing them about what to expect and what symptoms were within the normal range. They were therefore more likely, with the woman, to identify health problems.

I was very poorly after the birth due to infection and being so stressed in hospital, I was exhausted when I finally got home and my midwife helped me realise what was normal and what wasn’t and she was the one who identified that I had the infection. (Caesarean birth)

My episiotomy opened and was infected. The midwife that came to visit me was excellent at reassuring me and checking that everything was okay. (Assisted hospital birth)

The midwife was brilliant and very understanding after an awful experience at the hospital. c-section stitches got infected and she came to see me straight away. I can’t fault the care after discharge at all. (Caesarean birth)

For women who sustained physical trauma from a perineal tear or episiotomy, it was important that the wound was well stitched, that they had adequate pain relief and their dignity was respected. They also needed their midwives to check their wound was healing normally.

Despite sustaining severe injury during the birth, my postnatal medical care was excellent. I received prompt, skilled surgery and good pain relief, both during my hospital stay and in the weeks after, meaning that I didn’t suffer any pain and I have still come away from the birth experience with a very positive outlook! I even received a follow up appointment after 12 weeks to ensure I was having no related problems. I cannot fault my medical care at all! (Spontaneous hospital birth)

### Table 9. Physical care in the first month after birth

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours (n=1249)</th>
<th>2-7 days (n=1243)</th>
<th>8-30 days (n=1239)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all the physical care needed</td>
<td>56%</td>
<td>51%</td>
<td>45%</td>
</tr>
<tr>
<td>Got some of the physical care needed</td>
<td>24%</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>Got a little of the physical care needed</td>
<td>12%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Did not get the physical care needed</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Significant association between time periods (Chi square, $p \leq 0.01$)
The midwives regularly checked my episiotomy stitches and how well I was healing, either by asking me or when I asked them. This was a really big thing for me. The presence of a midwife in my home was reassuring – this was my first baby and it was a terrifying time! (Spontaneous hospital birth)

I had a tear at delivery so required a spinal anaesthetic/catheter etc. The midwives helped me to retain my dignity, provided pain relief when I needed it and helped with my baby when I was immobile. The medical staff explained clearly the nature of my injury and were honest about the possible complications. Follow up was discussed. When I had to return to hospital 12 hours after discharge because of complications I was treated with compassion and was never made to feel as though I was making a fuss. (Spontaneous hospital birth)

Unfortunately many women’s reasonable expectations were dashed. At a time when they were celebrating the birth of their first baby and having come through the birth, they needed care and attention to help them get clean and comfortable and to begin feeding their baby. Yet frequently basic physical care needs were overlooked.

When we got to the postnatal ward, everything had to be begged for – assistance to express my colostrum manually and then by pump, change of pads, removal of catheter, a meal…a shower. It was a fiasco and not at all what we planned for. (Spontaneous hospital birth)

At the hospital after birth, I didn’t feel well at all. My husband struggled to get things I need sorted. My first night there was a nightmare, with a newborn, without any experience, feeling unwell…I felt absolutely lonely. The night staff was horrible, I asked a question and I got a very rude answer, I was there terrified of asking for help. (Spontaneous hospital birth)

For some women important aspects of clinical care seem to have been neglected for days, resulting in them feeling tired, unwell and at the risk of further complications. These included identification and treatment of anaemia and wound infection, and appropriate assessment of uterine involution* and blood loss.

The after birth care was minimal…I got very anaemic and felt very rough with permanent motion sickness type symptoms and loss of appetite but nobody told me what I needed to feel better. About 10 days after the birth, eventually one midwife arranged for a prescription from my GP. When I eventually came back home, he said that I was very close to needing a blood transfusion. I was expressing milk throughout and managed to breastfeed my baby after surgery but I did find the whole experience exhausting. (Assisted hospital birth)

I was discharged from hospital feeling weak and faint and nobody picked up that I had a PPH* (including the three midwives who visited me at home) until six days later when I was rushed back into hospital by ambulance having passed an enormous blood clot and bleeding again. This was despite the midwives writing on my notes that I needed to be monitored for blood loss and infection. (Spontaneous hospital birth)

As Table 9 shows, in the period 8-30 days after birth the proportion of women who felt that they got little or none of the physical care they needed increased to 23%. A number of women reported symptoms of infection or other health problems being overlooked.
The midwife that was assigned after birth didn’t seem to care and was always in a hurry to go. She didn’t check my stitches even though it was in my notes from the hospital so they ended up infected. (Assisted hospital birth)

The midwife ignored what I said about pain, discharge and rigours and hence the delayed treatment of a serious infection. (Spontaneous hospital birth)

My c-section wound became infected about a week after I was discharged from the ward. The midwives did not appear to have the most recent information about wound care and I was seen by different midwives so there was little continuity in the care and advice I was given. (Caesarean birth)

I had thrombophlebitis* in my leg postnatally about a week after birth and I found it initially difficult to access help. I was concerned at that point that it was a DVT.* I phoned my midwife/central team who weren’t available, then phoned the postnatal ward who told me to phone my GP. The GP surgery was shut for lunch but when I eventually got through they were very helpful and came within a couple of hours. However, I found having to “go round the houses” to get there very stressful. (Spontaneous hospital birth)

Infections and other health concerns were often resolved once clinical care was provided but some resulted in long-lasting physical and emotional effects.

An infection was not spotted and this led to further complications. I was concerned about the scar for a long time but no one took me seriously. (Caesarean birth)

Some women noted that less attention was paid to their physical recovery, compared with attention given to their baby.

Midwifery care was awful. Each visit after the birth became shorter and shorter and I lost interest in them. It appeared to me to be a complete tick box exercise for my health and that they were more interested in the baby. (Spontaneous hospital birth)

I feel that my own comfort and progress was not taken seriously. I had quite a bad tear and deep stitches, it was difficult to get them checked and I was made to feel as though I was wasting time. It was very difficult to receive conflicting advice from various midwives and health visitors. (Spontaneous hospital birth)

4.3. Information

Women have a range of information needs related to their own health and physiological changes after birth, and related to the care and wellbeing of their baby. Generally, first-time mothers expect to be guided by health professionals on aspects of how and when to feed and to change their baby. They may be concerned about what is normal in relation to cord care, babies’ bowel movements, rashes and birthmarks, for example. On the hospital ward, parents need to know what is available for their use and where things are stored, such as clean cot sheets and nappies. They need to know what to expect in terms of blood loss, and may need information about care of stitches and options for pain relief.

It is important that staff provide information on keeping babies safe. For example, in the early days a midwife should check that parents know about putting babies down to sleep in their cot lying on their back with their feet at the base, so that they cannot wriggle down and get covered by bedding. Parents should also be given guidance on layers of clothing as newborn babies cannot regulate their own body temperature in the way older children and adults can.
For parents with a premature or sick baby, or a baby who is being observed because they may have additional needs or risk factors, there is need for clear explanations and regular updates on their progress.  

NICE guidance on postnatal care recommends that women should be offered relevant and timely information to promote their own health and wellbeing and that of their baby. They should be made aware about how to recognise and respond to common health problems, for example, jaundice, constipation and diarrhoea.  

In the first 24 hours after birth, only 45% of first-time mothers felt that they had received all the information and advice they needed about their own health. After the first week the rate dropped to just 35% (see Table 10). A quarter of first-time mothers said they got little or none of the information and advice they needed during the first 24 hours. Yet, overall, results were poorest for the period after the end of the first week.

<table>
<thead>
<tr>
<th>Information and advice about own health in the first month after birth</th>
<th>First 24 hours (n=1253)</th>
<th>2-7 days (n=1250)</th>
<th>8-30 days (n=1243)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all the information and advice needed</td>
<td>45%</td>
<td>43%</td>
<td>35%</td>
</tr>
<tr>
<td>Got some of the information and advice needed</td>
<td>30%</td>
<td>37%</td>
<td>36%</td>
</tr>
<tr>
<td>Got a little of the information and advice needed</td>
<td>18%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Did not get the information and advice needed</td>
<td>8%</td>
<td>4%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Significant association between time periods (Chi square, p≤0.01)

Some women complained that they were not welcomed onto the postnatal ward and told about the facilities and the usual routine.

I was not shown where to find basic supplies (towels, bowls for nappy changes) and when I asked nurses for them they made it clear I was an annoyance. (Caesarean birth)

In the first 24 hours after the birth the midwives in the hospital were overworked, one was very rude and blunt. I was not shown where any of the facilities were or how to get meals. (Assisted hospital birth)

Women valued midwives and later health visitors taking an interest in their health and making suggestions about what they could do to assist healing and recuperation after birth.

The midwife took a real interest in my own health and told me exactly what I needed to be doing and what supplements to take to aid my own recovery following the third degree tear I sustained during birth. (Spontaneous hospital birth)

The midwife who visited me at home after I was discharged was immensely kind and reassuring. I was shown how to sit on cushions and she explained how to take the pain/swelling medication I had been given for maximum effectiveness. (Assisted hospital birth)

I saw a health visitor when I was having my daughter weighed at a drop-in session and was able to ask questions about my own health and got some really good, sensible advice. (Caesarean birth)

However, as noted above, many women felt that health professionals paid more attention to the needs of the baby than their own recovery, and that the management of specific health problems were overlooked.
I was surprised, after leaving the unit that so little attention was given to my health. I felt guilty asking questions about me when all consideration seemed to be for the baby. (Spontaneous birth centre birth)

Although I was given good advice in hospital about caring for my baby, I was given far less information about my own recovery. I later had complications from my stitches and I feel that this could have been avoided if I had been given more specific information. (Spontaneous hospital birth)

I developed haemorrhoids but no one checked me or gave me advice on this before I was discharged, I mentioned this to the midwives at the home visits but again didn’t really receive a lot of advice. (Spontaneous hospital birth)

In contrast to their own health information needs, at all times during the first month after birth, a higher proportion of women felt that they had received all the information they needed about their baby’s health (see Table 11). Throughout the first week, including the first 24 hours, half of the first-time mothers (52%) said they got all the information and advice they needed about their baby’s health. However, during the first month after birth, around one in seven women felt that they had received a little or no information they needed about their baby’s health.

Table 11. Babies’ health information and advice in the first month after birth

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours (n=1252)</th>
<th>2-7 days (n=1255)</th>
<th>8-30 days (n=1250)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all the information needed</td>
<td>52%</td>
<td>52%</td>
<td>46%</td>
</tr>
<tr>
<td>Got some of the information health needed</td>
<td>31%</td>
<td>34%</td>
<td>39%</td>
</tr>
<tr>
<td>Got a little of the information needed</td>
<td>11%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Did not get the information needed</td>
<td>6%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Women who given birth to premature babies or who had babies who were unwell particularly valued being provided with detailed and timely information. This provided the much needed reassurance during a very stressful time.

My son was born four weeks early as my waters had started to trickle from 34 weeks. He was assessed by the paediatrician and luckily he did not need to go into SCBU.* He was kept under observation for three days and then developed jaundice so in total we were in hospital for one week. Everyone was good at explaining. We saw several midwives during our time and they were all superb. Overall I could not fault the hospital maternity unit and all the specialists that looked after my son during the first week. We also had several visits by the health visitor which were always great. (Spontaneous hospital birth)

The midwives who cared for my son and I in hospital were consistently helpful, supportive and reassuring and my community midwife was caring and very supportive in the early days. My son was readmitted to hospital at three days old with severe jaundice and the care given to all of us as a family by the staff in special care and the postnatal ward was excellent. The nursing staff explained what was happening and made sure we were aware of all the treatments that my son underwent. (Spontaneous hospital birth)

So, it is evident that some hospitals clearly were managing to provide a high standard of woman-centred postnatal care. Care that was praised by women was often positive in a range of respects. For example, the comment above went on to say:
The nursing assistant who bought me tea and toast in the middle of the night was an absolute lifesaver. (Spontaneous hospital birth)

In contrast, inconsistent information was a problem for women and sometimes conditions were inadequately explained both by midwifery and medical staff.

Night-time staff on the maternity ward were rarely available and gave inconsistent and unclear advice leading to my baby requiring extra treatment (under a lamp for jaundice), which could have been avoided. (Assisted hospital birth)

I would have valued some more information on the risks associated with jaundice and also on tongue tie. I was told by the paediatrician that my son had tongue tie but he did not explain what it meant. (Assisted hospital birth)

4.4 Women who had operative births

Women who have operative births, that is births by caesarean section or assisted with forceps or ventouse, tend to have more pain during the postnatal period than women who have had a spontaneous vaginal birth. This is usually both greater in extent and more prolonged. This can make it more difficult to sit comfortably and to sleep well, affecting the extent to which women can feed and look after their baby, and how they feel in themselves.54,55 Women who have had either a planned or unplanned caesarean may also be subject to poorer psychological outcomes,55 and therefore need postnatal support which is responsive to their particular emotional needs,56 as well as additional clinical care and information about recovery. Unplanned caesarean births, in particular, have been found to be associated with disappointment, sadness and a sense of inadequacy.57

Overall, women who had an assisted birth or caesarean consistently reported a bigger care gap in relation to emotional support, physical care and information about their own and their baby’s health compared with women who had a spontaneous vaginal birth (see Tables 12-15). Looking across three time periods, the first 24 hours, 2-7 days and 8-30 days after birth, the trend is very clear, indicating that women who had had a caesarean had the greatest level of unmet need. In particular, the results show that the greatest gap in care concerns women’s need for emotional support. Fewer women who had had an assisted birth or a caesarean reported that all their emotional support needs were met. Commenting on the first 24 hours after birth, one third of women who had forceps/ventouse or a caesarean said their emotional needs were met (34% and 35% respectively) compared with half of women having a spontaneous birth (49%) (see Table 12). A significantly higher proportion also said that little or none of their emotional needs were met (39% and 43% respectively, compared with 25%) at this time.

This trend continued throughout the first month. At 8-30 days after birth, women who had had a caesarean birth continued to feel least well supported in terms of emotional support, physical care and their informational needs. Women whose birth had been assisted with forceps or ventouse also had greater unmet needs than women who had had a spontaneous birth. At 8-30 days, up to a third of women who had had a caesarean felt that their needs for emotional support (35%) and information in relation to their own health (32%) had been overlooked.

In terms of information about their baby’s health, women who had had an operative birth were significantly less likely to feel their needs had been met in the first 24 hours after birth. There were no significant differences at 2-7 days or 8-30 days after birth.
**Table 12. Emotional support in the first month after birth by type of birth**

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=592)</td>
<td>Assisted (n=322)</td>
<td>Caesarean (n=333)</td>
</tr>
<tr>
<td>Got all the emotional support needed</td>
<td>49%</td>
<td>35%</td>
<td>34%</td>
</tr>
<tr>
<td>Got some of the emotional support needed</td>
<td>26%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>Got a little of the emotional support needed</td>
<td>14%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Did not get the emotional support needed</td>
<td>11%</td>
<td>19%</td>
<td>23%</td>
</tr>
</tbody>
</table>

** Significant difference between modes of birth for each time period (Mann Whitney, p≤0.016)**

**Table 13. Physical care in the first month after birth by type of birth**

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=592)</td>
<td>Assisted (n=318)</td>
<td>Caesarean (n=334)</td>
</tr>
<tr>
<td>Got all the physical care needed</td>
<td>62%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Got some of the physical care needed</td>
<td>21%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Got a little of the physical care needed</td>
<td>11%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Did not get the physical care needed</td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

** Significant difference between modes of birth for each time period (Mann Whitney, p≤0.016).**
### Table 14. Women's health information in the first month after birth by type of birth

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=592)</td>
<td>Assisted (n=322)</td>
<td>Caesarean (n=334)</td>
</tr>
<tr>
<td>Got all the information and advice needed</td>
<td>52%</td>
<td>42%</td>
<td>35%</td>
</tr>
<tr>
<td>Got some information and advice needed</td>
<td>27%</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>Got a little information and advice needed</td>
<td>15%</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>Did not get information and advice needed</td>
<td>6%</td>
<td>8%</td>
<td>12%</td>
</tr>
</tbody>
</table>

** Significant difference between modes of birth for each time period (Mann Whitney, p≤0.016).

### Table 15. Babies' health information in the first month after birth by type of birth

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth</th>
<th>8-30 days after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=594)</td>
<td>Assisted (n=321)</td>
<td>Caesarean (n=332)</td>
</tr>
<tr>
<td>Got all the information and advice needed</td>
<td>58%</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>Got some information and advice needed</td>
<td>27%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>Got a little information and advice needed</td>
<td>10%</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Did not get information and advice needed</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
</tr>
</tbody>
</table>

** Significant difference between modes of birth for the first 24 hours after birth period (Mann Whitney, p≤0.016).
Women who had positive experiences of postnatal care valued practical assistance to move around and feed their baby. Reassurance and support from midwives was needed both in hospital and once at home as well as the continued support from health visitors.

