National Maternity and Neonatal Investigation

Experiences and Insights of Women, Birthing People and their Support Partners from the Maternity and Neonatal Call for Evidence

A pathway-based report combining thematic analysis of experiences, supported by quantitative context

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Executive Summary

This report presents findings from the National Maternity and Neonatal Investigation's Call for Evidence, which gathered experiences from over 10,000 women and people who have been pregnant, alongside over 600 support partners across England.

The Call for Evidence provides insights from across the full maternity and neonatal pathway, including pregnancy, labour and birth, postnatal and neonatal care, experiences of loss, serious illness and mental health. It combines quantitative survey data with large-scale qualitative analysis to describe experiences of care. Together, these findings provide a picture of how maternity and neonatal care is experienced.

Cross-cutting themes

Across the pathway, experiences highlight the importance of both the care provided and how that care is experienced in practice. Key themes include variation between services and settings, differences in how concerns are recognised and responded to, and the role of clear and timely communication in supporting understanding of care. These patterns were evident across all stages of the pathway, although they were expressed in different ways.

For example, during labour and birth, variation was particularly evident in how concerns were heard and acted on in a timely manner. In contrast, accounts of neonatal care more often reflected confidence in clinical care alongside variation in communication and involvement.

Accounts also reflect how much people feel involved in decisions, the extent to which care is coordinated between services, and how consistently support is provided at key transition points. This includes entering maternity care, moving between services, admission for labour, escalation of care, transitions from hospital to community services, and access to specialist or follow-up support.

Relationships with staff play a central role in how care is experienced. Compassion, respect and empathy are consistently described as important, alongside feeling listened to and taken seriously. Emotional impacts are evident across all stages of the pathway, alongside practical challenges in accessing support when it is needed.

Distinct patterns in experiences were reported for different demographic groups. For example, younger women and birthing people and those from minority ethnic groups were less likely to feel their concerns were listened to during pregnancy or labour and birth compared with older or white women and birthing people. They were also less likely to feel that their mental health concerns were taken seriously. These findings highlight the importance of care that is not only clinically effective, but also compassionate, consistent and responsive to individual needs.

Experiences across the pathway

Pregnancy

Experiences during pregnancy included issues with access to care, timing of appointments and monitoring. Some women and birthing people described strong and supportive relationships with midwives, while others experienced fragmented care and difficulty getting concerns recognised.

Experiences also varied in the information provided to support decision-making, alongside differences in the level of support for emotional wellbeing.

Labour and birth

Experiences of labour and birth differed in how supported and involved women, birthing people and support partners felt. Some described feeling listened to and supported, while others described challenges in having their concerns acknowledged, particularly in relation to pain and labour progression.

Communication during labour played a key role in shaping experience. Where staff explained what was happening, involved people in decisions and provided reassurance, care was described as feeling more supported. Where it was limited or unclear, experiences were described as more difficult and, in some cases, distressing. Staff availability, responsiveness and the involvement of support partners were also important to how care was experienced.

Postnatal care

There was a range of views on the support available after birth, particularly in relation to physical recovery, feeding support and mental health.

Some described difficulty accessing help on postnatal wards and after transition from inpatient areas, as well as uncertainty about who to approach with concerns. Experiences of communication and continuity between hospital and community services also varied, affecting feelings of being supported during this period.

Neonatal care

Accounts of neonatal care were often described as emotionally challenging. Many parents focused on the care their baby received, along with their own involvement and access.

Experiences were influenced by how clearly staff explained the baby's condition and treatment, and how far parents were involved in decisions and day-to-day care. Some described feeling informed and included, within family-integrated care settings, while others described difficulties in accessing information or spending time with their baby. The emotional impact of neonatal care extended beyond the period in hospital for many families.

Experiences of loss

Experiences following pregnancy loss or baby loss highlighted differences in how communication, compassion and support were provided. Some parents described clear communication and sensitive care, while others experienced gaps in information and support, including around bereavement services.

The way care was delivered, particularly the level of compassion shown and the clarity of the information provided, influenced how experiences were understood and processed. Experiences of follow-up and ongoing support also varied.

Serious illness

Serious illness was shaped by how symptoms were recognised and responded to, and how care was communicated and delivered.

Some people described challenges in having concerns acknowledged and addressed. Communication and involvement in care decisions also determined how these experiences were understood. These experiences had both physical and emotional impacts.

Mental Health

Accounts of mental health support varied across the pathway. They were influenced by how concerns were recognised, the timeliness of support, and the availability of follow-up care.

Support partners also described their own experiences of support. Where support was available and accessible, it was described as beneficial. Where it was not (only 1 in 10 support partners agreed that they were offered appropriate support for their mental health), people described continuing negative emotional impact.

Introduction

This report summarises what people told us through the National Maternity and Neonatal Investigation's Call for Evidence (CfE). It focuses on the experiences of people who have been pregnant, as well as those who supported them, including partners, family members, friends and carers.

The CfE invited people across England to share their experiences of maternity and neonatal care. Two surveys were used: one for people who had been pregnant and one for those who supported them. Together, they were designed to understand what care felt like from both perspectives: those receiving care directly and for those supporting them through pregnancy, birth, postnatal and neonatal experiences.

This report brings together the main themes from the responses. It highlights where care worked well, where people felt supported, and where they experienced problems, gaps or harm. The findings are based on what people chose to share through the CfE. They may not provide a complete picture of all maternity and neonatal services in England, but they offer important insight into the experiences, concerns and priorities of those who responded. Further analysis will be undertaken, alongside other sources of evidence, to inform the work of the National Maternity and Neonatal Taskforce[1].

The purpose of this report is not only to describe what people told us, but to honour their experiences by ensuring they are heard, understood and reflected accurately. We are deeply grateful to everyone who took the time to respond. We recognise the emotional weight of what people shared, and the trust involved in sharing it.

[1] More information about the Taskforce can be found here: National Maternity and Neonatal Taskforce - GOV.UK

Methods and respondents

This section outlines how women, birthing people and their support partners were invited to respond to the National Maternity and Neonatal Investigation's CfE surveys, how the data were processed and analysed, and the key considerations for interpreting the findings.

Survey format and access

The surveys were launched on 20 January 2026 and remained open for 8 weeks, closing on 17 March 2026. The surveys included closed, tick-box-style questions, as well as open-ended questions where individuals could write detailed comments.

The surveys covered the full maternity and neonatal pathway, from before pregnancy through to postnatal care. Women, birthing people and their support partners could choose which parts of their experience they wanted to share, and all questions were optional. This allowed participants to focus on what mattered most to them and to describe their experiences in their own words.

Respondents were invited to focus on a single pregnancy when completing a survey, with the option to complete the survey multiple times for different pregnancies.

Four surveys were made available on the Investigation's website:

1. **Standard pregnancy survey**: Designed for women and birthing people to share their own experiences of maternity and neonatal NHS services in England. The survey contained 109 questions, covering the full maternity and neonatal pathway.
2. **Standard support partner survey:** Designed for individuals to share their experiences of supporting someone who accessed maternity and neonatal NHS services in England during pregnancy, including fathers, non-birthing partners, family members, friends, or other support people. The survey comprised 104 questions.
3. **Easy read pregnancy survey:** A plain English (United Kingdom) version of the standard pregnancy survey.
4. **Easy read support partner survey:** A plain English (United Kingdom) version of the standard support partner survey.

Translated versions of the surveys were available in seven languages alongside British Sign Language (BSL) options. Respondents could also request a paper copy of an easy read survey or to participate in a one-to-one interview with an interpreter.

In the United Kingdom (UK), the National Health Service (NHS) is the collective term for the four healthcare systems of England, Scotland, Wales and Northern Ireland. As healthcare is devolved, the surveys were open to individuals aged 16 and over who had

accessed maternity and neonatal services in England. Individuals under 16 could participate with support from a responsible adult aged 16 and over.

Respondents

The pregnancy surveys were completed by 10,042 women and birthing people who had experienced pregnancy and accessed maternity and neonatal services in England. Of these, 60 completed the easy-read version, and one responded via the British Sign Language (BSL) option.

The support partner surveys were completed by 624 people who had experienced supporting someone accessing maternity and neonatal NHS services in England during pregnancy. Support partners included family members, partner or spouse, friends, or other support people. Of these, 23 completed the easy-read version, and one responded via the BSL option.

Table 1 summarises the relationship of the support partner survey respondents to the pregnant woman or birthing person. Information on the respondent demographics is detailed in Appendix B.

Due to suppression rules, values that are below 10 in a particular group have been suppressed in Table 1 and are denoted with an asterisk.

Table 1. The relationship of the support partner survey respondents to the pregnant woman or birthing person

Response	Frequency[1]	Percentage[2]
Family member	289	46%
Partner or spouse	254	41%
Other[3]	40	6%
Friend	32	5%
Unknown relationship	*	*

[1]Frequency denotes the total number of people who responded to the surveys by participant group.
[2]Percentages may not add up to 100% due to rounding and the suppression of figures below 10.
[3]Other includes, but is not limited to, birth doulas, midwives, and representatives of charities.

Generalisability

While the survey received a large number of responses, the findings may not be fully representative of all who have accessed maternity and neonatal services in England.

Where findings are presented by age, ethnicity or other characteristics, they should therefore be interpreted as reflecting the views of respondents rather than the wider population.

All survey questions were optional, allowing respondents to choose which parts they wanted to complete. Therefore, variation in responses may reflect differences in experiences or differences in question completion rates.

Additionally, as respondents could complete the survey more than once for different pregnancies, the number of unique respondents is unknown; therefore, quantitative findings (analysis of responses to the structured questions) are reported as the number of responses rather than respondents.

Analysis

Closed-question (tick-box-style) responses were analysed by looking at simple summaries, such as percentages, and by using statistical tests to identify any meaningful differences between groups. Analyses were conducted across all responses and, where appropriate, by demographic group. Analysis to identify meaningful differences between demographic groups (e.g., age and ethnicity) were limited to the pregnancy survey, as the number of responses within minority demographic groups in the support partner survey were insufficient to support meaningful comparisons. Furthermore, if the number of responses to a question from any group was less than 100, the findings for this group was not reported as these numbers are too low to allow for statistical testing to be accurate.

For the reporting of demographic differences, only findings that show a group has deviated from the typical experience and was statistically significant have been reported. No findings that showed only descriptive differences between groups have been included.

Open-ended survey responses were analysed using an AI (artificial intelligence)-assisted descriptive form of thematic analysis, guided by Braun and Clarke's (2006)[2] six-phase framework. This framework guides researchers through initial familiarisation with data, followed by generating codes which capture notable features before identifying, reviewing and refining themes, and then finally writing up the analysis. The analysis was "inductive", meaning that codes and themes were developed directly from the responses. Therefore, the findings are grounded closely in respondents' verbatim responses, rather than being decided in advance based on existing theory. Additionally, the analysis focused on identifying shared patterns in respondents' explicit accounts, rather than interpreting underlying or latent meaning.

AI was used as a tool to support, rather than replace, analyst judgement. The approach followed standard analytical steps typically undertaken by a human team, with AI

[2] Braun, V and Clarke, V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), pages 77 to 101. DOI: https://doi.org/10.1191/1478088706qp063oa

enhancing efficiency while experienced analysts retained oversight and decision-making responsibility throughout. A bespoke AI tool supported coding, codebook development, thematic organisation, and the generation of findings. Analysts quality assured all AI outputs to ensure credibility and consistency. Full traceability to the original responses was maintained. Additionally, the outputs were sense-checked with the Investigation team, Expert Advisors and Chair.

The report does not cover every section of the survey – the data collected will be retained for the duration of the Taskforce to support further pieces of analysis in line with the privacy notice[3].