I had an emergency c-section and for the first 2 days in the hospital the midwives would help me with whatever I had to do. They were very helpful and reassuring when I had to walk around the first time after the c-section. I had trouble breastfeeding and they were helpful and supportive when I was trying to latch the baby on. This was also true with the midwives that came to visit me at home, and they stayed and watched me breastfeed to ensure I was doing it correctly. I think the reassurance and support from midwives and health visitors is very important, especially for first-time mums. (Caesarean birth)

Conversely, women who felt less well supported described how their pain and the after effects of surgery made it difficult for them to move around and care for their babies. In the worst cases, women felt isolated, abandoned and helpless in hospital. Requests for pain relief, practical help and support from health care staff were commonly dismissed or met with rudeness. Sometimes there was a considerable delay before anyone came. It was not uncommon for women to feel like a burden or a nuisance to staff and therefore reluctant to ask for further help. Some left hospital earlier as a result.

I found the midwives in hospital during the night after I had given birth to be distant and dismissive and did not take my request for pain relief seriously after a major episiotomy; I was in a great deal of pain and had to ask three times before being brought paracetamol. I was left alone and catheterised so couldn’t get out of bed to attend to my baby - every time I requested help I was treated as if I were a major inconvenience and taking up too much of their time. Very disappointing! (Assisted hospital birth)

After the birth no one explained to me what had happened and nor did anyone explain how much pain I would be in. We were just left to get on with it. Someone should have sat down with me to explain. Once at home midwives almost shrugged me off. It was “oh you’ll be fine”. Well I wasn’t, I was really bad and they did not recognise the impact on me. (Assisted hospital birth)

The hospital care was totally inadequate. Not enough midwives meant I was left unable to care for my baby... Lack of staff. Midwives refused to empty my bag when a catheter was reinserted. Next morning the bag had overflowed and I was soaked in urine. I was made to walk to the loo and mopped down in front of other patients and visitors. I could not get out of bed to get my baby, could not lift him, or get back onto the bed to feed. It was difficult to get staff to help. I left on the third day for better care at home, when medically I was not ready to leave. (Caesarean birth)

One woman described that she was haunted by her birth experiences and felt that emotional support from health care staff was lacking and at times inappropriate.

The antenatal and labour care I received was excellent, but as soon as the baby was born I felt I was on my own. There was little/no emotional support offered to me. I spent the first night on the ward less than two hours after the birth of my son in floods of tears and unable to sleep as every time I closed my eyes the nightmare of my birth experience came flooding back. Nobody came to check on me to see if I was ok even though I know I was sobbing loudly and uncontrollably. Every single night of the three nights I spent in the hospital were the same. The first morning I stood up to be greeted by a screaming baby and when I got up from the bed simply bled all over the floor and was in floods of tears – I didn’t know what to do for the best and again nobody came to help
Another time I had gone to the bathroom and returned to my son crying when one of the male midwives came over and reprimanded me for leaving a screaming baby and told me I was disturbing everyone on the ward and made me go and sit in the day-room! … I was appalled by the language / terminology used in my notes as well – the reason for my forceps intervention – described wonderfully as “lack of maternal effort” a phrase that still haunts me. (Assisted hospital birth)

Women also commented on the way in which some staff communicated with them when they needed specific information about their recovery or where they had particular needs. In this context, some women felt that staff were not thoughtful enough or unable to tailor information and support to their individual needs.

During my discharge talk, I asked the midwife how long my stitches (for an episiotomy) might take to dissolve and she couldn’t say. I explained that it would be helpful to have a rough idea, and she said ‘how long is a piece of string’. Clearly this was unhelpful. (Assisted hospital birth)

I felt that qualified maternity staff on the ward in hospital leaves a lot to be desired (sic). They were rude, usually quite abrupt and generally lacked the care skills I would expect to see in nursing staff. I am a disabled lady with restricted and reduced mobility, my husband was refused (not allowed) to stay with us in hospital and I was expected to shower myself having just had a c-section. I couldn’t get out of bed to feed my daughter and had to wait sometimes up to half an hour for someone to come and see us whilst my daughter cried and I was helpless to get her. (Caesarean birth)

Among this group of women, care from health professionals in the period following discharge from hospital was also subject to some criticism.

We didn’t see a midwife for two days after discharge and this was upon calling her as I developed a haematoma along the scar line. (Caesarean birth)

At times women felt that midwives were rushed and had not paid attention to key health concerns documented in their notes.

I found that the community midwives were abrupt and at times rude, they appeared very busy and only really interested in getting in and out as quick as possible. I felt that they were keen for me to start formula feeds in order for my baby to reach her birth weight ASAP so that we could be discharged. I found them to be unsympathetic when I was upset with regards to this and didn’t offer me any options or really discuss the matter with me. One midwife visited me at home and despite reading my notes for 10 minutes still didn’t realise, until I informed her following irrelevant questioning, that I had had a c-section due to breech presentation. She was also explaining that she was discharging both me and my baby until I again informed her that my baby was losing weight. All of this information was in my notes which she obviously wasn’t taking much notice of. (Caesarean birth)

4.4.1 Comparing the experiences of women who had planned and unplanned caesareans

The National Sentinel Caesarean Section Audit survey found that 76% of first-time mothers had a positive preference for a spontaneous vaginal birth (p101). So, understandably, being advised that they need to have a caesarean birth can be disappointing for women. However, the same study found that when women knew
during pregnancy that they had a health problem or that their baby was lying in a breech position, they were less likely to favour a vaginal birth, though this was still the preference of six in ten first-time mothers (p101). When a caesarean is planned during pregnancy there is more time to consider the idea, to explore the reasons and possible options for care. The most common reasons for an unplanned caesarean are slow progress or concerns that the baby is distressed. When a caesarean section is arranged at short notice during labour, women sometimes feel they lacked information and were not fully involved in the decision making, so feel they have little control over what happened. As a result, the emotional impact of having a caesarean that is planned in advance can be different from that of an unplanned operation, and can also be affected by a woman’s age and health status.

Here we compare the perspectives of women who had planned and unplanned caesarean births. In the 2009/10 NCT survey sample, 26% of first-time mothers had a caesarean birth (7% planned; 19% unplanned). Although the overall proportion of caesarean births in the NCT sample is broadly similar to the proportion for England (25%), the ratio of planned to unplanned is different. Maternity data for all women in England indicate that 10% of caesareans are planned and 15% are unplanned, with broadly similar proportions for the other UK countries. This means that those who had an unplanned caesarean were over-represented in the NCT sample. However, the numbers in the planned caesarean group are small and any differences in experiences are less likely to reach statistical significance.

Around a third of women who had either a planned or unplanned caesarean birth reported that they got all the emotional support they needed during all three phases of postnatal care (see Table 16). A higher proportion of women who had caesareans reported that their needs for emotional support were not met or that they only got a little of the support they needed. However, the differences were not statistically significant.

Table 16. Emotional support in the first month after birth by type of caesarean

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours</th>
<th>2-7 days</th>
<th>8-30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unplanned</td>
<td>Planned</td>
<td>Unplanned</td>
</tr>
<tr>
<td>(n=268)</td>
<td>(n=65)</td>
<td></td>
<td>(n=269)</td>
</tr>
<tr>
<td>Got all support needed</td>
<td>35%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Got some support needed</td>
<td>21%</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>Got a little support needed</td>
<td>19%</td>
<td>25%</td>
<td>18%</td>
</tr>
<tr>
<td>Did not get support needed</td>
<td>25%</td>
<td>14%</td>
<td>22%</td>
</tr>
</tbody>
</table>

In relation to physical care, similar proportions of women who had a planned or unplanned caesarean reported that they got all the physical care they needed in the first week. However, in the period 8-30 days woman who had an unplanned caesarean seem to have felt less well supported (see Table 17).
Table 17. Physical care in the first month after birth by type of caesarean

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours</th>
<th>2-7 days</th>
<th>8-30 days*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unplanned (n=269)</td>
<td>Planned (n=63)</td>
<td>Unplanned (n=266)</td>
</tr>
<tr>
<td>Got all the physical care needed</td>
<td>50%</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>Got some of the physical care needed</td>
<td>28%</td>
<td>31%</td>
<td>37%</td>
</tr>
<tr>
<td>Got a little of the physical care needed</td>
<td>11%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Did not get the physical care needed</td>
<td>11%</td>
<td>11%</td>
<td>10%</td>
</tr>
</tbody>
</table>

* Significant difference between types of caesarean at 8-30 days after birth (Mann Whitney, p≤.05)

Women who had an unplanned caesarean valued having an opportunity to discuss with a professional how their labour had developed and why the caesarean had been needed. This helped them come to terms with what had happened. They also valued their partner being well supported and informed.

My midwife was a real support; talking me through the events that led to the emergency c-section and why decisions had been taken. This helped relieve some of the trauma my partner and I felt. (Unplanned caesarean)

There was excellent care on the ward. I was fully informed about my birth complications and my husband felt well supported with information too. (Unplanned caesarean)

Women felt that not being given this opportunity had a negative impact.

I would have liked someone to go through what happened at the birth and why things happened the way they did. I ended up having an emergency c-section and my baby had some difficulties arising out of the cord being around his limbs so I would have liked to know exactly what happened. (Unplanned caesarean)

4.5 Comparing the experiences of postnatal care in different birth settings

A high proportion of first-time mothers have their baby in a hospital labour ward. It is often difficult to distinguish the precise status of different units. One recent large England-wide study grouped hospital labour wards and ‘alongside’ birth centres (i.e. on the same site as a hospital) altogether and found almost 96% of first-time mothers gave birth ‘in hospital’. The Healthcare Commission reported that ‘the vast majority of births take place in obstetric units (93%). Of the remainder 3% take place in alongside maternity units, 2% in freestanding maternity units and 2% at home’. In this survey, it 86% of first-time mothers gave birth in a hospital labour ward. We wanted to compare the postnatal care experiences of women who had their baby in different birth settings: a hospital labour ward; a birth centre or at home. In the NCT sample there were enough
women in each group to make this possible as more women choose ‘away from labour ward’ options for birth than in the general population. We compared the experiences of first-time mothers who had a spontaneous birth so as to control for one key difference, mode of birth, which is an important confounder affecting experiences.

Among those first-time mothers who had a spontaneous vaginal birth, there was an association between place of birth and women’s rating of the care they received during the first 24 hours and 2-7 days after birth. Women who gave birth in a hospital labour ward reported a greater level of unmet need compared with those who had their baby at home or in a birth centre (see Tables 18-21). More women who had had their baby at home or in a birth centre reported that all their emotional support, physical care and information needs were met in the first 24 hours after birth. The biggest gap in care concerned women’s need for emotional support with 57% who gave birth in hospital reporting that their emotional support needs were not fully met (see Table 18). There were also significant differences in terms of information about their own health. About half of women (47%) who gave birth in hospital felt all their needs were met compared with three quarters of women who gave birth at home (see Table 20).

Women often felt that community midwives providing care at home births, and those working in birth centres, had more time to discuss things and give specific advice to prevent problems developing. It is not possible to show from this study whether they had more time available to provide support, information and practical help as there was less post-operative care to attend to when women gave birth away from a labour ward setting, or whether their attitudes were more woman-centred, or both. Many women described how these midwives were attentive and actively concerned about their welfare.

*Both the midwife who had looked after me while pregnant and the midwife present at my home birth came to check on me after I had given birth. They were very reassuring, caring and helpful. It was very important to me that they were able to spend a good amount of time with me to check that both me and my baby were well. I never felt that they had to rush away. One of the most important pieces of information was given to me by my midwife about how to look after my stitches so they didn’t get infected – tea tree oil and lavender in a bottle of water. … My care was excellent. (Spontaneous home birth)*
Table 18. Emotional support in the first month after birth by place of birth for women who had spontaneous births

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth</th>
<th>8-30 days after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=426)</td>
<td>Birth centre (n=96)</td>
<td>Home (n=62)</td>
</tr>
<tr>
<td>Got all the emotional support needed</td>
<td>43%</td>
<td>57%</td>
<td>76%</td>
</tr>
<tr>
<td>Did not get all emotional support needed</td>
<td>57%</td>
<td>43%</td>
<td>24%</td>
</tr>
</tbody>
</table>

** Significant association for the first 24 hrs (Chi square, p≤0.01). *Significant association for 2-7 days (Chi square, p≤0.05).

Table 19. Physical care in the first month after birth by place of birth for women who had spontaneous births

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=427)</td>
<td>Birth centre (n=95)</td>
<td>Home (n=62)</td>
</tr>
<tr>
<td>Got all the physical care needed</td>
<td>57%</td>
<td>72%</td>
<td>82%</td>
</tr>
<tr>
<td>Did not get all physical care needed</td>
<td>43%</td>
<td>28%</td>
<td>18%</td>
</tr>
</tbody>
</table>

** Significant association for first 24hrs and 2-7 days (Chi square, p≤0.01).
Table 20. Women’s health information in the first month after birth by place of birth for women who had spontaneous births

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth*</th>
<th>8-30 days after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=426)</td>
<td>Birth centre (n=95)</td>
<td>Home (n=62)</td>
</tr>
<tr>
<td>Got all the information and advice needed</td>
<td>47%</td>
<td>60%</td>
<td>76%</td>
</tr>
<tr>
<td>Did not get all information and advice needed</td>
<td>53%</td>
<td>40%</td>
<td>24%</td>
</tr>
</tbody>
</table>

** Significant association for first 24 hrs (Chi square, p≤0.01).  * Significant association for 2-7 days (Chi square, p≤0.05).

Table 21. Babies health information in the first month after birth by place of birth for women who had spontaneous births

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>First 24 hours**</th>
<th>2-7 days after birth</th>
<th>8-30 days after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=427)</td>
<td>Birth centre (n=97)</td>
<td>Home (n=62)</td>
</tr>
<tr>
<td>Got all the information and advice needed</td>
<td>55%</td>
<td>64%</td>
<td>71%</td>
</tr>
<tr>
<td>Did not get all information and advice needed</td>
<td>45%</td>
<td>36%</td>
<td>29%</td>
</tr>
</tbody>
</table>

** Significant association for first 24 hrs (Chi square, p≤0.01).
4.6 Comparison of findings with the 1999/2000 NCT postnatal care survey

Results of the NCT 1999/2000 postnatal care survey showed that woman’s emotional needs were neglected, that there was insufficient consistent support and guidance to help women establish breastfeeding, and that in the first 24 hours after birth and in the period 11-30 days women were least satisfied with their postnatal care. Other studies have shown that women rate their postnatal care less favourably than antenatal or intrapartum care. As discussed in the introduction, government policy documents and NICE guidance have made clear recommendations to improve postnatal care.

We wanted to compare women’s ratings of their care a decade after our previous survey. Our findings for 2009/10 suggest that far from there having been an improvement in the standard of postnatal care, there may have been an overall decline. As the samples for the two surveys were self selecting, known and unknown variation in the samples may account for the differences we found. However, our results give cause for concern. Women continue to say that emotional support is lacking and there appears to be a trend towards fewer women having all the emotional support they need (see Table 22).

The 1999/2000 survey did not provide a detailed separate analysis for first-time mothers so comparisons are made between the whole sample in 1999/2000 and 2009/10, and with first-time mothers in 2009/10 (see Table 22).

In both surveys women said their emotional support needs were less well met than other aspects of care during the first month after birth. A calculated average (mean) across the three time periods shows that 39% of first time mothers and 41% of all women who took part in the 2009/10 survey felt they got all the emotional support they needed compared with 47% who took part in the 1999/2000 survey. Similar trends are evident in relation to women’s needs for physical care and information indicating little improvement (see Table 22).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All mothers</td>
<td>First-time</td>
<td>All mothers</td>
</tr>
<tr>
<td>Got all the emotional support needed</td>
<td>47%</td>
<td>39%</td>
<td>41%</td>
</tr>
<tr>
<td>Got all the physical care needed</td>
<td>59%</td>
<td>51%</td>
<td>53%</td>
</tr>
<tr>
<td>Got all the information needed about own health</td>
<td>51%</td>
<td>41%</td>
<td>43%</td>
</tr>
</tbody>
</table>

The three time periods 0-3 days, 4-10 days and 11-30 days in 1999/2000 and 24 hours, 2-7 days and 8-30 days in 2009/10 were given equal weight despite being of varying length. Overall ratings for the whole month were calculated as a simple mean.
4.7 Summary of findings

The findings regarding women’s experiences of emotional support, physical care and health information suggest that in the ten years since the NCT published its last postnatal care survey there has been no significant improvement to address the gap in care reported then both by NCT and other independent researchers. In fact it seems there may have been a decline in the extent to which woman-centred quality standards are being met during the postnatal period. Consistent with our earlier survey findings, emotional support was less adequately provided by healthcare staff than other aspects of care. Women who had an operative birth were less satisfied with their care than other women. Women using a birth centre or having a home birth felt better supported than similar women (who had had a spontaneous birth) who had conventional hospital care, first in the labour ward and then on the postnatal ward. There was undoubtedly sensitive and compassionate care being provided to a high standard in many units. However, women’s accounts also described feelings of isolation, staff shortages, poor communication and even rudeness. It appears that low staffing levels on postnatal wards and in the community was one contributory factor having a negative impact on the quality of care.
Breastfeeding and bottle feeding

For a mother, feeding her baby is fundamental to making an emotional connection and establishing a lasting bond. Feeling able to nourish and comfort her baby, is central to feeling good about herself as a mother, and for the baby being fed is essential for survival. The first 24 hours after birth can set the scene for a positive feeding experience or disruption that can have long term implications. For breastfeeding, which involves physiological lactation and the learning of a social skill, the first 24 hours is especially important.53

Previous research has shown that most women in the UK intend to breastfeed and many of those are strongly motivated.64 Across the UK almost 8 in 10 first-time mothers start breastfeeding (76%), although nearly 4 in 10 of these women have stopped in the first six weeks, because they did not receive the right information or sufficient support.64 So it is vital that women get the kind of support, guidance and encouragement they need.

Breastfeeding has a major role to play in public health, as it is one of the most effective ways of reducing health inequalities.65 It is able to contribute to the achievement of several government health objectives, including: a reduction in the infant mortality rate, reduction of preventable infections and unnecessary paediatric admissions in infancy, halting the rise in obesity in under 11s, improving children’s life outcomes and general wellbeing, and breaking the cycle of deprivation.65

In addition to providing complete nutrition for the development of healthy babies, breastmilk has an important role to play in protection against gastroenteritis* and severe respiratory infections, acute ear infection, atopic dermatitis,* juvenile asthma,* type 1 and 2 diabetes,* childhood leukaemia,* sudden infant death syndrome (SIDS).* A large UK study found that a significant proportion of admissions to hospital as a result of diarrhoea (53%) and lower respiratory tract infection (27%) could have been prevented each month by exclusive breastfeeding.67

Breastfeeding in infancy is also associated with lower mean blood pressure, lower total cholesterol, higher performance in intelligence tests, a lower prevalence of overweight/obesity and type-2 diabetes in later life.68

The infant feeding section of the NICE postnatal care guideline recommends that a ‘supportive environment’ for breastfeeding is created in the woman’s place of birth and as part of community-based care. This includes healthcare facilities having a written breastfeeding policy and an externally evaluated structured programme that encourages breastfeeding, usually the Baby Friendly Initiative, as a minimum standard.18,69 It emphasises the need for women to have rest, privacy, access to food and drinks when they need them, and in particular:

‘Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding’.18

The guidance emphasises the particular needs of women following a caesarean, narcotic analgesia or general anesthetic, as they are likely to require additional support. There is also evidence from previous research that a strong positive emphasis on creating a supportive environment for breastfeeding can be associated with women who formula feed lacking information, including information on how to make up bottles safely, and feeling excluded and less valued as mothers.4,70 NICE recommends that women who are...
giving their babies formula feeds ‘should be offered appropriate and tailored advice
to ensure this is undertaken as safely as possible, and optimises infant development,
health and nutritional needs’.\textsuperscript{18}

We were interested in how well supported and informed women felt with feeding their
baby during the first few days and later on in the baby’s first month after birth. Issues
that have been well documented in earlier studies have been a lack of well-informed
guidance and encouragement, shortage of staff to provide a consistent supportive
presence during the initiation of breastfeeding, conflicting advice, and inadequate
support for women with a premature or sick baby, including poor facilities for
expressing breastmilk.\textsuperscript{47,64}

The previous NCT postnatal care survey showed that women who had had an operative
birth, who were generally less mobile and in more pain, often reported a gap between
their need for support to feed their baby and the support available.\textsuperscript{32}

5.1 Feeding in the first month after birth

This sample of women, who were mainly NCT members, included a high proportion
of first-time mothers who exclusively breastfed and very few who were not either
exclusively breastfeeding or combining breastfeeding with formula feeding (see Figure
3). However, the proportion exclusively breastfeeding declined significantly from
87\% in the first 24 hours after birth to 76\% by the end of the first week, and reduced
further during the period 8-30 days (to 72\%). This would suggest that some women
experienced difficulty getting breastfeeding established. These exclusive breastfeeding
rates are considerably higher than rates for first-time mothers in the UK overall, which
the 2005 Infant Feeding Survey reported were 67\% at birth, and 26\% at 4 weeks.\textsuperscript{64} As
these national data indicate, although there was a decline in exclusive breastfeeding in
the NCT sample, particularly during the first week, in the national cultural context the
pattern of maintenance was generally very positive.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Infant feeding patterns in the first month after birth}
\end{figure}

5.2 Skin to skin care

Evidence suggests that skin to skin contact between mother and baby at birth reduces
crying, improves mother and baby interaction, keeps the baby warmer and helps wom-
en go on to establish breastfeeding successfully.\textsuperscript{71} The NICE guideline on postnatal care
recommends that within the first hour of giving birth women should not be separated from their baby, they should be encouraged to have skin to skin contact and ‘should not be asked about feeding method until after first skin to skin contact’.  

Findings from this survey suggest that encouragement of skin to skin contact has been extensively implemented:

- 79% (n=985/1255) of first-time mothers reporting that they were encouraged to have skin to skin contact with their baby within the first 24 hours after birth.

NCT was also interested to know how many fathers were encouraged to have close physical contact with their baby. Around one in three women (35%; n=410/1182) women reported that their partner was also encouraged to have skin to skin contact with their baby in the first 24 hours after birth.

We found a significant association between the method of feeding in the first 24 hours after birth and whether women reported having been encouraged to have skin to skin contact: 83% of exclusively breastfeeding women reported that they had been encouraged to have skin to skin contact with their baby in the first 24 hours after birth compared with 65% who combined breastfeeds (see Table 23). The rate was lower still for first-time mothers who formula fed from birth (42%) but the numbers are small in this group.

Table 23. Skin to skin contact encouraged and type of feeding in the first 24 hours

<table>
<thead>
<tr>
<th>Skin to skin contact encouraged</th>
<th>Breastfed exclusively (n=1070)</th>
<th>Combined feeding (n=117)</th>
<th>Formula fed (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>83%</td>
<td>65%</td>
<td>42%</td>
</tr>
<tr>
<td>No</td>
<td>17%</td>
<td>35%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Significant association (Chi square, p≤0.01)

5.3 Help and support with feeding

Assistance with breastfeeding has been identified as the most common postnatal care need for women. For first-time mothers, in particular, breastfeeding can be a challenge. They often have little prior experience of what the practical reality of breastfeeding will be like, and they need encouragement and reassurance. Attention to the position of the baby and the way he or she is latched on has been identified as important for minimising discomfort for the mother and damage to her nipples. NICE recommends that guidance to achieve good positioning is a key aspect of necessary support during the phase when breastfeeding is being initiated. NICE also emphasises the importance of women feeding soon after birth and the need to know about the benefits of breastfeeding including the significance of colostrum in the early days. The Guidance says that woman should be asked about their experience with breastfeeding at each contact to find out how she is feeling and to identify any need for additional support.

NICE recommends that women who are giving their babies formula feeds are shown 'how to make feeds using correct, measured quantities of formula, as based on the manufacturers instructions, and how to clean/sterilise feeding bottles and teats and store formula milk.'
We asked women whether they got the help and support with feeding their baby that they needed from healthcare staff. Less than half of first-time mothers felt that they had received all the help and support they needed in the first 24 hours after birth (45%) with similar rates at 2-7 days and 8-30 days after birth (see Table 24). Three out of ten women said they got little or none of the help and support they needed in the first 24 hours after birth and after the first week. In the period 2-7 days there was also a significant care gap (25%).

<table>
<thead>
<tr>
<th>Table 24. Help and support for feeding in the first month after birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all the help and support needed</td>
</tr>
<tr>
<td>Got some of the help and support needed</td>
</tr>
<tr>
<td>Got a little of the help and support needed</td>
</tr>
<tr>
<td>Did not get the help and support needed</td>
</tr>
</tbody>
</table>

Women appreciated having time spent with them to establish and sustain breastfeeding. They valued active reassurance and a style of communication from health professionals that was positive and clearly non-judgemental. This was especially important when women felt breastfeeding was not going well.

Breastfeeding was tough. I needed someone to talk to me about it from day 1 and especially in a non-judgemental way as I felt guilty that my milk hadn’t come in and breastfeeding wasn’t working. The people I found most supportive were midwives and nurses on the children’s ward. We had to go back into hospital due to too much weight loss for my baby. (Spontaneous hospital birth)

After a very long labour the midwives in the hospital made every effort to make me feel confident and encouraged me to make my own decisions about my new baby. I had a lot of trouble breastfeeding, coupled with a very hungry baby, and even though I pressed the bell what felt like 100 times each day, they still came in with a smile and a friendly word to help me latch him on. Once I was home I continued to have bleeding nipples and he continued to be very hungry and unsettled (colicky baby) but when the midwives and health visitors visited they always stayed with me until he was ready for a feed so they could give me advice, sometimes they stayed for over an hour just to help, even on a weekend! (Spontaneous birth centre birth)

A number of woman specifically commented that staff involving their partner in the care and support they provided was a particularly positive aspect of their care.

We did have some problems feeding at first but the staff at the hospital were excellent in helping me breastfeed and I felt they really cared and wanted me to succeed. They also involved my husband in all the advice and encouraging him to help. (Spontaneous hospital birth)
All special care baby unit staff were excellent. They allowed me some time to recover from the birth, provided a friendly person to listen to, assisted with efforts to breastfeed, taught us to express and store breastmilk, taught my husband to change nappies, taught us both how to cup feed and bottle feed expressed milk, how to change and bath our baby, etc. We could not have managed without this additional support. (Spontaneous hospital birth)

Among those first-time mothers who were critical about the lack of support, feedback suggested that some midwives were not practising ‘hands-off’ techniques.24,75

Postnatal ward at [name] hospital was awful. There was no clear information from staff on why we were asked to stay in hospital. I didn’t feel I was given support as a new mum and instead felt left to get on with it. Staff were very rude and uncaring. Breastfeeding support consisted of my breasts being grabbed and being forced into my baby’s mouth. One of the midwives declared to another that she had got this baby feeding as if it was a contest. I’m not sure how this was supposed to be helpful to me learning to breastfeed. (Spontaneous hospital birth)

I did have one nurse who was trying to shove my nipple in his mouth rather than bringing him to my breast. I was not very pleased with this as it was rather forceful. (Assisted hospital birth)

Too often the breastfeeding counsellors/advisors simply took over and manhandled me rather than showing me what to do. (Spontaneous hospital birth)

At times midwives were perceived as insensitive, unkind or judgemental.

The community midwives blamed my husband and I when our son did not latch on. I was even “banned” from the cushions by one of the midwives. It was so stressful so we hired a private lactation consultant who diagnosed our son with ‘tongue-tie’. It was referred to a surgeon who did a minor operation. Since then he latched on beautifully. The experience with the midwives made our lives stressful when things were already difficult. We found no support at all. (Spontaneous hospital birth)

Women were asked ‘Did you get the help and support you needed from healthcare staff with feeding your baby’. First-time mothers who were combining breastfeeding with formula feeding during the first week after birth were significantly more likely to say that they lacked help and support compared with those exclusively breastfeeding. For example, during the period 2-7 days, 41% and 21% respectively said they got little or none of the help and support they needed. This pattern continued during the remainder of the first month after birth (see Table 25). Women’s recollections suggest that this pattern was started on day one after birth when just a third of those breastfeeding women who also used formula said they had all the help and support they needed (32%), compared with 47% of those exclusively breastfeeding. This reflects the findings of the last UK wide Infant Feeding Survey.64
Table 25. Amount of help and support with feeding in the first month after birth (exclusive breastfeeding vs. combined feeding)

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours**</th>
<th>2-7 days after birth</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed exclusively (n=1069)</td>
<td>Formula fed (n=39)</td>
<td>Breastfed exclusively (n=927)</td>
</tr>
<tr>
<td>Got all</td>
<td>47%</td>
<td>36%</td>
<td>52%</td>
</tr>
<tr>
<td>Got some</td>
<td>26%</td>
<td>18%</td>
<td>27%</td>
</tr>
<tr>
<td>Got a little</td>
<td>15%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Did not get</td>
<td>12%</td>
<td>31%</td>
<td>8%</td>
</tr>
</tbody>
</table>

** Significant difference between types of feeding for each time period (Mann Whitney, p≤0.01).

5.3.1 Bottle feeding mothers

First-time mothers who were formula feeding from birth were also less likely to feel that they had all the help and support they needed, compared with those who were exclusively breastfeeding (see Table 26). On the first day the proportion of formula feeding mothers recalling that they received little or none of the support they needed was 46%. This was reduced later in the first week (to 24%) but increased again afterwards to 43%

Table 26. Amount of help and support with feeding in the first month after birth (exclusive breastfeeding vs. formula feeding)

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed exclusively (n=1069)</td>
<td>Combined feeding (n=116)</td>
<td>Breastfed exclusively (n=927)</td>
</tr>
<tr>
<td>Got all</td>
<td>47%</td>
<td>32%</td>
<td>52%</td>
</tr>
<tr>
<td>Got some</td>
<td>26%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Got a little</td>
<td>15%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Did not get</td>
<td>12%</td>
<td>23%</td>
<td>8%</td>
</tr>
</tbody>
</table>

** Significant difference between types of feeding for first 24 hrs and 8-30 days (Mann Whitney, p≤0.01).

Women commented that they were offered little information spontaneously.

Unless you were breastfeeding... no one seems to tell you anything about bottle feeding. I had to ask specific questions to get any help with it. (Assisted hospital birth)

Not one healthcare person talked about bottle/formula feeding your baby. This puts huge amounts of pressure on women who think they are doing something wrong if they choose not to breastfeed. It should not be a taboo subject. (Spontaneous hospital birth)

There was strong emphasis on breastfeeding even where this may not be right for mother and baby due to health complications. (Spontaneous hospital birth)
5.4 NCT Support

NCT wanted feedback about its own services, including informal local services and support provided by NCT-trained breastfeeding counsellors and postnatal leaders. NICE recommends that ‘women should be offered skilled support including mother-to-mother or peer support from the commencement of breastfeeding’, and defines ‘peer counsellors’ as ‘women who have received specific training in counselling skills to provide support to breastfeeding women’. Some NHS trusts employed breastfeeding counsellors, trained by NCT or other voluntary bodies, and the feedback from women was positive. Women valued the normalisation of any difficulties they experienced in the early days when they were working to establish breastfeeding.

Establishing breastfeeding was the most important thing that did not go well. What was good was that midwives were all caring and no one made me feel bad. What was absolutely excellent were the NHS breastfeeding counsellors. The counsellor came to see me, was proactive in ringing me up and asking how I was. Told me she would come to me anytime, was calm, nice, and friendly, normalised everything for me, was very reassuring and knew a lot, basically everything you could hope for. (Spontaneous home birth)

There was a breastfeeding workshop on weekdays in the hospital, hard to get to after a caesarean but it was helpful. The breastfeeding counsellor in the hospital did do bed visits as well. (Caesarean birth)

Free-text feedback shows that in some cases, women who had had protracted breastfeeding difficulties that they had been unable to overcome, lasting several days or even longer, eventually turned to an NCT breastfeeding counsellor. It is not know how many days old babies were when non-NHS support was sought.