[3] Call for Evidence Privacy Notice (2026), available at: MatNeoInv-Privacy-Notice-CfE-200126.pdf

Experiences across the pathway

Pregnancy

This section brings together the experiences of pregnancy care among women, birthing people and support partners, drawing on accounts of accessing services, clinical assessment, communication, and relationships with staff. Additionally, women, birthing people and support partners answered structured (closed) questions about their experiences.

Pregnancy care (also called antenatal care) refers to the care women, birthing people, their babies and their support partners receive throughout pregnancy. This may involve antenatal appointments, scans, tests, advice and support for physical or mental health.

Approximately 6,000 women and birthing people and 250 support partners responded to the closed questions in the pregnancy section of the surveys. Reporting of positive experiences in pregnancy varied – at least 45% of all women and birthing people reported positive experiences in the closed questions (see Appendix B). However, in a third of responses, participants said they did not feel staff offered support for their emotional wellbeing when they needed it. A similar proportion also said they had not received enough information to make decisions about their birth preferences.

Almost half of the responses from support partners indicated they did not feel emotionally supported. A third of responses indicated a lack of information to enable them to provide support and understand the birth preferences of the woman or birthing person they were supporting.

Responses from younger women and birthing people (those aged 24 and under) were more likely to disagree that their concerns were taken seriously (30%) when compared with responses from those 25-34 years or 35-44 years (both 13%).

Thematic narrative

A total of 5,109 women and birthing people (51% of the pregnancy survey respondents) and 213 support partners (34% of the support partner survey respondents) completed the free text question on experiences of pregnancy care.

Experiences of pregnancy care are reflected across five themes:

1. Contact with and access to care
2. Clinical assessment, monitoring and follow-up
3. Continuity of care
4. Risk, informed choice and decision-making
5. Relationships with healthcare staff.

Across these themes, accounts highlighted variation in the timeliness, consistency and responsiveness of care. They also emphasised how information is shared and how individuals are listened to, involved and supported.

Contact with, and access to, care

Support before 20 weeks of pregnancy was viewed as "*very minimal*"[4]. Women, birthing people and support partners described challenges in accessing care throughout the pregnancy.

There were reports of repeated attempts to contact services, with respondents describing unanswered calls and emails, or delays in receiving responses:

> *"I phoned the clinic who'd given the medication. After 46 calls, the phone was answered. I was told they could do nothing & to take her to A&E if really concerned or ring 999."* (Support partner)

Booking appointments were sometimes arranged after the recommended timeframes, extending into later stages of pregnancy. Where women and birthing people contacted services with concerns early in pregnancy or with symptoms that did not meet clinical thresholds for assessment, they were sometimes advised to wait or would not be seen, leaving these unresolved:

> *"I began to feel physically and mentally unwell. I rang my GP who told me "You don't need to call us until 8 weeks". When my symptoms worsened, I pushed again and had to fight to get an appointment with the GP[...] and they gave me the number to the Early Pregnancy Unit (it felt like just to get me off the phone) - I called EPU and explained my mental and physical state and all they said was `you are not in pain or bleeding so we can't help you'."* (Woman/birthing person)

These experiences suggest restrictive access and lack of holistic assessment for both physical and mental health needs as well as women and birthing people having to navigate a system which is complex at times.

Some respondents noted that routine care had proceeded as expected, with appointments attended and follow-ups arranged. However, waiting was a consistent challenge for both groups. For example, if women and birthing people needed to use the maternity triage service, they were met with long waits. Some reported waiting several hours without updates, food, or water, including while in pain or distress. This highlights

[4] Note: Italicised text throughout the report is taken directly from survey responses.

both access delays and concerns about conditions while waiting, with potential implications for safety and dignity:

> *"I had to use triage services twice due to high blood pressure during pregnancy which was reassuring that it was available, even if it did result in waiting in triage for seven hours without food or drink before being admitted."* (Woman/birthing person)

Location was an additional challenge to accessing care. Some women and birthing people described travelling long distances to reach services or being referred outside their local area. Distance and appointment timing also reduced the likelihood of support partners being able to attend. For some, this was described as unmanageable, particularly when unwell or in later pregnancy:

> *"I was vomiting more than 10 times a day and was expected to travel over an hour to get any medical assistance which was completely impossible."* (Woman/birthing person)

Structural barriers also affected support partners' ability to be present and involved in care. Some described finding it "*difficult accessing appointments due [to] leave allowed from work*", and some mention previous COVID-19 restrictions. Physical accessibility also affected access, with some partners unable to attend appointments due to environments that did not accommodate mobility needs. These barriers limited partners' involvement in care, including their ability to be present for appointments, hear information directly, support women and birthing people and participate in discussions.

Clinical assessment, monitoring and follow-up

Experiences of clinical monitoring and responses to symptoms varied. Some described missed or inconsistent checks and delayed action, while others outlined prompt assessments, clear communication and timely intervention.

Assessment

When symptoms were reported, responses were mixed. Some women and birthing people described being advised to attend healthcare services immediately and receiving in-person care, which provided reassurance: *"my antenatal midwife was fantastic, and when I attended MAU for reduced movements, they were incredibly helpful and supportive."* Support partners similarly described clinicians as recognising risks quickly and arranging tests or interventions perceived to prevent harm: "*She fortunately had a good outcome because one consultant at [Trust] stepped in and save her and my daughter's life.*"

However, others described receiving advice over the phone rather than being offered in-person assessment, even when symptoms continued or worsened. Women and birthing

people highlighted repeated attempts to raise concerns about their symptoms, including feeling unwell or experiencing severe pain, without receiving care:

> *"Over two weeks, across 21 interactions with the maternity unit, I requested an urgent scan five times and was refused each time—told not to come in. My symptoms were extreme; I felt like I was going to die and made this very clear. This was not my first baby at this hospital, yet no consideration was given to what I knew was not normal."*
> (Woman/birthing person)

Support partners reported that no one checked back or escalated care, even after repeated contact, reflecting gaps in follow-up and continuity of care. In some cases, these repeated missed opportunities were perceived by respondents to have preceded serious outcomes:

> *"Her baby died one day before the due date, on the THIRD reported incident of reduced fetal movement. Had a consultant reacted to the lack of fetal movement, the baby might now be alive."* (Support partner)

Support partners described similar variation to women and birthing people. Some reported symptoms being dismissed or described as normal, even when persistent or severe, which delayed escalation. For example, accounts referred to specific conditions such as pre-eclampsia, kidney problems, or anaemia, where warning signs were present but not identified, taken seriously, or acted upon at the time:

> *"My wife was very sick during the whole of her pregnancy, but wasn't taken seriously by midwives or maternity triage, which left me in a place where I couldn't give my wife the care she needed. She was told that being as ill as she was, was normal and that she just had to get on with it which left her feeling like she was being silly and overreacting."*
> (Support partner)

These experiences suggest staff's normalisation of symptoms and lack of clinical response contribute to delayed recognition of need.