While in the hospital, the baby was not interested in the breast so the staff were unable to help me. Subsequently, when I returned home the feeding was very painful and I ended up with very cracked nipples - so much so that the baby vomited blood causing us a lot of anguish and we had to return to hospital. I then developed sores and had to stop feeding for a week - midwives/health visitors were unhelpful to say the least, fortunately an NCT breastfeeding counsellor came round to help and things have been brilliant since then. (Assisted hospital birth)

I had a tongue-tied baby which the midwives did not recognise. Breastfeeding was very difficult to the point where I had to express for three weeks just to let my nipples heal. I decided only to take NCT advice and the NCT breastfeeding counsellor saw me three times, helped diagnose and fix the tongue tie, saved my nipples, sanity and eventually saw me back exclusively breastfeeding. I would have given up without this support. (Caesarean birth)

Many of these women sought support from the NCT by contacting a local NCT breastfeeding counsellor (29%; n=330/1152) or by calling the NCT Breastfeeding Line (26%; n=301/1158), a UK-wide service enabling women in all areas to have access to an NCT-trained breastfeeding counsellor by telephone, regardless of whether there is a breastfeeding counsellor available locally.

The midwife advised me to feed my baby every four hours when he was a few days old. It was horrendous – three days later and a tearful call to the NCT breastfeeding helpline put a stop to that, and I went back to feeding on demand. (Spontaneous hospital birth)
I had very sore nipples during week two of breastfeeding my baby. I was repeatedly told that the latch was wrong but was given very different advice about how to rectify this issue by different health professionals. The info was not helpful and I only managed to continue breastfeeding because I was SO determined, I carried on through the pain and through the use of the excellent NCT breastfeeding helpline. (Assisted hospital birth)

Of those who made comments about NCT breastfeeding counselling services (n=35), 21 made positive comments, three made neutral remarks and 10 had some criticisms, mainly about NCT antenatal breastfeeding sessions not having prepared them sufficiently for how breastfeeding might feel in the early days and initial feeding challenges.

My milk didn’t come in. Nobody had warned me this could happen. NCT classes had been unrealistic about how straightforward breastfeeding is. (Spontaneous hospital birth)

I’d been told at my NCT antenatal class was that it wouldn’t be uncomfortable or painful unless I was doing it wrong. Therefore, I didn’t feed my baby properly for the first 12 hours as I was sure I was doing it wrong and kept giving up... once it was explained better and I was helped to latch him on, we got on fine. The discomfort associated with the first 24 hours needed to have been explained better in the first place. (Spontaneous birth centre)

Before I had the baby the NCT breastfeeding class at the time was good, as soon as I actually started feeding I realised it was terrible. ... We were told if you breastfeed correctly is won’t hurt. I don’t know any mums this was true for. (Assisted hospital birth)

NCT antenatal classes too, whilst well delivered by our trainer, only seem to tell a skewed version of what to expect, concentrating on the positives of breastfeeding whilst barely mentioning how difficult it is. (Spontaneous hospital birth)

However, there were also women who said that the NCT antenatal session had given them useful preparation.

We were in the hospital waiting to be discharged for two  days ... they were so busy that we were basically forgotten by the paediatricians who could have signed us out, before we finally complained. So I didn’t really receive much guidance or even have anyone check whether I was feeding my little girl correctly ... I just got on with things based on previous experience of friends and family breastfeeding and guidance notes from the NCT antenatal course we had attended. (Spontaneous hospital birth)

Every midwife I spoke to had a different opinion on how to breastfeed, including ... (the) position to hold the baby in (and) how to get the baby to latch on. Fortunately, I had taken the NCT breastfeeding classes which helped me decide which information to ignore! (Spontaneous hospital birth)

NCT breastfeeding counsellors have breastfed their own children and are trained to provide accurate information, coupled with active listening skills and a non-judgemental, person-centered approach, which enables families to make their own decisions. Their code of conduct emphasises the importance of a non-directive approach and strengthening mothers’ confidence in their own abilities.
5.5 Consistency of information and advice

Access to consistent, evidence-based information is an important aspect of support for breastfeeding and is also important for safe formula feeding. Women also need to understand that introducing formula milk is likely to reduce their milk supply if they are breastfeeding, and so, until lactation is well established, other approaches should be used whenever possible, to address any feeding difficulties. Information needs to be tailored to individual circumstances and discussed in a sensitive way. Conflicting messages can be particularly frustrating and undermine women’s confidence.

Half of the first-time mothers surveyed (52%; n=647/1252) felt that they had not received consistent information and advice in relation to feeding their baby.

Many women experienced confusion and emotional strain as a result of conflicting information about feeding, both in hospital and at home.

Every single health worker or midwife I spoke to both in hospital and afterwards at home had different advice to give... For example, some said feed on demand and some said feed every few hours, some said wake a baby to feed it. Some said never wake a sleeping baby! (Spontaneous hospital birth)

I found the experience of breastfeeding quite confusing and distressing. I had far too many people coming in to advise me. For example, I had a ‘breastfeeding specialist’ on the ward who told me not to put my baby to the breast, but to have skin to skin contact and wait for baby to find the nipple. Two minutes later another midwife came in and asked me what I was doing and why I wasn’t guiding my baby to the nipple when she was obviously hungry. I also had conflicting advice on whether or not to offer both breasts and how long my baby should be feeding for. (Caesarean birth)

Professionals have noted the different practices of different practitioner groups which can contribute towards women receiving conflicting advice, and the different approaches of midwives and health visitors was commented upon by women.

Most people gave us different and sometimes conflicting advice. The difference was especially apparent between the advice from the midwives and the health visitor. (Assisted hospital birth)

Table 27 shows that a significantly higher proportion of women who combined breastfeeding and formula feeding felt they did not receive consistent advice.

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consistent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfed exclusively (n=1079)</td>
<td>50%</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Combined feeding (n=119)</td>
<td>33%</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>Breastfed exclusively (n=933)</td>
<td>54%</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>Combined feeding (n=266)</td>
<td>27%</td>
<td>47%</td>
<td>31%</td>
</tr>
<tr>
<td>Breastfed exclusively (n=893)</td>
<td>53%</td>
<td>53%</td>
<td>31%</td>
</tr>
<tr>
<td>Combined feeding (n=261)</td>
<td>31%</td>
<td>69%</td>
<td>31%</td>
</tr>
</tbody>
</table>

**Significant association between type of feeding and consistency of feeding information in all three time periods (Chi square p ≤0.01).
It is possible that underlying feeding difficulties or health problems created a greater need for advice and made both conflicting advice and, independently, the introduction of formula feeds more likely.

Absolutely no help given with info on how to go about bottle feeding and as I was severely anaemic I had little choice but to top the baby up with formula as I was not producing enough milk for her. (Spontaneous hospital birth)

On the other hand, it may have been that inconsistent advice included both better and poorer quality information and this variation increased the likelihood of formula supplementation being advised and introduced.

Information was totally conflicting – in fact if you were not level headed, it would have driven you spare! Different amounts of formula, (my son was badly dehydrated and we needed to give him formula to perk him up), also he had a tongue tie which went unnoticed in hospital, and was only noticed in week two by an emergency midwife I called out in desperation as breastfeeding was just not working. Also, in hospital every nurse/midwife showed me different methods to feed and this was confusing. (Spontaneous hospital birth)

Different people gave different advice on when we should feed, whether we should wake the baby up to feed or let him sleep. We got conflicting advice on any impact of offering a bottle with either expressed milk or formula in addition to continuing breastfeed. (Caesarean birth)

In some cases there was inadequate communication between paediatric and midwifery staff.

Despite paediatricians telling me that the baby needed extra top up as well as breast milk, some midwives tried to encourage me to avoid formula top up. This is when my baby was severely jaundiced and dehydrated. (Caesarean birth)

5.6 Baby feeding after an operative birth

Having a caesarean section or a birth assisted with forceps can impact on the feeding experiences of women. This is widely recognised and NICE specifically states that ‘Additional support with positioning and attachment to commence breastfeeding should be offered to all women who have had:

- narcotic analgesia or general anaesthetic, as the baby may not initially be responsive to feeding;
- a caesarean section, particularly to assist with handling and positioning the baby to protect the woman’s abdominal wound;
- initial contact with their baby delayed.’

Although the majority of first-time mothers who had either a caesarean (82%) or an assisted birth (84%) exclusively breastfed their baby in the first 24 hours after birth, the proportion was lower than for those who had a spontaneous birth (91%). In women who had had a caesarean birth, the rate of exclusive breastfeeding also fell more rapidly. By the period 8-30 days, women who had had either a spontaneous birth or an assisted birth had very similar feeding profiles but exclusive breastfeeding was significantly lower for those who had had a caesarean (see Table 28 on p56).
5.6.1 Skin to skin care

Mode of birth was associated with skin to skin contact. Around a quarter of women who had an operative birth felt they were not encouraged to have skin to skin contact in the first 24 hours after birth (see Table 29). Of the 251 women who felt they were not encouraged to have skin to skin contact, two thirds (68%) had had an operative birth.

Table 29. Mothers skin to skin contact in the first 24hrs according to type of birth

<table>
<thead>
<tr>
<th>Skin to skin contact</th>
<th>First 24 hours**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spontaneous vaginal (n=591)</td>
</tr>
<tr>
<td>Yes</td>
<td>86%</td>
</tr>
<tr>
<td>No</td>
<td>14%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p≤0.01).

Almost three quarters of women who had an operative birth reported that their partner was not encouraged to have skin to skin contact with their baby significantly more than those who had a spontaneous birth (see Table 30).

Table 30. Partners’ skin to skin contact in the first 24hrs according to mode of birth

<table>
<thead>
<tr>
<th>Skin to skin contact</th>
<th>First 24 hours**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spontaneous vaginal (n=591)</td>
</tr>
<tr>
<td>Yes</td>
<td>43%</td>
</tr>
<tr>
<td>No</td>
<td>57%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p≤0.01).

5.6.2 Help and support with feeding

Women who had had a caesarean birth felt less well supported with feeding their baby compared to women who had either a spontaneous vaginal birth or an assisted birth throughout the first month after birth. Approximately a third of women who had a caesarean birth felt that they got little or no help and support with feeding during the first month after birth (24hrs: 34%; 2-7 days: 30%; 8-30 days: 33%) (see Table 31 on p56).

I got no help or advice from the hospital staff on breastfeeding. No one came to see me or help me in the three days I was there. Some of the midwives on duty just kept saying get him to latch on properly but no one showed me anything. I just used my own instinct which didn’t always work – it is not as easy as you think it should be! Sore nipples, unhappy baby, sleepless stressful nights. (Caesarean birth)

There were not enough midwives on the ward to cope with the extra care needs particularly in the first 24 hours after a c-section. I could not get hold of a member of staff for about an hour in the night when I was bed bound and my son needed feeding. I was not given any help with breast feeding in hospital or shown any positions that would make it easier after a c-section. (Caesarean birth)
Some of the women who had had an operative birth began the work of initiating breastfeeding after already having undergone a difficult labour, while coping with a painful abdominal scar or perineum, or both. For women whose birth experience had not been all that they had hoped for, their feeding experience was especially important.

The midwife kept telling me I was malnourishing my child as he lost 15% of his birth weight in first week and (I was) being pushed to bottle feed. I was emotionally unstable after a traumatic birth and did not feel supported in my desire to breastfeed exclusively. (Caesarean birth)

While some felt under pressure to introduce formula and others felt they would have liked to give their baby formula to relieve anxieties about breastfeeding.

I had every intention of breastfeeding but could not get the baby to latch on. I had to leave the hospital unsure that I would be able to feed my baby and he was frantic with hunger. Even though I had regular home visits from maternity staff, my problems continued. Even though I was grateful to receive so much help, I feel that the staff who saw me could have been more flexible and understanding. Breastfeeding made the first few weeks of my baby’s life utterly miserable for me and has subsequently made me extremely ill. I was desperate for someone to say it would be okay to combine breast and bottle feeding, but the staff I saw refused to discuss formula feeding. I found this hard-line approach very upsetting at a time when I needed support. (Caesarean birth)

5.6.3 Consistency of advice and information

There was also a significant association between mode of birth and whether women felt they had received consistent advice and information in relation to feeding. Over half of women whose birth was assisted with forceps or ventouse (55%), and 60% of who had a caesarean, felt that they had not received consistent advice and information, compared to 45% of women who had a spontaneous vaginal birth (see Table 32).

<p>| Table 32. Consistency of information and advice on baby feeding by mode of birth |
|---------------------------------|-------------------------------|-----------------|-----------------|----------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Spontaneous vaginal (n=589)</th>
<th>Assisted (n= 322)</th>
<th>Caesarean (n=334)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the information and advice you received about feeding your baby consistent?</td>
<td>Yes</td>
<td>54%</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>46%</td>
<td>55%</td>
<td>60%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p≤0.01).
Table 28. Feeding patterns in the first month after birth by mode of birth

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours</th>
<th>2-7 days after birth</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=540)</td>
<td>Assisted (n=269)</td>
<td>Caesarean (n=273)</td>
</tr>
<tr>
<td>Breastfed/fed expressed breastmilk</td>
<td>91%</td>
<td>84%</td>
<td>82%</td>
</tr>
<tr>
<td>Combined breastfeeds with formula feeds</td>
<td>6%</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Formula fed</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

** Significance association at 8-30 days (Chi square, p≤0.01).

Table 31. Help and support with feeding in the first month after birth by mode of birth

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours**</th>
<th>2-7 days after birth**</th>
<th>8-30 days after birth**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal (n=540)</td>
<td>Assisted (n=269)</td>
<td>Caesarean (n=273)</td>
</tr>
<tr>
<td>Got all help and support</td>
<td>49%</td>
<td>43%</td>
<td>39%</td>
</tr>
<tr>
<td>Got some help and support</td>
<td>24%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Got a little help and support</td>
<td>14%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Did not get the help and support</td>
<td>13%</td>
<td>13%</td>
<td>17%</td>
</tr>
</tbody>
</table>

** Significant difference between modes of birth for each time period (Mann Whitney, p≤0.016 for all phases of care).
5.7 Place of birth

In order to compare the baby feeding experiences of women with broadly similar birth experiences, we analysed the feedback of all first-time mothers who had had a spontaneous birth in different settings: a hospital labour ward, a midwife-led birth centre or at home.

5.7.1 Skin to skin care

Place of birth was associated with encouragement of skin to skin contact. More of those who gave birth in hospital (16%) reported that they were not encouraged to have skin to skin contact with their baby compared with those who gave birth in a birth centre (7%) or at home (6%) (see Table 33).

Table 33. Mothers’ skin to skin contact in the first 24hrs according to place of birth

<table>
<thead>
<tr>
<th>Skin to skin contact</th>
<th>First 24 hours*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=423)</td>
<td>Birth centre (n=98)</td>
</tr>
<tr>
<td>Yes</td>
<td>84%</td>
<td>93%</td>
</tr>
<tr>
<td>No</td>
<td>16%</td>
<td>7%</td>
</tr>
</tbody>
</table>

* Significant association (Chi square, p≤0.05).

Similarly more women who gave birth in hospital (62%) reported that their partner was not encouraged to have skin to skin contact with their baby compared with those who gave birth in a birth centre (52%) or at home (37%) (see Table 34).

Table 34. Partners’ skin to skin contact in the first 24hrs according to place of birth

<table>
<thead>
<tr>
<th>Skin to skin contact</th>
<th>First 24 hours**</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=401)</td>
<td>Birth centre (n=93)</td>
</tr>
<tr>
<td>Yes</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>No</td>
<td>62%</td>
<td>52%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p≤0.01).
5.7.2 Help and support with feeding

There was a trend towards better support for feeding being provided to women having a home birth or using a birth centre (see Table 35).

Table 35. Feeding support in the week after birth by place of birth for first-time mothers who had spontaneous births

<table>
<thead>
<tr>
<th></th>
<th>First 24 hours</th>
<th>2-7 days after birth*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital (n=427)</td>
<td>Birth centre (n=97)</td>
</tr>
<tr>
<td>Got all the help and support needed</td>
<td>46%</td>
<td>55%</td>
</tr>
<tr>
<td>Did not get all the help and support needed</td>
<td>54%</td>
<td>45%</td>
</tr>
</tbody>
</table>

* Significant association at 2-7 days only (Chi square, p≤0.05).

The problems that women identified about lack of help and support in hospital included a lack of commitment to providing sensitive, individualised care, and a lack of training in practical approaches to prevent breastfeeding difficulties and to respond to them effectively if they occurred.

There was very poor breastfeeding support in hospital. This really shocked me as I thought it would be better based on the promotion of breastfeeding by the NHS during my antenatal care. In my experience it seemed all the hospital based health professionals wanted to do was to tick a box saying my baby had been fed. As we were having trouble establishing breastfeeding they kept trying to force my baby onto the breast and when he wouldn’t feed or fed for a very short time kept advising formula ‘top ups’, until, in my sleep deprived state I agreed. After discharge from the hospital my postnatal care thankfully improved. (Spontaneous hospital birth)

Postnatal care at the hospital was dreadful – with unhelpful breastfeeding support, so I self-discharged in the end as I was worried about my son and thought I could get more help at home. Problems included a very noisy ward; scalding showers; a lack of hygiene; I was told to pull myself together by a nurse when I was crying through exhaustion as I hadn’t slept at all for 4 nights. (Spontaneous hospital birth)

Lack of sufficient midwifery staff with time to spend with women was also identified as a cause of problems.

I was given no information on looking after my baby or feeding her at the hospital and the midwives there were too busy to spend any time with me. I was left alone and felt it difficult to get any help. I couldn’t wait to leave. Once discharged I was seen the midwife was very unsympathetic to my breastfeeding problems - she just kept saying it was vital I breastfeed without helping me work out how. (Spontaneous hospital birth)

I was left in the ward alone. There was a lack of assistance to get breastfeeding going. There was just no staff hence why baby formula fed and that was not my intention. (Spontaneous hospital birth)
Several women mentioned unresolved feeding difficulties contributing to neonatal jaundice. Despite recommendations of the NICE postnatal care guideline to breastfeed frequently and not to supplement routinely with formula for babies with jaundice, formula milk was introduced to treat jaundice and this in turn undermined breastfeeding.

Midwives were completely overwhelmed with the problems faced during breastfeeding. They were unable/unqualified to help establish breastfeeding. They only build up pressure to force me into already painful breastfeeding without providing any support/help. This resulted in my baby not getting enough milk, due to which the jaundice went from mild to a bad case. I finally had to give the baby formula to “treat” the jaundice and could not get my baby back on the breast afterwards. (Spontaneous hospital birth)

These accounts suggest that many units do not have in place an externally evaluated structured programme that encourages breastfeeding, such as the Baby Friendly Initiative In contrast, women who had their baby at home were more likely to report staff taking time to help them get feeding established.

After having Lily at home and being shown how to breastfeed by the midwives, I then struggled on day one and phoned the midwives for support. They sent round a maternity care assistant and she was fantastic and spent a good hour helping us with feeding. She also showed us properly how to bath Lily. I never felt the midwives or maternity care assistant were in a rush. The two midwives who were with me for the birth stayed for at least two hours afterwards. (Spontaneous home birth)

Having my daughter at home meant I had to have a number of check ups after the midwives left. One to one care and advice in my own home meant they spent hours helping me breastfeed, then kept coming back and texting us to make sure I was managing feeding. (Spontaneous home birth)

I needed a great amount of support with breastfeeding as I found it very hard, but was determined. The midwives, health visitors and NCT counsellors helped and supported me fully. I would not have continued breastfeeding without the help from them all. I feel strongly that all women who want to breastfeed should get all the support they need as it is not easy for everyone!! (Spontaneous home birth)

Some women, who gave birth in a birth centre, stayed for a few days before going home and made positive comments about the individualised support they received during their stay. One woman described how this boosted her confidence.

I found it helpful to stay in the birth centre for three nights after the birth as I was able to establish breastfeeding and got lots of help and support with it. It also meant that when I went home, I felt fully recovered and confident with my baby. (Spontaneous birth centre birth)

One woman described a number of difficulties that were overcome with committed support upon her return to the birth centre.

I gave birth in a midwife-led unit and stayed there for five days initially. I had difficulty in establishing breastfeeding and my son was heavily bruised and jaundiced. I was always given full support both emotional and physical. I went home for a few days and after seeing a community midwife went back into the unit because my son had lost too much weight. Breastfeeding experts were on hand and we came up with a plan to get my milk supply back up and to make sure that everything was working well. I would not be breastfeeding...
now if it was not for the practical advice and emotional support of all the staff at the unit and the community midwives. Establishing breastfeeding was the hardest thing I have ever done and the best thing I have ever done. (Spontaneous birth centre birth)

5.8 Comparison of findings with the 1999/2000 NCT postnatal care survey

Comparison of the current findings with those of the 1999/2000 survey suggests that there has been little change in the provision of help and support with feeding (see Table 36). Women continue to report problems in this area and many were critical about the level of support provided in hospital. Feedback about the consistency of feeding advice shows some improvement, however. Around half (53%) of all women in 2009/2010 felt they always got consistent advice, compared to 41% in 1999/2000. The proportion saying information and advice was not consistent is higher in this survey, around half, than in some other British surveys which have indicated a proportion of around one in four or five having this experience.22,31

Table 36. Baby feeding information and support

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All mothers</td>
<td>First-time mothers</td>
<td>All mothers</td>
</tr>
<tr>
<td>Got all the help and support with feeding</td>
<td>47%</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Given consistent information and advice about feeding</td>
<td>41%</td>
<td>48%</td>
<td>53%</td>
</tr>
</tbody>
</table>

5.9 Summary of findings

In summary, a large majority of first-time mothers exclusively breastfed their baby during the first month and most of those who were not exclusively breastfeeding combined breastfeeding with formula feeding. In line with other research, the survey showed exclusive breastfeeding rates declining as early as the first week after birth suggesting that women were not receiving optimal support and information. One positive development is that a high proportion of women reported that they were encouraged to have skin to skin contact in the first 24 hours after birth; a third of women also reported that their partners received the same encouragement. There were gaps in both the level of help and support provided to women and in relation to consistency of advice. Breastfeeding mothers who introduced supplementary formula feeds and those who formula feeding reported lower levels of support than those who maintained exclusive breastfeeding. Women who had had a caesarean birth also reported significantly lower levels of support than other mothers. Whatever their method of feeding, women valued a sensitive, kind and non-judgemental approach and active encouragement. This was particularly important in the early days when feeding skills were first being learnt and at times when breastfeeding seemed not to be going well.
Have NICE recommendations for postnatal care been implemented?

There is increasing evidence that involving people in decisions about their care not only leads to more knowledgeable and satisfied patients, but may result in better recovery and health. This is also likely to result in more cost-effective use of health services. The NICE postnatal care guideline recommends that:

- A documented, individualised postnatal care plan should be developed with the woman.

The clinical care guideline is also explicit about the ethos of care, the quality of communication expected and the involvement of women and their families:

- ‘Women and their families should be treated with kindness, respect and dignity at all times with consideration given to privacy and where care is provided in a maternity care unit, to creating a clean, warm and welcoming environment.’
- ‘The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.’
- ‘The woman should be fully involved in planning the timing and content of each postnatal care contact so that care is flexible and tailored to meet her social, clinical and emotional needs and those of her baby and family.’(p12)

The earlier chapters of this report, which have replicated the NCT’s investigation carried out in 1999/2000, have already demonstrated that there are very considerable gaps in the quality of postnatal care. In the current study, 3-4 years after publication of the NICE postnatal care guideline in 2006, we wanted to know the extent to which there was evidence from a woman’s perspective that the positive vision for postnatal care advocated by NICE had become a reality. We were interested to find out whether:

- women had a postnatal care plan,
- care was tailored to the needs of the individual, and
- care was based on a partnership approach, including joint decision making.
Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

• A documented, individualised postnatal care plan should be developed with the woman, ideally in the antenatal period or as soon as possible after birth to include:
  - relevant factors from the antenatal, intrapartum and immediate postnatal period
  - details of the healthcare professionals involved in her care and that of her baby including roles
  - and contact details
  - plans for the postnatal period.

This should be reviewed at each postnatal contact.

• There should be local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals. These protocols should be audited.

• Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognise and respond to problems.

• At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions and to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur.

• All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated structured programme that encourages breastfeeding, using the Baby Friendly Initiative (www.babyfriendly.org.uk) as a minimum standard.

• At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.

• At each postnatal contact parents should be offered information and advice to enable them to:
  - assess their baby's general condition
  - identify signs and symptoms of common health problems seen in babies
  - contact a healthcare professional or emergency service if required.

Source: Routine postnatal care of women and their babies (p6)
6.1 A written care plan

We asked women whether they had been consulted about a personal postnatal care plan. The NICE guideline recommends that antenatally, or if this is not possible, in the first 24 hours after giving birth, health professionals should work with women to develop a written postnatal care plan tailored to their needs. The care plan should:

- describe how women will progress over 6-8 weeks after birth and include relevant factors from their care before, during and immediately after birth,
- provide details of the healthcare care team to be involved in providing postnatal care,
- say who is the single coordinating professional, and
- include space for keeping a record of their care.

We found that

- 96% (n=1150/1202) of first-time mothers surveyed said that they had not been not involved in drawing up a postnatal care plan as recommended by NICE.

Women’s free text comments about what was especially good or poor about their care provide detail about their experiences. We received 1081 comments from first-time mothers. Without being specifically prompted, many women reported poor co-ordination and planning of the care they received. The impact of lack of co-ordination often appeared to be increased by a lack of continuity of care from an individual carer or named care coordinator (see Chapter 7). Some women had a single health professional as a point of contact, but others were unclear about who would visit them and when.

I was transferred from my antenatal midwife team to a different hospital/ team for postnatal care without being told or asked – I wasn’t given any new contact details. I did not see a midwife until three days after I had returned home – I had to call and ask them to come out – the first appointment no one showed up or called to let me know. (Spontaneous hospital birth)

Not having a midwife as point of contact for postnatal care was disappointing. (Caesarean birth)

Once I was discharged I needed to phone up to ask for a midwife appointment as they didn’t know I had been discharged and even then they kept saying I was someone else’s responsibility. (Spontaneous hospital birth)

Because we live on the border of two counties we had to ring up a number of services to get the midwife to come to us in the first instance and were passed around the different local hospitals before this happened. (Spontaneous hospital birth)

For women with more complex clinical needs lack of planning and co-ordination was particularly problematic. During the very early days this was draining for women who were lacking sleep.

The aspects of care that were not good were lack of communication/thought between healthcare professionals. Nobody considered the impact on the baby of the mother having general anaesthetic plus no food, water or sleep for two days. The general attitude of staff on the ward was that I was being lazy when requiring some help with physical activities in the days after birth, e.g. lifting/ changing baby. Feeding plan did
not include advice on mother's nutrition. No opportunity for sleep/rest as feeding programme was half an hour feeding on each breast, half an hour expressing on each breast (no double pump available), then formula top up. When burping and nappy changing factored in, only about 25 minutes left to sleep every three hours – day and night. And this was often filled with staff coming to check my blood pressure and/or monitor / give medication to baby. Again, no sign of joint planning to avoid this. (Caesarean birth)

Once women left hospital, lack of co-ordination and planning meant that some who clearly needed home visits were not given them.

My local area does not do home visits at the weekend. I was discharged on a Friday, received a call on the Monday to arrange a visit on Tuesday which was cancelled so I went to them. Then I was told that it was important that they see me at home; they arranged a visit on a Saturday even though they don’t do weekends, and then of course never turned up...so I went to them again. The third visit was cancelled due to lack of staff so I went to them. All this time, I could barely walk. (Assisted hospital birth)

So there was a significant lack of care planning and co-ordination between hospital staff and community midwifery and between healthcare professionals and women. Often women had to be proactive in order to get even one or two home visits, and some women went to a clinic when they would prefer a home visit.

In addition, women fed back to us that they found the lack of scheduled appointment times created another difficulty for them at a time when they had many pressures to cope with and wanted to be able to work around their baby, sleeping when they could or going out if the need or desire arose.

There was confusion over when the midwives would come. Given a 2-3 days period, I wanted to get out occasionally and felt trapped waiting in. (Spontaneous birth centre birth)

The midwives did not specify a time when they would visit. They would just say a date so you would have to wait at home wondering when they might come, so you couldn’t even go to bed for a sleep. (Spontaneous birth centre birth).

The only criticism is that the midwife visits were anytime between 10.00am and 4.00pm during the day and they couldn’t tell us when so we had to wait in all day. With a new baby and nice weather, we were keen to get out and about and this stopped us on the three occasions we had to wait for the midwife. (Spontaneous birth centre birth)

It was quite intrusive having a midwife come to the house every day as we never knew what time to expect them. We spent all day at home waiting not knowing whether to get on with things. When appointments were made they were not always able to attend at the agreed time due to other work pressures. (Spontaneous birth centre birth)

6.2 Kindness and respect

Another way in which the overall quality of postnatal care can be assessed and the extent to which care can be judged to be tailored to the needs of the individual is indicated by the way in which midwives communicate and interact with women.
Women were asked to rate the care they received from midwives during the first week after birth. Most women reported that midwives were always or mostly kind and understanding (80%) and treated them with respect (83%) during their postnatal care (see Table 37).

Table 37. Views about the care from midwives in the first week after birth

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes/never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives were kind and understanding</td>
<td>45%</td>
<td>35%</td>
<td>20%</td>
<td>1252</td>
</tr>
<tr>
<td>Midwives treated you with respect</td>
<td>53%</td>
<td>30%</td>
<td>17%</td>
<td>1247</td>
</tr>
</tbody>
</table>

First-time mothers who rated their midwifery care highly said that they valued midwives who were kind and reassuring, giving positive feedback to them so that they knew they were doing well. They commented on what a difference it made when the midwives followed the usual conventions of polite communication, such as introducing themselves, and saying ‘hello’ and ‘goodbye’. Women also appreciated having midwives who were ‘active listeners’, which involves acknowledging what the woman is concerned about and allowing time to explore with her how she is feeling, as well as responding constructively.

Reassuring and kind maternity staff kept telling me how well I and my baby were doing. Extremely important when it is your first baby and you are feeling a little lost! (Spontaneous hospital birth)

Some midwives showed kindness and actually listened to what I said. Doing the basics like saying hello when coming on shift and goodbye when leaving and treating me like a real person. (Caesarean birth)

However, approximately one in five women were less positive reporting that midwives sometimes or never showed them kindness and understanding (20%) or treated them with respect (17%). Some of the criticisms women had were midwives who didn’t know them or what they valued, and midwives’ attention being primarily on record keeping or drug rounds. Women wanted midwives to focus on them, finding out how they were feeling and exploring any concerns.

In the recovery room just after the caesarean, I wasn’t sure how long I would be there or whether I could breastfeed in there ... I only knew how important the first hour or so is for initiating breastfeeding as I had been on the NCT course. The nurse seemed surprised that I wanted to breastfeed ... When I was moved up to the ward I was left for several hours and I worried about feeding my baby (I couldn’t reach her – I couldn’t move) I ended up phoning my husband on my mobile in tears and asking him to come as soon as visiting was allowed instead of pressing my buzzer as I felt so disempowered. ... For the next 24 hours my recollection is that I only saw a midwife when it was a drug round. ... When the evening came a midwife came and sat down next to me looking like she had all the time in the world and I felt like crying I was so grateful someone was going to help me. I really hadn’t anticipated how emotional I would be after the birth and how I wouldn’t be able to ask for help. (Caesarean birth)
Women wanted to be listened to and given an opportunity to talk. When a midwife had knowledge of their birth experience and what their earlier postnatal care had involved, they felt valued and supported. When this kind of understanding was absent, and there was no growing relationship, the content of the interaction during each contact with a health professional was especially important but less likely to be perceived positively.

Midwife support was appalling – every time a different midwife appeared who did not know the baby and her development at all. The midwife spent most of the time filling in her form, did not feel the need to listen nor treat me with respect. (Spontaneous hospital birth)

In the first two weeks I saw about four different midwives who never arrived when they said they would and it was evident that they had not been briefed about my situation. On one occasion my husband asked the lady and her trainee to leave as they were useless. (Spontaneous hospital birth)

Sometimes women were able to express what they perceived to be the limitations of care in one setting by contrasting it with care in another.

The kindness of midwives and personal care of midwives at home in contrast to a different face every hour in hospital – I had to go into hospital for two hellish days for a fourth degree tear after a wonderful home birth. (Home birth)

When midwives were insensitive their words made a big impact on women. Some people working in a large institution seemed to disregard usual conventions of politeness and respect.