Monitoring and follow-up

Women and birthing people described routine monitoring as inconsistent. Expected checks such as blood pressure, urine testing and fundal height measurement were not always carried out or were completed irregularly. Some women and birthing people linked

these missed checks with late identification of conditions such as pre-eclampsia, or growth restriction:

> *"I was not offered regular urine tests during my pregnancy and I later developed pre-eclampsia. I think due to my age, it was assumed that I was healthy and was having a healthy pregnancy until it became evident at my final scan that my son was in distress."* (Woman/birthing person)

Women and birthing people raised concerns about the accuracy and interpretation of test results. For example, some women and birthing people described tests or scans indicating no immediate concern, followed by unexpected deterioration or preterm labour shortly afterwards. Others reported conflicting clinical messages. These experiences were described as distressing and reduced confidence in care:

> *"I was told by two doctors (only one did the actual talking) that there was no heartbeat. Whilst in floods of tears, a consultant came along to do final checks - and there was a strong heartbeat - and everything was fine."* (Woman/birthing person)

Some women and birthing people experienced variation in how clinical measurements and assessments were conducted across services. Differences in tools and methodologies, particularly for fetal growth monitoring, were described as leading to inconsistent classification of risk and influencing management decisions. In these cases, variation between services was perceived to introduce avoidable uncertainty and risk:

> *"In my case, different trusts used different fetal growth calculators. [...] This resulted in my baby being classified differently at each trust, directly influencing management decisions. Growth assessment tools should be standardised nationally, or at minimum aligned when a woman transfers care. Variation in methodology creates avoidable risk."* (Woman/birthing person)

Continuity of care

Continuity of care was central to building trust and confidence for women, birthing people and support partners during pregnancy. Women and birthing people who saw the same midwife throughout pregnancy described this continuity as having had a positive impact in fostering familiarity, personalised care and a sense of being known:

> *"I was given a good level of care, with one midwife throughout, which is very important in my view to build a rapport and trust. I attended all my appointments and had some extra ones to monitor my son's growth. I felt like I was being well looked after."* (Woman/birthing person)

In contrast, some women and birthing people reported seeing multiple midwives and clinicians across appointments, with limited continuity of care. As a result, professionals were not always familiar with their medical history, previous concerns or personal circumstances.

Some women and birthing people also reported that records were not consistently reviewed before appointments. This meant they were required to repeat their history, concerns and sensitive personal information, which added to the burden of care and increased the risk that important details could be missed.

Where continuity of care was limited, these challenges were often compounded by the absence of an ongoing relationship with a trusted healthcare professional:

> *"I rarely saw the same midwife prior to giving birth so there was a concerning lack of continuity in terms of my medical history - I had to keep repeating things to ensure that each new midwife had the full picture."* (Woman/birthing person)

Support partners reported similar experiences, particularly where care involved multiple staff with little continuity, which was described as "*a real instance of the left hand not knowing what the right was doing – exacerbated by a shortage of midwives*". They reported interactions with different clinicians who appeared rushed or disengaged, sometimes providing inconsistent or contradictory information:

> *"I don't think you could call it 'care'. Different nurses who appeared disinterested and overworked, and who ran through a mechanical checklist and answered questions with answers that contradicted NHS guidance."* (Support partner)

Women and birthing people also reported that communication between midwives, GPs, and hospital teams was not consistent, with one person noting that "*the different teams clearly work in silo and this just adds added stress when they don't communicate properly.*" Reliance on paper notes and parallel record-keeping systems often required women and birthing people to carry or manage information themselves. Women and birthing people reported that these system-level inefficiencies led to inconsistencies in advice and a lack of shared understanding across healthcare staff. As a result, women and birthing people

described improvements that could be made to avoid important information being overlooked:

> *"My full history being transferred from [...] [digital platform one] to [digital platform two] as this would have ensured information about my previous pregnancy - small placenta, baby with low birth rate, cervical fibroid would have been visible to all and I would have received the appropriate care (aspirin for placenta health)."* (Woman/birthing person)

These disruptions in continuity not only affected information sharing but also made it more difficult to build trusting relationships, contributing to women and birthing people feeling less known, less listened to, and needing to advocate for themselves: *"I was having to constantly advocate for my own care"*.

Risk, informed choice, and decision-making

Framing of risk and decision-making

Women and birthing people described receiving risk information in ways that emphasised adverse outcomes, sometimes without explanation of likelihood or alternatives. In some accounts, risks were presented in stark or alarming terms (for example, *"you could die"* and *"your babies could die"*) or in ways that were perceived as one-sided or inconsistent with other sources of information. Others described being encouraged repeatedly to accept tests or procedures they did not want. In some cases, this framing of risk was reported to have lasting health impacts:

> *"Gestational diabetes with my second (2021) was handled terribly. Narrative that my BMI would increase risk of loss or still birth handled terribly (and misinformed). I believed any sugar of any kind would harm my baby and developed an eating disorder. When I disclosed this, I was praised for following a strict diet to protect my baby. I still suffer with disordered eating four years later."* (Woman/birthing person)

Women and birthing people described how the framing and communication of risk information limited opportunities for shared decision-making; for example, feeling steered towards certain interventions and affecting how they engaged with recommended care: "*I was advised to take aspirin, however its importance wasn't emphasised, and I didn't take it regularly. If its importance and impact had been emphasised, I may have taken it better.*" Recommendations were reportedly presented as precautionary or necessary, without clear discussion of alternatives or uncertainty, leading some women and birthing people to feel "*forced*" into accepting care they would not otherwise have chosen:

> *"Late on in my pregnancy I was tested for Gestational Diabetes. I was told my first result was fine but the second result was borderline so I now needed to take metformin as a precaution. Myself and my partner questioned this, as we did not want to take medication if it was not needed. We both felt this choice was forced on us and we were yet again guilted into doing something because our baby would suffer."*
> (Woman/birthing person)

These experiences suggest that, where risk-based recommendations were not accompanied by clear explanation or discussion of options, women and birthing people could feel decisions were being made for them rather than with them.