I stepped outside of my room for a few seconds with my baby to (check) the instructions given to my husband. My question wasn’t answered and I was told abruptly to go back inside my room and not ‘to wave my baby around in the corridor’ which was certainly not what I was doing and I felt unnecessarily rude – I said nothing as I felt disempowered but it still makes me angry five months later! (Caesarean birth)

I felt patronised by hospital staff telling me off for ‘breaking rules’ like how and where to change baby and not walking around with baby, although these rules were never actually communicated until you broke one. It felt like being back at school. (Spontaneous hospital birth)

The trend was for women who had operative births to feel less happy about the level of kindness, understanding and respect experienced. Around 1 in 5 women (19%) who had an assisted birth and almost a third of women who had a caesarean (30%) felt that midwives were only kind and understanding either some of the time or never (see Table 38).
Table 38. Views about the care from midwives in the first week after birth by type of birth

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes/never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midwives were kind and understanding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>53%</td>
<td>32%</td>
<td>15%</td>
<td>591</td>
</tr>
<tr>
<td>Assisted</td>
<td>42%</td>
<td>39%</td>
<td>19%</td>
<td>321</td>
</tr>
<tr>
<td>Caesarean</td>
<td>34%</td>
<td>36%</td>
<td>30%</td>
<td>335</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>45%</td>
<td>35%</td>
<td>20%</td>
<td>1252</td>
</tr>
<tr>
<td><strong>Midwives treated you with respect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>62%</td>
<td>27%</td>
<td>11%</td>
<td>558</td>
</tr>
<tr>
<td>Assisted</td>
<td>51%</td>
<td>33%</td>
<td>16%</td>
<td>321</td>
</tr>
<tr>
<td>Caesarean</td>
<td>41%</td>
<td>31%</td>
<td>28%</td>
<td>333</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td>53%</td>
<td>30%</td>
<td>17%</td>
<td>1247</td>
</tr>
</tbody>
</table>

** Significant differences (Mann Whitney, p=≤0.016).

Sixteen per cent of women who had assisted births and just over a quarter of women (28%) who had a caesarean felt that midwives treated them with respect only some of the time or never (see Table 38). Further analysis was carried out controlling for place of birth. When the views of all women who had had their baby in hospital were compared, excluding women who had given birth at home or in a birth centre, there were still significant differences though the extent of the difference was reduced.

Care in hospital was abysmal. I’d rather give birth in a third world country than in (hospital’s name). Midwives had total lack of respect for mothers...it was so bad I eventually discharged myself but it took hours as I couldn’t find a midwife for love or money! (Caesarean birth)

6.3 Communication and involvement in decisions

To explore women’s experiences further in relation to the NICE recommendations for postnatal care, women were asked about care throughout the first month after birth. They were asked whether they felt their personal needs and preferences were taken into account, and about the extent to which they were involved in decision making about their own and their baby’s health. They were also asked whether they had the opportunity to ask questions and discuss anything that was worrying them. Most first-time mothers who responded to the survey felt that healthcare professionals always or mostly took into account their personal needs and preferences (70%). However, almost a third of women (30%) gave a negative response (see Table 39).

Three quarters of women (76%) felt they were either always or mostly involved in decisions about their own care and around four out of five women (81%) felt they had always or mostly been involved in decisions about their baby’s care. A similar proportion (79%) felt that they were always or mostly given the opportunity to ask questions about their care, and 73% felt that they were able to discuss things that were worrying them.

I felt listened to and that my views and opinions as baby’s mother were important considerations whilst planning our care. I felt there was consistent support when we went home from hospital. (Spontaneous hospital birth)

I wasn’t made to feel that my questions were silly or unimportant, I was taken seriously. (Caesarean birth)
However around a quarter of women felt less involved in decisions and less able to ask questions and discuss their worries (see Table 39). The results suggest that health professionals are more likely to involve first-time mothers in aspects of their baby’s care than they are to discuss aspects of the woman’s own health, or to create an opportunities for a women to express herself and have her concerns addressed.

Table 39. Views about communication and involvement in decisions

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes/never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal needs and preferences</td>
<td>30%</td>
<td>40%</td>
<td>30%</td>
<td>1256</td>
</tr>
<tr>
<td>Fully involved in decisions about own care</td>
<td>42%</td>
<td>34%</td>
<td>24%</td>
<td>1254</td>
</tr>
<tr>
<td>Fully involved in decisions about baby’s care</td>
<td>51%</td>
<td>30%</td>
<td>19%</td>
<td>1254</td>
</tr>
<tr>
<td>Opportunity to ask questions</td>
<td>49%</td>
<td>30%</td>
<td>21%</td>
<td>1255</td>
</tr>
<tr>
<td>Able to discuss things that were worrying me</td>
<td>40%</td>
<td>33%</td>
<td>27%</td>
<td>1252</td>
</tr>
</tbody>
</table>

Women’s comments indicate that they often felt reluctant to ask for help and unable to discuss things with health professionals if staff did not create an opportunity and express willingness to listen. Lack of continuity of carer was highlighted by women repeatedly as an aspect of care that was poor and could have been improved. Low staffing levels on hospital postnatal wards were also identified as a causal factor limiting the quality of postnatal care. Some staff were also perceived as having a negative attitude, lacking in sensitivity and good communication skills. These were commonly raised as problems with hospital postnatal care.

In hospital there was a never ending stream of midwives, I didn’t see the same one twice. The quality of their care varied significantly, some were kind and took the time to discuss issues and offer advice others made me feel like a ‘fuss-pot’ or were dismissive. (Spontaneous hospital birth).

Some women who had a history of depression or were struggling with depressed mood in the postnatal period felt unable to get consistent support and suffered as a result of poorly coordinated care and nobody acting as a ‘single coordinating professional’, as recommended by NICE.

I was supposed to receive additional support after discharge from hospital due to my mental health – however, because there were so many midwives and communication about patients was poor my visits from the midwife were cancelled three times in our first week at home and I didn’t see my own midwife until day 10 when she came to sign me over to the health visitor...It was very difficult for me to discuss/talk about how I was feeling with ‘strangers’. (Spontaneous hospital birth)

As with other aspects of postnatal care, those first-time mothers who had had operative births were less positive about communication and involvement in decisions during the first month after birth compared with those who had had a spontaneous vaginal birth. Between a quarter and a third of women who had an operative birth felt less satisfied about these dimensions of quality of care (see Table 40).

The midwives and maternity support workers in hospital after birth were often very impersonal and not very emotionally forthcoming. This made me feel unsupported and unsure of myself at a very challenging time. I saw so many different health care workers it was difficult to feel I could connect to any one or feel like any one of them had my interests at heart let alone knew what they were. (Caesarean birth)
6.4 Summary of findings

In summary, from the perspective of these first-time mothers, a very small minority felt that they were involved in developing a care plan with midwives in the first 24 hours after birth and many felt that their care lacked coherence and coordination. Most reported that midwives were kind and respectful but many women had heartfelt stories to tell of being treated insensitively at a time when they were vulnerable. Generally, during the first month after birth, health professionals seemed more likely to involve first-time mothers in aspects of their baby’s care than to discuss aspects of the women’s own health, or to create an opportunity for the woman to talk about her feelings and concerns. Women who had had an operative birth had less positive experiences than women who had a spontaneous birth.
Structural and organisational aspects of care

The final results chapter looks at structural aspects of postnatal care including opportunities for women to be cared for by someone they know and with whom they have been able to form a relationship. We report on the women’s perceptions of the level of midwifery staffing in hospital, birth centre or after a birth at home and the patterns of care provided by community midwives, health visitors and maternity support workers.

Maternity support workers (sometimes called maternity care assistants), are a relatively new members of the maternity care team. They work under the supervision of qualified midwives providing aspects of postnatal care and support in hospital and in the community, including infant feeding advice.78

7.1 Perceived level of midwifery staffing

One of the themes that has emerged already from the free-text comments reported in earlier chapters is a perception that the quality of postnatal care is limited by understaffing of this phase in the care pathway. The issue has come up in other studies, including the Audit Commission’s survey and our own previous postnatal care survey.29,32

We asked ‘Thinking back, were there enough midwives to provide you with the care and support you needed?’ Around six out of ten first-time mothers who gave birth in hospital (58%) felt there were always or mostly enough midwives to provide postnatal care. This was significantly lower than the proportion who said this among women who gave birth in birth centre (77%) or at home (92%). This means that a large proportion felt there was a lack of midwives (see Table 41).

Table 41. First-time mothers’ views about whether there were enough midwives to provide care and support

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes/never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>After birth in a hospital</td>
<td>30%</td>
<td>28%</td>
<td>42%</td>
<td>1075</td>
</tr>
<tr>
<td>After birth in midwife led unit/birth centre</td>
<td>52%</td>
<td>25%</td>
<td>23%</td>
<td>106</td>
</tr>
<tr>
<td>After a birth at home</td>
<td>67%</td>
<td>25%</td>
<td>8%</td>
<td>61</td>
</tr>
</tbody>
</table>

In NCT’s 1999/2000 survey one third of all respondents, of whom two thirds were first-time mothers, said there were never or only sometimes enough midwives to provide them with the level of care they needed in the first days after birth. In the current study, the proportion is much higher; overall 42% of all women who responded to the survey (regardless of parity) felt there were never or only sometimes enough midwives to provide them with care and support they needed. This was much more of a problem for first-time mothers who had their baby in hospital (42%) than for those who used a birth centre (19%) or had their baby at home (8%) (see Table 41).

Women who had a hospital birth often referred in the free text response at the end of the questionnaire, to staffing levels as an aspect of care that was not good or could have been improved, complaining that staff were too busy to spend time with them. Although the hospital staff were kind and caring, they were very short staffed and overworked and I did not see or get adequate support from them during the first 48 hours after the birth of my son. (Assisted hospital birth)
There were not enough midwives on the postnatal ward to help with breastfeeding and other support. (Caesarean birth)

In contrast, some women also used the free text question on ‘what was especially good or important about your care?’ to comment on sufficient staffing levels as well as positive staff attitudes. There were some positive examples of postnatal care reported from women who had a hospital birth.

I was fortunate enough to have had a straightforward birth and didn’t need too much support afterwards. But I felt there was always someone there to help if I needed it. (Spontaneous hospital birth)

However, positive feedback was more frequent from women who had given birth in a birth centre or at home and tended to be more detailed and expansive.

I gave birth in a midwife led unit. I was always given full support, both emotional and physical, that I needed from midwives and maternity care assistants. Someone was always on hand to give advice and guidance. (Spontaneous birth centre birth)

I was cared for by a lovely team of midwives during my pregnancy who then attended my birth at home and carried out my postnatal care at home. All the midwives in the team knew the details of my (positive) birth experience (even those who weren’t present) so I never had to repeat my story. It was great to have my visits at home and not have to go anywhere especially in those early days, and I had a contact number where I could contact one of the midwives in the team at any time. Visits were never rushed and I felt well cared for. (Spontaneous home birth)

Women who had operative births were less satisfied with the level of support and care they received from midwives compared to those who had spontaneous vaginal births. Almost half of these women felt that there were ‘never’ or only ‘sometimes’ enough midwives (see Table 42).

<table>
<thead>
<tr>
<th>Type of birth</th>
<th>Always</th>
<th>Mostly</th>
<th>Sometimes</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal</td>
<td>38%</td>
<td>30%</td>
<td>21%</td>
<td>11%</td>
<td>544</td>
</tr>
<tr>
<td>Assisted</td>
<td>30%</td>
<td>23%</td>
<td>27%</td>
<td>20%</td>
<td>322</td>
</tr>
<tr>
<td>Caesarean</td>
<td>23%</td>
<td>29%</td>
<td>24%</td>
<td>24%</td>
<td>333</td>
</tr>
</tbody>
</table>

**Significant differences between modes of birth (Mann Whitney p≤0.016). These differences remained significant when each mode of birth was compared individually with both of the others using a Bonferroni adjustment.

7.2 Continuity of care

Another theme that emerged from the feedback and has been reported in earlier chapters relates to ‘continuity of carer’, i.e. whether or not women had care from the same individual at different contacts or were seen by a succession of different people. The importance for women of this aspect of care has been discussed and debated a good deal over the last two decades. The importance for women of this aspect of care has been discussed and debated a good deal over the last two decades. It was clear from the survey that continuity of carer during the postnatal period was important for the women who took part. There are different ways of organising midwives and providing midwifery services and each system of organisation has different characteristics and is affected by a range of
factors. These factors include:

- the degree of integration between hospital-based and community-based services,
- the size of maternity units and of caseloads,
- whether there is a defined caseload for individuals or small groups of midwives,
- whether midwives working in the community are attached to GP practices or cover a geographical area, and
- whether different individuals in the system share the same ethos and approach.

These factors all affect the extent to which women have continuity of carers during the first 24 hours after birth, and after discharge from the maternity unit if they have given birth in a hospital or birth centre.

Continuity of carer throughout pregnancy, birth and the postnatal period seems to be most common where midwives carry an individual caseload, or where a small team of midwives share responsibility for a group of women, and they attend them during labour and birth as well as providing antenatal and postnatal care.  

For women planning a home birth, continuity of carer is easier to arrange than for women booking a hospital birth as community-based midwives generally provide all of their antenatal, intrapartum and postnatal care. In contrast, women who give birth in hospital, often have their antenatal care from community-based midwives, their care during labour and while on the postnatal ward from midwives employed in the acute sector, and then return to community-based care. Birth centres have a range of different staffing arrangements in place, however, they tend to be small in size and to value the principle of continuity of carer, working within a social model of care.  

One ethnographic study of a freestanding birth centre in England revealed how the midwives paid specific attention to supporting women during matrescence, the period of becoming a mother, a time when mothering the mother is important. Women can expect to receive support from midwives for up to 10 days, or sometimes up to 28 days after birth, depending on need, after which there is a hand over to health visitors. The National Service Framework document for England went further, saying 'maternity services should provide for the mother and her baby for at least a month after birth or discharge from hospital, and up to three months or longer depending on need', however, in practice, this length of midwifery involvement is rare. The current survey did not address timing of discharge from the midwife or handover to the health visitor.

Research shows that women who have care from a small team of midwives or a primary caseload-carrying midwife is associated with positive experiences for them in terms of access to information and advice, and their overall satisfaction with care.  

Studies suggest that increased continuity of carer leads to greater consistency of care and advice and the opportunity for women to raise concerns and develop a trusting relationship, all of which are aspects of care valued very highly by women.  

Women were asked about the number of contacts they had with midwives and maternity support workers and the number of different individual midwives and maternity support workers who provided their care after discharge from a maternity unit or birth at home. One in five first-time mothers (20%) reported fewer than three contacts with a midwife, a quarter (26%) had three contacts, a further fifth had four contacts, and a third recalled five or more visits (see Table 43).
Just over half of first-time mothers (51%) reported having contact with three or more different midwives, and around 21% (n=222) also recalled having care from a maternity support worker (see Table 44). This suggests that few women were able to have several contacts with just one or two community-based midwives, which is further demonstrated in Table 45.

Table 44. Number of different midwives and maternity support workers who provided care after discharge or birth at home

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3 or more</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>2%</td>
<td>16%</td>
<td>31%</td>
<td>51%</td>
<td>1206</td>
</tr>
<tr>
<td>MSWs</td>
<td>79%</td>
<td>15%</td>
<td>4%</td>
<td>2%</td>
<td>1051</td>
</tr>
</tbody>
</table>

As this was a retrospective survey, requiring women to think back over anything up to 12 months to recall how many contacts they had had with different healthcare staff within a specific period, it is likely that some details will not be accurate. However, it also seems likely that something so important as getting adequate care during the first few days at home with a new baby would be remembered more clearly than many other recollections. This suggestion is reinforced by women’s often vivid recollections of their feelings and events at that time.

We asked women how important they felt it was to be seen by the same midwife throughout their postnatal care. Most women (71%) felt that it was important or very important. Table 46 shows that women who had had their birth assisted with forceps or ventouse (77%) were most likely to feel it was beneficial to see the same midwife throughout their care (Mann Whitney p=<0.016).

Table 45. Number of contacts with midwives by number of different midwives who provided care

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 or more</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One midwife</td>
<td>24%</td>
<td>21%</td>
<td>24%</td>
<td>17%</td>
<td>14%</td>
<td>194</td>
</tr>
<tr>
<td>Two midwives</td>
<td>1%</td>
<td>27%</td>
<td>28%</td>
<td>20%</td>
<td>24%</td>
<td>377</td>
</tr>
<tr>
<td>Three or more midwives</td>
<td>0%</td>
<td>4%</td>
<td>26%</td>
<td>24%</td>
<td>46%</td>
<td>598</td>
</tr>
</tbody>
</table>

Table 46. First-time mothers views about continuity of midwife carer by mode of birth

<table>
<thead>
<tr>
<th></th>
<th>Very important</th>
<th>Important</th>
<th>Moderately important</th>
<th>Not very important</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All first-time mothers</td>
<td>41%</td>
<td>30%</td>
<td>26%</td>
<td>3%</td>
<td>1207</td>
</tr>
<tr>
<td>Spontaneous vaginal births</td>
<td>37%</td>
<td>30%</td>
<td>29%</td>
<td>4%</td>
<td>575</td>
</tr>
<tr>
<td>Assisted</td>
<td>45%</td>
<td>32%</td>
<td>20%</td>
<td>3%</td>
<td>310</td>
</tr>
<tr>
<td>Caesarean</td>
<td>43%</td>
<td>28%</td>
<td>27%</td>
<td>2%</td>
<td>317</td>
</tr>
</tbody>
</table>
Many women valued being able to make a trusting relationship with an individual midwife. They felt that it made it easier to talk about any worries and the midwife was more likely to know when they were anxious or upset. Every time I saw the midwife she made me feel that I was the most important person she’d seen that day. I’d had the same midwife from 16 weeks gestation onwards and it was so nice not having to explain things over and over. She became a friend in the end and my husband and I were really sad when she signed me over to the health visitor. (Spontaneous hospital birth)

I was glad that I saw the same midwife in my home visits as this helped me to develop a relationship with her which made it easier for me to discuss any problems and I felt it gave her the ability to gauge my moods and pick up on any emotional changes. (Spontaneous hospital birth)

I think having one midwife for the duration of my pregnancy and aftercare helped me trust my midwife and the care I was receiving. (Spontaneous home birth)

Those who saw numerous midwives described having to re-tell their birth stories and update health professionals about their care needs, which they found frustrating. It also tended to undermine any sense of being supported by staff as they were advising the health professional on their health and recent experiences, rather than the health professional having a sense of their progress, and their feelings. Midwives who were able to explain developments and options from a position that was informed by knowing the individual were highly valued. Conflicting advice was referred to as a particular problem by women who had care provided by many different healthcare workers.

Keeping the same midwife would be a good improvement as they’d understand what you’d been through instead of having to explain it all to each person that saw you. (Spontaneous hospital birth)

(It was not good) being visited by different midwives every day for a week until I broke down and the care was changed. There was little emotional understanding of what I had been through and how I was coping both physically and emotionally. I had to go through my labour and hospital history at the beginning of each visit for the benefit of each different midwife which I found upsetting and draining. My baby’s lack of breastfeeding and hunger was not dealt with in a consistent manner and no plan was in place. Advice was conflicting and counterproductive. (Assisted hospital birth)

I would have liked the same midwife/health visitor as there was concern about jaundice and the different staffs’ perception was not clear. (Assisted hospital birth)

I think it would be beneficial to see the same midwife for postnatal care rather than a team of individuals who you have no bond with. I think so much of the support postnatally is of an emotional type which is near impossible to establish when you are seeing someone different every time. Also, as they all seem to have their own opinions and ways of doing things it can be confusing and you receive mixed messages. You also have to go back over old ground every time you see someone different or rely on notes which seem to be scant at best. (Spontaneous hospital birth)

For women who found the weeks after birth difficult emotionally, lack of continuity of carer left them more isolated and may have reduced the likelihood of professionals picking up on the extent of the problem.
I found the first month extremely difficult, but didn’t want to be labelled as having PND so I found it very difficult to talk to health professionals to get help. None of the professionals I saw knew me before the birth or saw me enough times to be able to see that I was struggling… I even downloaded the Edinburgh postnatal depression scale so that I could prepare my answers before the health visitor tested me so I wouldn’t fail it. I would have benefited from having been able to develop a relationship with a midwife or health visitor before birth so that they could be more proactive in supporting me and could perhaps see that I was struggling. (Caesarean birth)

However, some women did not mind seeing several different midwives particularly they were kind and encouraging and the care was well co-ordinated. If women felt listened to, able to ask any questions and did not get conflicting advice, this went a long way towards satisfying their requirements.

Although I saw more than one midwife, it was explained to me who was on duty and when they would be coming. I found that helpful and found both midwives and their accompanying student to be kind and considerate. (Spontaneous birth centre birth)

The midwives were all different and some gave conflicting advice, but they were all lovely, and understanding and caring and helpful. (Caesarean birth)

I did not mind having several midwives attending to me… I was offered extra visits, encouraged that I was doing a good job and I felt listened to. (Spontaneous hospital birth)

One woman said that having a student midwife visit her with the qualified midwives provided an additional opportunity for information and support as one could talk with her partner and address his questions and practical support needs while she was examined.

I had agreed to let a student midwife be present so I got three midwives at my home which was excellent and meant one was able to talk to my husband through the initial tests and show him nappy changing and dressing while I was being checked over. (Spontaneous home birth)

Most first-time had at least one home visit from a midwife (96%), but 4% missed out on home visits entirely. Around 15% of first-time mothers had at least one of their contacts with a midwife at a health centre or surgery. Only 4% (n=46) of this sample of mainly older, highly educated women saw a midwife at a children’s centre.

There was no significant association between the number of midwifery community contacts and mode of birth. However, there was an association with place birth and the number of midwifery contacts. More than half of women who had a home birth (56%) had five or more contacts. We do not have data to show whether an increased number of contacts was associated with breastfeeding difficulties or other health-related issues.

Of the 30 women who had no home midwifery contacts after discharge from the maternity unit, seven (23%) had at least one contact with a maternity support worker. Some women commented about their lack of support (see below), but details about why they were not contacted are not available in all cases. Most, but not all, were women who had their baby in hospital (85%); and two thirds had an operative birth (66%) compared with 52% in the sample.

Longer stays in hospital were associated with fewer midwifery contacts after discharge from the maternity unit (Spearman’s rho -0.088, p=0.005). Thirty percent of women
who had no contact with a midwife and 46% of women who had only one contact with a midwife once at home stayed in hospital for five days or longer because either they or their baby were needing additional care.

I was in hospital for seven days after the birth because the delivery was difficult and therefore my baby developed quite bad jaundice. He had to go to the SCBU and I got a uterine infection. Throughout this time the midwives were kind and very patient and most importantly they enabled me to breastfeed my baby every three hours despite the fact that for three days he was downstairs in a phototherapy crib. (Assisted birth)

The postnatal care of some women whose baby was in SCBU was neglected. There was confusion about where the responsibility lay; community midwives seemed to expect that postnatal checks were being provided in hospital and if women had been discharged hospital staff assumed community-based staff would look after them.

When my baby was readmitted to SCBU I had real trouble accessing support services for myself. The community midwife told me that I would have these in hospital but maternity unit staff were constantly too busy to do these for me and I was made to feel a nuisance. (Spontaneous hospital birth)

Support from the community midwife was not good. Since I was visiting the SCBU she assumed I was getting care in hospital but that meant signing in as a patient. (Caesarean birth)

However, staff in some NHS trusts did manage to respond flexibly when the baby was an in-patient and the mother had been discharged.

I discharged myself ... as my baby was ill in SCBU and it was too upsetting on the ward with mothers and their new babies, but the midwives saw me daily on the ward daily and were amazing. (Spontaneous hospital birth)

One woman whose baby was in SCBU felt that her lack of community midwifery care was because midwives had assumed she was coping well in the early days.

Having a midwife come and visit the house was good, but I would have preferred to see more health professionals. I think they just decided I was doing fine and the baby was doing fine so they just left us to it. As this was my first child, I felt quite isolated and overwhelmed because there was a lot going on. (Assisted birth)

In some areas the system seemed unable to cope with the number of women requiring postnatal care.

The midwives were too busy to see me so I had no care from them. (Spontaneous hospital birth)

I was not seen by a midwife at all after being discharged. I was seen for the first-time by a health visitor 10 days after giving birth. So my baby’s weight wasn’t measured in the first week, I was struggling with breastfeeding, and despite phoning the health clinic twice I did not receive any support until 10 days later. (Spontaneous hospital birth)

We were interested to explore whether some NHS trusts were substituting visits from a midwife with visits from a maternity support worker care. There was no indication that this was the case, as there was no association between number of midwifery contacts and number of contacts with a maternity support worker (see Table 47). However, the...
variation in the number of community-based postnatal care contacts within 10 days was very considerable (range 0–10 or more (five or more midwife contacts, plus five or more MSW contacts).

**Table 47. Number of contacts with a MSW by number of midwifery contacts**

<table>
<thead>
<tr>
<th>No MSW contacts</th>
<th>1-2 MSW contacts</th>
<th>3-4 MSW contacts</th>
<th>5 or more MSW contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contact with a midwife</td>
<td>77%</td>
<td>74%</td>
<td>82%</td>
</tr>
<tr>
<td>1-2 MSW contacts</td>
<td>13%</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>3-4 MSW contacts</td>
<td>10%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>5 or more MSW contacts</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### 7.3 Length of contact time with health professionals

Women were asked about the length of each contact they had with midwives, maternity support workers and health visitors. The majority of first-time mothers said that they had had some contact with a health visitor during the first month after birth (96% n=1209) and most had received a home visit (90% n=1138). We asked women to recall up to five postnatal contacts with ‘a midwife or maternity support worker’ and with a health visitor and estimate the length of the contact. Around half of women reported having ‘up to 30 minutes’ contact with a midwife or maternity support worker for the first three contacts (see Figure 4). These first-time mothers suggested that the length of their contacts with midwives tended to shorten as time passed, so contacts of ‘up to 15 minutes’ were more common from the third contact onwards.

**Figure 4. Length of contacts with midwives**

Most women (83% n=980/1184) felt that the length of contact time they had with a midwife was always or mostly enough. Table 48 shows that women who had contacts with a midwife lasting more than 15 minutes tended to be more satisfied overall with the length of midwifery contact time they had. Women who had longer contact times for the first four contacts also felt better able to discuss things that were worrying them compared with women who had shorter contact times (see Table 49).
On average around half of women who had contact with a maternity support worker saw them for 15-30 minutes (see Figure 5). The proportion of women who saw a maternity support worker for up to 15 minutes only steadily increased after the first contact. Overall, more than three quarters of first-time mothers (77% n=203/265) felt that time spent with a maternity support worker was always or mostly enough. Women who had contact with a maternity support worker lasting more than 15 minutes tended to be more satisfied with the amount of time spent with them compared to those who saw them for less than 15 minutes or less during the first three contacts (see Table 50). After the third contact, additional contact time (greater than 15 minutes) ceased to make a significant difference to their feelings.

**Figure 5. Length of contacts with maternity support workers**

Contact time with health visitors fluctuated. Around 39% of these first-time mothers said that they spent 15-30 minutes with their health visitor at their first postnatal appointment, the most common length of contact time. For around 38% the appointment was longer, lasting either 30-60 minutes or more and for 13% contact lasted more than an hour (see Figure 6). By the third postnatal contact, the length of consultation time was most commonly 15 minutes or less. Most women (84%) felt that the time spent with health visitors was always or mostly enough. For all contacts, women whose contact with a health visitor lasted longer than 15 minutes were more satisfied with the amount of time spent with them compared to those who spent 15 minutes or less (see Table 51).
<table>
<thead>
<tr>
<th></th>
<th>1st contact**</th>
<th>2nd contact**</th>
<th>3rd contact**</th>
<th>4th contact**</th>
<th>5th contact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 mins (n=159)</td>
<td>14%</td>
<td>24%</td>
<td>33%</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>&gt;15 mins (n=1008)</td>
<td>86%</td>
<td>76%</td>
<td>67%</td>
<td>63%</td>
<td>60%</td>
</tr>
<tr>
<td>&lt;15 mins (n=270)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 mins (n=858)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 mins (n=323)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 mins (n=661)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 mins (n=261)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 mins (n=444)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 mins (n=192)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;15 mins (n=283)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Significant association (Chi square, p<0.01 for all contacts).

<table>
<thead>
<tr>
<th></th>
<th>1st contact**</th>
<th>2nd contact**</th>
<th>3rd contact**</th>
<th>4th contact**</th>
<th>5th contact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Views:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always or mostly able</td>
<td>51%</td>
<td>62%</td>
<td>73%</td>
<td>79%</td>
<td>83%</td>
</tr>
<tr>
<td>Sometimes or never able</td>
<td>49%</td>
<td>38%</td>
<td>27%</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>89%</td>
<td>90%</td>
<td>91%</td>
<td>93%</td>
<td>94%</td>
</tr>
</tbody>
</table>

**Significant association (Chi square, p<0.01 for first four contacts).
Table 50. Length of each contact with a maternity support worker and women’s views about the length of time of each contact

<table>
<thead>
<tr>
<th></th>
<th>1st contact**</th>
<th>2nd contact**</th>
<th>3rd contact**</th>
<th>4th contact</th>
<th>5th contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 mins (n=27)</td>
<td>13%</td>
<td>20%</td>
<td>29%</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>&gt;15 mins (n=180)</td>
<td>87%</td>
<td>80%</td>
<td>71%</td>
<td>68%</td>
<td>65%</td>
</tr>
<tr>
<td>Views:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always or mostly enough</td>
<td>67%</td>
<td>76%</td>
<td>78%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>Sometimes or never enough</td>
<td>33%</td>
<td>24%</td>
<td>22%</td>
<td>17%</td>
<td>17%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p=<0.01 for the first three contacts).

Table 51. Length of each contact with a health visitor and women’s views about the length of time of each contact

<table>
<thead>
<tr>
<th></th>
<th>1st contact**</th>
<th>2nd contact**</th>
<th>3rd contact**</th>
<th>4th contact**</th>
<th>5th contact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 mins (n=159)</td>
<td>9%</td>
<td>31%</td>
<td>45%</td>
<td>50%</td>
<td>52%</td>
</tr>
<tr>
<td>&gt;15 mins (n=1011)</td>
<td>91%</td>
<td>69%</td>
<td>55%</td>
<td>50%</td>
<td>48%</td>
</tr>
<tr>
<td>Views:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always or mostly enough</td>
<td>56%</td>
<td>75%</td>
<td>79%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Sometimes or never enough</td>
<td>44%</td>
<td>25%</td>
<td>21%</td>
<td>21%</td>
<td>21%</td>
</tr>
</tbody>
</table>

** Significant association (Chi square, p=<0.01 for all contacts)
Feedback about health visitor support was varied. Some women commented that it was one of the especially good aspects of their care.

Visits with my health visitor were particularly good. She always took the time needed, was supportive and friendly even when my opinions differed from hers and especially regarding co-sleeping and delayed vaccination. (Spontaneous hospital birth)

The help we received from our health visitor was the most helpful and we felt we really got to know her and that she had the time to see us and talk to us and help us. She was very non-threatening to first-time parents and didn’t make any of our questions seem silly. The midwives were extremely busy and had little time so it was good for us that the health visitor was so good. (Assisted hospital birth)

My local health visitor and her team have been fantastic. Very supportive, will see me at home instead of clinic if I’d rather, and spend time just talking if that’s what I needed. She gave practical advice, support and encouragement and treated me and my health as importantly as my baby’s. (Spontaneous hospital birth)

I appreciated the length of time that the health visitor gave to my first meeting and she talked about me as well as my baby. (Spontaneous hospital birth)

The women who responded to this survey, women who were typically in their 30s and well educated, are the kind of women that would be expected to find much of the support they need from family and friends, allowing the health visitor to target her services on more vulnerable families. If the health visitor did not signpost them to other sources of community-based support they felt particularly let down and isolated.

Unfortunately the service from the health visitor was, in my opinion, poor. I received one home visit and was left wondering what the role of the health visitor was. I was offered no further postnatal support - no mention of any local services such as mother and baby groups, no suggestions of organisations to contact for help in the early days of being a mother. The single thing that the health visitor discussed with me was the appointments at the baby clinic for getting my baby weighed. After the one visit I felt like the postnatal care was virtually non-existent.
care had ended and that if I had any concerns or questions or worries then I had nowhere to direct them. (Assisted hospital birth)

The health visitor was very poor. I was informed that I wouldn’t suffer PND as it was extremely rare and I was clearly fine. She had only been in the house for 10 minutes! I wasn’t informed of any local support groups. I had to find out about them by myself and wasn’t even given the address of the local baby clinic to attend. I was just told it was round the corner. It has been a nightmare. (Assisted hospital birth)

Some women criticised the information provided by health visitors, or both midwives and health visitors.