Gaps, inconsistencies, and self-directed decision-making

The challenges of how risk-information was presented were compounded by gaps and inconsistencies in the information women and birthing people received. Some women and birthing people reported not being informed about changes in risk status, specific clinical findings (such as concerns about fetal growth), or the implications of these findings for their care, as one person explained: "*I also wasn't told that my pregnancy was high risk. It wasn't until after the neonatal death review that it was included in the report.*" They reported difficulties obtaining clear explanations of clinical risks and the rationale underpinning recommendations:

> *"They couldn't or wouldn't tell us these things so that we can make an informed decision and simply stated that it would be outside of guidance, without a reference to what the guidance stated."* (Support partner)

Consequently, women, birthing people and support partners were often left to piece together information from other sources (e.g., antenatal classes, paid courses, mobile apps, and independent research) to understand their situation and navigate care:

> *"I went home and that evening spent hours researching both inductions and 'large' babies births, I found that the risks for both were ultimately similar (More than likely end in forceps, ventouse or emergency C-section) therefore, I decided to follow my instincts and cancel my induction (which I was forced to book) and allow my body and baby not be forced into an unnatural birth and for my body to be given chance to dilate and prepare for birth itself."* (Woman/birthing person)

This reliance on external and self-directed sources highlights how, in the absence of clear and balanced communication from maternity services, women, birthing people and support partners assumed responsibility for constructing the knowledge needed to support informed decision-making for their care.

Others described interactions where they felt spoken to in a way that belittled them, or where they felt expected to agree with decisions without explanation:

> *"I felt I was treated like a child who didn't know my body or what was best for me. I am an academic working in perinatal mental health and I found it very difficult to advocate for myself despite my privilege. The system is set up for women to agree. Woman-centred care it was not. It was like constantly battling a huge system and being told no constantly without any real evidence provided."* (Woman/birthing person)

Support partners also described experiences where they felt overlooked or marginalised. Some reported being present but not acknowledged in conversations, or feeling excluded from discussions about care and decision-making: "*As a partner I was seen as an invisible presence at appointments.*" In these situations, partners described uncertainty about their role and limited opportunity to contribute, particularly when trying to raise concerns on behalf of the woman or birthing person: "*I was not listened to when advocating for my wife.*"

Relationships with healthcare staff

Women and birthing people described positive experiences of receiving care where staff actively listened, communicated clearly, and responded to their concerns. These interactions were characterised by warmth and attentiveness, and care was experienced as personalised rather than task-focused:

> *"I thought the antenatal care I received throughout my pregnancy was exceptional. I felt the midwives were attentive and took my concerns seriously at the time. I had flagged up issues and went to the hospital for checks and never felt I was wasting anyone's time."*
> (Woman/birthing person)

Positive relationships with healthcare professionals were also described in specialist and multidisciplinary services. Women and birthing people reported feeling "*really listened to*" and respected in services such as fetal medicine, physiotherapy, antenatal classes, and bereavement care. In these instances, staff gave time to explain options and supported women and birthing people through complex or sensitive situations:

> *"The support we received from the 14 week scan to the birth was overall fantastic, we were offered support we didn't expect and had our wishes respected - we carried on with the pregnancy and were never made to feel that this was the wrong decision or any less important because our baby would not live long. We were well looked after by the FMU team, the midwives, the genetic and palliative care team at [Hospital name] and the community support teams."* (Woman/birthing person)

Support partners described similar positive experiences where they were actively included in care. In these accounts, partners reported being involved in discussions and supported: "*I didn't have many concerns but when I did I was always listened to and staff would ensure I was mentally stable*". This sense of inclusion enabled them to support decision-making alongside the woman or birthing person: "*I was treated as an equal partner on the pregnancy, and very included.*"

These experiences of feeling heard and included reinforced trust and confidence in maternity services. For some, experiences were contrasting, which undermined trust and confidence, particularly where they felt unheard or unsupported:

> *"I feel like nobody was looking out for me. As long as my baby was growing, they didn't care. At times I just wanted to end the pregnancy to escape it. I'm so scared of being pregnant and feeling the same way again."* (Woman/birthing person)

> *"Rather than recognising that I used a sperm donor. The phlebotomist had to write IVF which is not correct [...] the midwife asked about my husband on three different occasions – I'm a single mum by choice. Please recognise families of different shapes and sizes, and recognise a woman may not be married (to a man) or could be single [...] and recognise IUI as a method of conceiving."* (Woman/birthing person)

Women and birthing people also described how interactions could affect their willingness to speak up. Some described feeling judged or criticised when asking questions, making requests, or expressing preferences. This included situations where reasonable requests, such as asking for a female practitioner to conduct an intimate procedure, were met with negative or dismissive responses: "*Instead of accommodating this, the sonographer berated me.*"

Other women and birthing people described experiences of bias or stereotyping, particularly in relation to age and BMI, where care reflected assumptions about risk rather than individual circumstances. These interactions were perceived as judgemental, with some reporting prejudicial remarks in their records or encounters: "*My midwife made*

snide comments about my age and weight." Women and birthing people explained how these assumptions influenced care decisions, with some categorised as high-risk having birth options restricted on this basis. In these cases, recommendations were presented as fixed, sometimes accompanied by messages that their baby could be harmed if they did not comply, leading to feelings of pressure and loss of choice:

> *"Absolutely awful, I was a tick box for having a 'high BMI' I was forced into a birthing plan and was told my baby will die if I didn't do these things which after researching are not true. I was poorly treated because of my BMI by many doctors and midwives."* (Woman/birthing person)

Respect for identity influenced interactions and feelings of inclusion. Some support partners described positive interactions where staff adapted language appropriately and recognised family structures, reinforcing a sense of visibility and respect: "*she was so careful to address him as 'donor' and me as 'mum' from then on.*" Others reported instances where names were not used correctly, assumptions were made, or language did not reflect their identity, requiring them to challenge or correct staff.

> *"I am a gay solo mother by choice, with donor conceived children. Multiple staff members at the hospital where I was registered for my first pregnancy were judgmental or negative about this or asked unprofessional, invasive personal questions. I saw a different person at every single antenatal appointment and was expected to repeatedly explain and justify my identity and my family situation. I wasn't able to build up any kind of trusting relationship with any midwife or doctor."* (Woman/birthing person)

Labour and birth

This section brings together the experiences of care received during labour and birth among women, birthing people and support partners. It draws on accounts of communication with healthcare staff, clinical care and monitoring, decision-making, and the role of support partners. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Labour and birth care (previously referred to as intrapartum care) encompasses the care provided from the onset of labour through to the birth of the baby and delivery of the placenta. This may include pain management, monitoring of the woman, birthing person and baby's wellbeing, clinical assessment and decision-making, and immediate care following birth. Care during this stage may involve interactions with midwives, obstetricians, anaesthetists, neonatologists and other healthcare staff within maternity settings.

Approximately 8,000 women and birthing people and 400 support partners responded to the labour and birth closed questions. At least a third of respondents reported negative experiences during labour and birth across both surveys (see Appendix B). Only 38% of pregnancy responses and 32% of support partner responses conveyed that participants felt they had been listened to during labour and birth.

Responses from younger participants (aged up to 24) showed they were more likely to disagree (56%) that staff listened to them when they had concerns during labour and birth than those aged 35 to 44 (39%). Similarly, responses from the 'Asian or British Asian' ethnic group showed a higher likelihood of disagreeing (52%) than responses from the 'White' ethnic group (42%).

Women and birthing people feeling safe and supported during labour and birth had nearly an equal proportion of agreement (43%) and disagreement (40%). However, a much higher proportion (84%) of pregnancy responses agreed that they were able to have their birthing partner present when they wanted, and 68% of support partner responses agreed that they were able to be present and included.

Responses from the 'White' ethnic group were more likely to agree (56%) that they received pain relief and physical comfort when requested than those from the 'Asian or British Asian' (46%), 'Black, Black British, Caribbean or African' (49%), or 'Mixed or multiple ethnic groups' (45%) responses.

Thematic narrative

A total of 6,856 women and birthing people (68% of pregnancy survey respondents) and 331 support partners (53% of support partner respondents) completed the free text question on experiences of labour and birth care.

Experiences of labour care are reflected across five key themes:

1. Communication, understanding, decision-making and consent
2. Being listened to and taken seriously, particularly in relation to pain and symptoms
3. Staff availability and responsiveness
4. The role of partners in support and advocacy.

These experiences captured variation in how care was delivered, particularly in relation to responsiveness, communication, and recognition of women and birthing people's needs. They further illustrated how women, birthing people and support partners experienced involvement in decisions, access to support, and feelings of safety during labour.

Communication, understanding, decision making and consent

Women, birthing people and support partners described how important their communication with medical staff had been during labour. Staff tone and the time taken to explain labour progression, or birthing methods, to mothers, birthing people and their

support partners directly affected how well they understood what was happening, including the risks and consequences of choosing each option.

One person described their mixed communication experience during labour, with excellent care given by midwives who were being interrupted by overbearing doctors:

"The midwives during my birth were fantastic, they filled me with confidence and made me believe in my capabilities. They tried their absolute utmost to give me the birth that I wanted and for the most part succeeded. We unfortunately found the doctors to be very pushy, and while my labour was not a long one at all (4hrs 30 minutes), my partner repeatedly had to ask doctors to stop trying to intervene."
(Woman/birthing person)

Support partners reported not being told about the risks involved in induction, or the consequences of having a caesarean section. One support partner explains *"We were not given adequate information about the risks of different modes of delivery."* Partners described attempting to ask questions that were not answered or only partially addressed. One support partner made the point that if you aren't informed of all the risks, consent isn't complete:

"An induction plan was set by the Doctors, but we were not told of the risks associated with Propess pessary use to induce labour and not aware of the warning [signs] we needed to look [out] for re adverse reactions to the induction drug (Propess). We were not aware that using Propess carried risks, so no informed consent." (Support partner)

In acute situations, women, birthing people and partners described being asked to consent quickly, with limited time or explanation, which left decisions feeling rushed rather than considered. People reported feeling that full consent wasn't always given to medical staff to undertake examinations or act when things started to go wrong. Respondents reported being confused by heightened urgency to make decisions where risk to the baby was emphasised. This sometimes resulted in agreement without full understanding.

Women, birthing people and support partners felt that proper consent could not be sought if pain or exhaustion hampered their ability to understand information or make informed choices. One person explains how:

"I felt heavily pressured by a consultant to undergo a 37-week induction. Despite clearly stating I preferred a planned C-section—which I felt was safer and had already been discussed with my midwife—the

consultant's persistence forced me into a reluctant and tearful agreement." (Woman/birthing person)

Women and birthing people also described situations where staff gave instructions without reasoning, such as: "*I was put on a heart rate monitor and told not to move. No one explained why. I was in agony laying in my back in this one position and being told I could not move*". This led to uncertainty during already painful and upsetting moments. When explanations were missing or unclear, women and birthing people described not understanding diagnoses, interventions, or the reasons for care decisions, some said that they are still unclear about these events now.