Compared to the wealth of information provided to me by the midwifery team, I do feel that the health visitor was uninformative and offered nothing for the progress of my baby or my feelings. (Assisted hospital birth)

I am shocked at the lack of knowledge and professionalism of some of the health professionals, namely some of the midwives in my local area and health care visitors. Looking back on some of the advice I was given (my daughter is now 9.5 months old, so I have had time to reflect), it is not only incorrect information, but could have potentially been devastating for me - enough to potentially turn me away from breastfeeding or trigger postnatal depression. I was so vulnerable, and thank goodness I have sensible and supportive friends and family that offered advice to me. Also, the NCT breastfeeding helpline was wonderful, as well as the drop-in centre for breastfeeding. (Spontaneous birth centre birth)

The woman quoted above, while feeling let down and disappointed by the statutory health visiting services offered to her was able to find support from other sources. Indeed, all of this sample, by virtue of being in contact with the NCT, were able to access a range of local parent support services, both formal NCT breastfeeding counseling services and informal support from other parents. One woman who experienced considerable difficulties, and whose baby was very slow to regain his birth weight, still reported being able to manage by accessing information independently and getting support from an NCT group.

It was not good that I received conflicting advice about how to latch my baby on correctly and how often I should feed him as he was very sleepy after I was given pethidine. My baby didn’t regain his birth weight until he was six weeks old as he wasn’t feeding properly due to a poor latch and I was in a lot of pain. I was only able to correct the problem after speaking with the other women in my NCT group who had also had similar issues and watching internet videos of how to latch my baby on correctly. (Spontaneous home birth)

This survey did not ask women about their physical or their mental health or their relationships after giving birth, so is not able to identify systematically whether there were particular women with clinical or social needs who were not receiving the support they needed.

7.4 Use of NCT services

Around half of these first-time mothers (52%, n=81/157) had support from women they had made friends with while attending an NCT antenatal course or from the antenatal teacher involved in facilitating the course. And a quarter (24%, n=266/1103) attended an NCT informal drop-in group, for example a ‘bumps and babies’ coffee group.
I met up with my NCT pre-natal group which is a great source of support. (Spontaneous hospital birth)

I saw and continue to see the girls I met in my NCT antenatal group and have derived a huge amount of comfort from them. (Caesarean birth)

What was good was the support of friends from my NCT antenatal class – we meet up regularly. And the support of my NCT antenatal teacher and the breastfeeding counsellor who I have seen since birth. (Spontaneous home birth)

Meeting up with other mums from our NCT antenatal classes was a godsend. (Caesarean birth)

As reported in Chapter 5, around a half of these first-time mothers used NCT’s formal breastfeeding support services, using either a local NCT breastfeeding counsellor (29%; n=330/1152) or the UK-wide NCT Breastfeeding Line (26%; n=301/1158). Another formal NCT service, used by 9% of first-time mothers was the NCT Early Days postnatal course (n=92/1079). These courses were perceived positively and mentioned by several women as being a particularly important aspect of their postnatal care. Led by a parent facilitator, trained by the NCT on a diploma level course, new mothers are able to explore their new roles and relationships, their feelings looking after their baby and practical issues in a participative group they attend with their new baby.

The NCT early days course was particularly good. (Assisted hospital birth)

Joining the NCT and doing the parenting class was invaluable. Finding a group of women who gave birth the same time as me became my lifeline. We meet once a week and the support we give each other is fantastic. I would recommend to any new parent to join these classes. (Spontaneous hospital birth)

However, 48% of responding first-time mothers (n=515/1079) were unaware of NCT Early Days course and 66% (n=706/1063) were unaware of the NCT’s just-established postnatal telephone helpline. One woman felt she would have benefited from continued the emotional support if she had known about more NCT services.

I don’t think there was enough support after the baby was born, especially when we had had all of our midwife and health visitor visits. I also think it would be great if there was more emotional support for new parents. I was not prepared for the feelings and thoughts that were running around my mind, and it would’ve been great to be able to talk to someone about them, I was not aware of the NCT Early Days postnatal line, maybe this would’ve helped. Luckily I have a very supportive husband and we were able to discuss our feelings together. (Spontaneous hospital birth)

7.5. Summary of findings

In summary, women who gave birth in hospital tended to be less satisfied about staffing levels compared with those who gave birth in a birth centre or at home. While most women felt it was important to be seen the same midwife throughout their postnatal care, more than half reported receiving care from three or more midwives so they received little or no continuity of individual carer. Care from midwives was mostly provided in women’s homes and a third of women had five or more appointments. There was considerable variation in the number of community-based postnatal care
contacts; some women had no contact appointment or home visit with either a midwife or a maternity support worker while others said they had 10 or more contacts (five or more midwife contacts, plus five or more MSW contacts). On the whole, women tended to be satisfied with the length of time spent for each consultation with health care staff. Longer consultations with midwives in also resulted in women feeling better able to discuss things that were worrying them. Feedback about the care received from health visitors was mixed with some women feeling let down if health visitors did not signpost them to other community based support. Some women sought further postnatal support by using a range of NCT services including attending early days/postnatal course, and an informal drop in group. Some women continued to receive informal support from those they had met on an NCT antenatal course.
Discussion

Since the early 1990s, there has been an understanding that maternity services should provide care which is responsive to women’s needs and preferences. Often referred to as ‘woman-centred’ care, this principle has been reinforced in the intervening years in successive government policy documents from around the UK. More recently, the importance of service users’ experiences has been emphasised as one of three key components of high quality care, along with safety and clinical effectiveness. The White Paper, Liberating the NHS, highlights five ‘domains of care’ which the coalition Government intends to address, of which one is: ‘Ensuring people have a positive experience of care’. The document highlights the importance of health service users receiving care which demonstrates compassion, preservation of dignity, respect, and ‘the level of comfort, information and support they require’.

In keeping with the principle of ‘asking patients and carers to provide direct feedback on the quality of their experience, treatment and care’, this report presents the postnatal care experiences of a group of first-time mothers who were in contact with NCT, who gave birth between September 2008 and December 2009.

The findings indicate that in the ten years since NCT published its last postnatal care survey, there seems to have been very limited improvements in postnatal care and possibly an overall decline in the extent to which woman-centred quality standards are being met. In addition, there seems to be very limited evidence that the recommendations in the NICE postnatal care guideline have been implemented in accordance with the intended ethos.

There appear to have been some positive changes, including more women and their partners being encouraged to have skin-to-skin contact with their baby, a practice which encourages attachment and bonding as well as helping women to establish breastfeeding. There was also less reporting of inconsistent infant feeding information and advice than in 1999/2000.

In drawing together the messages from this study, first we acknowledge that the sample was both self-selected and not representative of the general population of first-time mothers in the UK. As a result the survey findings are not directly generalisable, a limitation of the design. However, as the sample was made up of NCT service users, mainly well educated women aged over 30, it is not unreasonable to suggest that they might be expected to benefit from the adverse care law and succeed in accessing higher quality services than average. The fact that they experienced such gaps in the care they received suggests that younger and less advantaged women are also likely to experience a serious gap, and potentially a greater deficit. Though it is possible that the inclusion of a more heterogeneous sample of women would lead to different results.

Women need kindness and reassurance, practical help with feeding and caring for their baby, and information and care to assist them during their own personal recuperation after giving birth. This survey shows that there are home birth and other community services, birth centres and hospital postnatal wards providing excellent, flexible and responsive care. However, a large minority of women have significant unmet needs. Our findings reinforce messages coming from other studies. It has been well documented that new mothers and their partners face challenges in adjusting to parenthood and the management of postnatal care by health professionals is an important factor influencing this process. Previous research has highlighted the
importance of positive experiences in the early days after childbirth, including practical and informational support. However, the existing model of postnatal care is falling short of meeting women's needs and expectations at a time of tremendous change in their lives. Physical problems that are not resolved can have a considerable impact on the quality of their lives and relationships with their babies. Evidence has shown that women who are satisfied with their care have improved physical and psychological health, whereas poor postnatal support contributes to physical and psychological morbidity.

A key recommendation in the NICE postnatal care guideline is that women should be involved in drawing up a written postnatal care plan, and that they should have a named postnatal care coordinator. Yet only a negligible percentage of first-time mothers said that they had such a plan and many reported uncoordinated care. Women felt they would have benefited from care provided by fewer midwives giving staff a better understanding of their experiences and them the opportunity to build up a trusting relationship.

It is particularly worrying that the responses of women who had had a caesarean or forceps delivery, including their detailed personal accounts about what was particularly good or bad about their care, suggest that they experience the greatest care gap. Operative births have increased over the last decade, though initiatives have been introduced to promote birth environments, staffing arrangements and models of care to facilitate normal birth and address avoidable interventions. As a result, increasing numbers of women find themselves learning to care for their baby and adjusting to motherhood while recovering from perineal trauma or major surgery. The quality of care for women who have had a caesarean birth is highly important; evidence suggests they need the chance to discuss birth options for future pregnancies, and more support to develop a positive relationship with their baby. Time to talk, the encouragement of skin to skin care, optimal support with infant feeding, attention to the mother's physical recovery and some pampering are therefore more rather than less important for this group of women.

The stories that these first-time mothers have shared suggest that for women who are healthy with a straightforward, low-risk, pregnancy there is much to recommend considering the option of planning a home birth or using a birth centre, as postnatal care tends to be regarded more favourably by women in those settings. Individualised care and support experienced in birth centres and after a birth at home was an important feature of women's positive experiences.

Some of the limitations women noted clearly seemed to be due to staffing shortages. As many as four out of ten first-time mothers (42%) said there were sometimes or never enough midwives on the hospital postnatal ward. There was also considerable variation in the number of postnatal care contacts women had once they had left the hospital or birth centre; some women had no contact appointment or home visit with either a midwife or a maternity support worker while others said they had 10 or more contacts (five or more midwife contacts, plus five or more MSW contacts). A lack of midwives was cited repeatedly and needs to be addressed if the quality of postnatal care is to be improved. However, the attitudes and practical skills needed to be able to assess and respond to women's physical and emotional needs in a holistic way were also questioned, and not only in circumstances where the staff were under time pressure.

One interesting finding to emerge which demands careful consideration is women's observation that more attention was paid to the welfare of their baby than to their own
health and wellbeing. As a mother’s full recovery and positive adjustment to her new role is central to the wellbeing of her baby and the rest of the family, this feedback is worthy of exploration in midwifery education and review by maternity services locally.

This survey focused on women’s experiences, replicating the earlier survey of postnatal care and addressing related questions. On this occasion, no data were sought directly from men or from same-sex partners about their experiences. It is positive to hear from women that a third of fathers were encouraged to hold their baby skin to skin during the first 24 hours after birth. However, the proportion indicated is considerably lower than the proportion of women encouraged to hold their baby this way, which reinforces the view that many men are currently not being fully involved in caring for their baby. Women’s accounts suggest that both they and their partners appreciate services which provide the opportunity for fathers to stay in the maternity unit overnight, enabling them to get to know their baby from the very beginning and provide practical assistance to their partner, as well as meeting their own information and support needs.

Finally, although there appears to be a positive trend towards rather less conflicting feeding information and advice, this aspect of substandard care was still reported by around half of first-time mothers in this survey. The negative impact of conflicting advice has been a strikingly consistent finding for many years and further efforts are needed to ensure that progress continues throughout the next decade in order that all women and babies have positive feeding experiences right from the start.
Conclusion and recommendations

Women's feedback and accounts of their experiences indicate widely varying standards of postnatal care. Around half of the first-time mothers indicate that they had high quality care that was responsive to their needs, provided by thoughtful staff who were empathetic and encouraging. However, there appears to have been very limited improvement in postnatal care during the last decade, despite record spending on the NHS and publication of a NICE guideline setting out standards for the Routine postnatal care of women and their babies.

Action is needed to address routine postnatal care, as well as more intensive targeted interventions for the most vulnerable families. This should ensure that all women have an individual postnatal care plan, a named care co-ordinator whom they can contact at any time, regular home visits according to need, opportunities to get to know their carers, a high and consistent standard of emotional support, physical care and information to address their own health and wellbeing and their baby's needs, particularly support with baby feeding.

Evaluation by NHS boards and trusts and their maternity services liaison committee is important. They should involve parents who have recently used services and informed parent advocates to review what is good and what needs improvement, setting objectives and monitoring progress.

It would appear that hospital postnatal care most urgently needs improvement. In particular, there is a need to improve staffing levels and to co-ordinate women's care. Women who have had a forceps or caesarean birth, who have a baby in SCBU, and those who have a history of mental health problems are among those with the greatest need. Managers should ensure that the 'postnatal pathway' for these groups of women is understood from their perspective. Many women want care from someone they can get to know rather than different carers for every contact. Also, they need to know when they leave hospital that community-based midwives and health visitors will be available to visit at home and will continue to provide adequate time, physical care and respectful attention. They want to be put in touch with local community support networks and offered services to help them adjust and develop confidence and resourcefulness as parents. Statutory service providers should encourage parents access to reliable on-line and community-based third sector services.

Overall, if postnatal services are to be truly designed around individual women's needs as advocated by the NICE guideline, women's voices must be heard about the aspects of midwifery and health visitor care which they value and appreciate, and their concerns must be addressed.
References


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Appendix 1: Glossary of terms and abbreviations

**Asthma** — symptoms of asthma are coughing, wheezing and breathlessness. Asthma is a long-term condition caused by inflammation of the bronchi (the small tubes that carry air in and out of the lungs).

**Atopic dermatitis (eczema)** — is a chronic skin condition causing the skin to become itchy, dry and scaly, with soreness and redness. Atopic means sensitivity to allergens (substances containing protein that cause an allergic response). Common allergens include house dust mites, tree and grass pollen, cats, dogs, milk, eggs and peanuts. Atopic eczema is common and mainly affects children.

**Deep vein thrombosis (DVT)** — a blood clot in one of the deep veins in the body, usually the leg, which may cause pain, swelling and complications such as pulmonary embolism, a blockage of one of the blood vessels in the lungs. Blood clots occur more commonly during pregnancy and after surgery.

**Diabetes (type 1 and 2)** — a long-term condition caused by too much glucose (sugar) in the blood, due to lack of insulin. People with Type 1 diabetes, sometimes known as juvenile diabetes, do not produce insulin (so need insulin injections). People with Type 2 diabetes, more common in older people and associated with obesity, accounts of 95% of diabetes cases. The body either does not produce enough insulin or their body's cells do not react to insulin.

**Gastroenteritis** — infection of the stomach and bowel causing diarrhoea, vomiting and dehydration.

**Leukaemia** — cancer of the white blood cells.

**National Institute for Health and Clinical Excellence (NICE)** — an independent organisation providing national guidance on promoting good health and preventing and treating ill health. NICE provides guidance to the NHS in England and Wales. Some guidance is adopted in Northern Ireland and the reviews of evidence are used in Scotland.

**Neonatal intensive care unit (NICU)** — a unit of a hospital specialising in the care of the most vulnerable babies, who need the most intensive and expert of medical and nursing care.

**Postpartum haemorrhage (PPH)** — excessive bleeding following birth.

**Pre-eclampsia** — can occur during pregnancy or immediately after birth, affecting the women’s health and, during pregnancy, restricting the baby’s growth. Symptoms include high blood pressure, protein in the urine, and fluid retention. The only way to prevent pre-eclampsia is to induce labour.

**Special care baby unit (SCBU)** — a unit of a hospital specialising in the care of small, ill and premature newborn babies.

**Sudden infant death syndrome (SIDS)** — the sudden unexpected death of an apparently well infant, for which there is no explanation (also called cot death). Usually occurring within the first six months, the risk is greater for babies born prematurely, or at a low birth weight, and for boys rather than girls.

**Thrombophlebitis** — inflammation of the veins.

**Uterine involution** — the return to normal size of the uterus (womb) after the birth of a baby.
NCT Postnatal services

NCT provides training for healthcare professionals and peer supporters and a range of antenatal and postnatal services including:

- **Postnatal courses and drop-ins** — these are participative, parent-centered sessions attended by mothers and babies, fathers and babies or mixed groups of parents. Led by a trained facilitator, the sessions provide an opportunity to share ideas and explore issues about being a parent and caring for a baby.

- **Integrated courses** — these involve sessions before and after the birth.

- **Breastfeeding counselling services** — including antenatal breastfeeding preparation groups, one-to-one support on postnatal wards, drop-ins, support at breastfeeding cafés and telephone counselling.

- **Training for health professionals** — NCT Professional offers a range of conferences and workshops for health professionals with clearly defined aims and learning outcomes. The training can enhance partnership work and service improvement for NHS trusts, primary care trusts, Sure Start projects, service teams, universities and other educational bodies.

NCT postnatal leaders and breastfeeding counsellors are all qualified to diploma level. They are equally experienced at running groups and providing one-to-one support.

For more information on our services, please visit [www.nct.org.uk/professional](http://www.nct.org.uk/professional)