One support partner described the poor communication received by his partner and how her communication needs were not respected by staff during labour:

"We were not kept informed of decisions that were being made and why they were being made. The hospital staff did not do a sufficient job of asking about her personal circumstances and needs to give her the support she needed - she has been diagnosed with ADHD and therefore has different/additional needs throughout labour and this was not taken into account at all." (Support partner)

Being listened to, and taken seriously, about pain and other concerns

Women, birthing people and support partners described how responses to pain affected their care and safety. Support partners advocated for pain relief and found themselves being ignored. Women and birthing people described experiencing severe levels of pain that were not believed or were seen to be overreacting and ignored. One person said:

"I was made to feel like an inconvenience to the midwife on MLU, despite being the only patient in her care. I was repeatedly denied pain relief, and I was only given basic pain relief when my husband went to ask. Apart from that I was ignored." (Woman/birthing person)

Support partners also described the trauma of seeing women and birthing people left in severe pain with limited or delayed access to analgesia including "*being told to take paracetamol for end stage labour!*". Another described pain being ignored until a consultant intervened:

"My partner was in severe pain and it took almost five hours and the obstetric consultant describing the treatment of my partner as 'cruel' for

the anaesthetist to be called for despite us asking for more effective analgesia throughout labour." (Support partner)

There were also examples of epidurals not working effectively, with pain continuing while staff maintained that analgesia was in place rather than listening to the woman or birthing person who was concerned and in pain:

"She was in dreadful pain even though she was supposed to have been given an epidural. He and she had asked for the epidural to be topped up to be told she could not be in that amount of pain as she had the epidural. For it [then] to be found that it had not been taped and was half out so not taking effect." (*Support partner*)

Another person explained that she was made to feel *"completely powerless and hopeless"* continuing *that "no one was listening to me or my husband and nothing we said seemed to matter at all. It was terrifying, in the place where I was supposed to feel safe, supported and cared for, I felt the opposite"*.

Families also described situations where they were told that they could not be in labour despite their pain. A support partner relayed that his partner was: *"told her pains were pubic pain. Six hours later she rang again and was told to come in – she delivered her baby boy alone in the front seat of her car"*. Another person reported that intense contractions and increased dilation were not responded to by staff:

"By approximately midnight my contractions had intensified considerably, and I was experiencing significant pain. Despite raising this repeatedly, I was again told it was unlikely that I was in labour and left alone on the antenatal ward." (Woman/birthing person)

Some families reported feeling that medical staff were discriminatory toward their partners when they asked for help with pain, one described his feelings about his partner's treatment:

"I truly believe she was not listened to as stereotyped as a demanding overweight black woman making a fuss, when in fact the epidural was not sited or working properly, this led to anxiety following the birth." (Support partner)

"I was in pain and asked for more pain relief. The midwife who had a South African accent [...] told me I should be used to pain given where I

was from. I was born in [...] but I am Nigerian heritage
(Woman/birthing person)

Another support partner reported a woman or birthing person not having her pain treated properly because of perceived staff prejudices: "...requested pain relief on multiple occasions and had been refused due to her substance use [...] felt that she was being judged and hospital staff thought she was medication seeking".

"On more than one occasion, I perceived the behaviour towards me as discriminatory and racist. It was only after I asserted myself and made my professional background known that the approach changed."
(Woman/birthing person)

Alongside medication, women and birthing people also felt judged about their choices of where to give birth, with one person saying: "*I had to justify multiple times why I was having a C-section and was demonised for it.*"

There were examples of excellent care as well, with pain being well-managed and staff trying to give those in labour an experience that most closely aligned with their wishes:

"I gave birth at home and mostly felt in control. The midwife respected my birth plan and left me alone. I was able to be in my oxytocin bubble and had a lovely physiological birth. I actually really enjoyed giving birth and felt very powerful and it makes me sad that I am the exception rather than the rule." (Woman/birthing person)

Staff availability, clinical safety and response

Women and birthing people described being left alone for extended periods, sometimes during advanced labour or while experiencing significant pain and uncertainty. These absences meant women and birthing people were unsure what was happening and unable to access help when needed:

Some women and birthing people described being left without monitoring or review during key stages of labour, contributing to fear about their safety and that of their baby: *"Between approximately midnight and 4:00am I was left alone in my room and was not checked on during this time." (Woman/birthing person)*

Failures in monitoring were also highlighted, including gaps in observation and missed opportunities to identify risk: *"Monitoring within the guidelines was not followed for several*

hours and there was a gap of over an hour towards the end of labour where [woman/birthing person's name] was not monitored at all." (Woman/birthing person)

Support partners also described similar experiences, with women and birthing people being left alone while in labour or distress: *"She was left alone on an antenatal ward overnight and had dilated to 10cm with no midwife present and no monitoring of our baby." (Support partner)*

There were repeated examples of attempts to seek help that were not responded to. Women and birthing people described pressing call bells, asking for assistance, or relying on partners to escalate concerns when no staff were present: *"I was pressing my buzzer no one was coming. I couldn't get out of the bed and was laid there with vomit all over me and the floor."* (Woman/birthing person)

These delays were often linked to perceived understaffing and overstretched services: *""The staff were majorly overstretched, the ward was not safe and you were lucky to see anybody. I was not checked until 6pm after being there since 10am."* (Woman/birthing person)

Women, birthing people and support partners described a wide range of experiences in clinical safety and basic care during labour. Some described timely, coordinated care and safe environments, while others reported serious issues with equipment or resources affecting care and outcomes:

> *"My son suffered a birth injury as a result of tick box focused midwives who didn't observe the elevation in his heart rate before it dramatically dropped. He was deprived of oxygen for over 20 minutes resulting in HIE grade 2 event. When trying to find his heartbeat, the CTG monitor was broken which delayed the finding of his bradycardic heart reset. When they tried to revive him the stethoscope was missing from the resuscitator and the mask was too small."* (Support partner)

However, in instances when staff were present, attentive and responsive, women, birthing people and partners described feeling reassured, supported and safe:

> *"The midwifery team at [Trust Name] were excellent, and they kept my wife and son alive. The calm atmosphere and constant attention enabled my wife to focus on birthing with little distraction, intervention and feeling of danger..."* (Support partner)

The role of partners in support and advocacy

Women and birthing people described partners as critical sources of reassurance, particularly during difficult or uncertain moments. Where partners were present, they

helped interpret information, provide comfort and support decision-making meaning women and birthing people felt more supported and less alone.

Support partners also described actively advocating for women and birthing people, often prompting staff, seeking updates or raising concerns: "*I seemed to be doing a lot of chasing of staff to ask for updates.*" (Support partner)

In many cases, partners felt responsible for bridging gaps in care where staff were not consistently present. However, their ability to do this was sometimes limited when concerns were dismissed or not acknowledged: "*I was often ignored and left second guessing.*" (Support partner)

Partners described the distress of being excluded or left waiting without information: *"I was taken into a small room and had to wait with no information on what was happening."* Even when present, partners described feeling unprepared or unsupported in their role, particularly when communication was limited.

Practical factors also affected involvement. Partners frequently described poor facilities, fatigue and lack of rest impacting their ability to provide support: *"I was awake for over 24 hours. There was nowhere comfortable to rest."*

Restrictions on partner presence were also a significant issue. Women and birthing people described being left alone at key stages due to ward policies, particularly during induction or early labour:

> *"Unfortunately it reached the time where my support (husband) had to leave due to the ward rules for evening hours. This was the worst rule imaginable, it should not have been in place and added to my trauma I experienced. When it appears that more and more partners/family members are expected now to provide care to plug the gaps in substandard and unsafe care. This is unacceptable and degrading when you are in a vulnerable situation."* (Woman/birthing person)

Postnatal

This section brings together the experiences of care following birth among women, birthing people and support partners, drawing on accounts of postnatal support, clinical care, communication, and interactions with healthcare staff. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Postnatal care refers to the care provided to women, birthing people and their babies after birth. This may include support with recovery, feeding, physical and mental health, monitoring of the baby's well-being, and guidance on caring for a newborn. Care during

this period can involve midwives, neonatal staff, health visitors, and other healthcare professionals across hospital and community settings.

Approximately 6,500 women and birthing people and 300 support partners answered the postnatal closed questions. Approximately half of women and birthing people who responded felt that they hadn't received the support they wanted during the postnatal period to recover physically or to feed their baby (see Appendix B). Over two thirds of women and birthing people (66%) knew who to contact if they had concerns about theirs or their baby's health, but only 40% of support partners felt that same.

Responses for both surveys reported negative experiences of postnatal mental health support – 53% of women and birthing partners did not receive mental health support that met their needs and an even higher proportion (72%) of support partners were not offered mental health support.

Thematic narrative

A total of 9,532 women and birthing people (95% of pregnancy survey respondents) and 215 (34% of support partner respondents) completed the free text question on experiences of postnatal care. Experiences of postnatal care are reflected across seven subthemes:

1. Postnatal ward environment
2. Support while staying in hospital
3. Communication from staff
4. Community postnatal care following discharge
5. Physical recovery
6. Feeding support
7. Mental health and emotional support.

Across themes, these experiences showed variation in how care was delivered, particularly in relation to communication, involvement, and continuity. They also illustrated how these factors shaped women and birthing people's and support partners' understanding, confidence, and sense of support during the postnatal period.

Postnatal ward environment

The postnatal ward environment affected women and birthing people's recovery, dignity and rest after giving birth, it also influenced their partner's ability to provide support: *"Curtains were drawn and [I] was alone tired [and] expected to feed baby alone."* (Woman/birthing person)

The conditions varied widely with some families describing clean, supportive settings, while others reported poor facilities and lack of basic amenities such as "*freezing cold*" showers and windowless rooms.

Women and birthing people described wards as busy and noisy, with shared bays limiting privacy and rest: *"There was very little support, dire food, and a noisy environment in a four bedded ward with midwives who didn't seem able to use quiet voices".* (Woman/birthing person)

Support partners described similar conditions, including cramped spaces, lack of natural light, and limited access to basic amenities such as toilets or food. These conditions made prolonged stays difficult and contributed to fatigue:

> *"The ward was extremely cramped and uncomfortable – we did not even see daylight for six very long and awful days."* (Support partner)

In some women and birthing people's accounts, a lack of basic hygiene contributed to feelings of distress and a lack of dignity. These feelings were heightened when requests for cleaning were delayed or refused:

> *"I was left in the same pus, blood, sweat and vomit covered sheets and pillow for five days. Even after my partner offered to change the sheets for me they refused."* (Woman/birthing person)

Overall, poor environmental conditions with inadequate cleanliness compounded the negative experiences of women, birthing people and their support partners and limited their recovery following labour and birth.

Support while staying in hospital

Women, birthing people and support partners described difficulties with accessing the support they needed while they were staying on the postnatal ward. Delays in responses from staff were often linked to staffing pressures. "*No one came if you rang the bell*" was mentioned in the responses, including in situations where they were concerned about their baby, but the mother or birthing person was alone and could not move:

> *"My baby started grunting so I pressed the emergency call bell, only for no one to come (I still couldn't move at this point…)."* (Woman/birthing person)

Support partners described wards where "*there was rarely a member of staff to be seen.*" A feeling of limited staff presence on the ward fuelled concerns that "*nobody else would*" monitor their babies other than the mothers, birthing people and support partners. This fear negatively impacted recovery while in hospital:

> *"I was not able to recover properly as I was awake nearly all night, despite being exhausted, as my daughter was very unwell and I knew that if I didn't keep an eye on her overnight, nobody else would."* (Woman/birthing person)

The effect of limited and delayed support from staff was further exacerbated for those women and birthing people whose support partners could not stay with them overnight on the postnatal ward. This was especially difficult for those who had had caesarean sections or suffered complications during labour and birth.

The absence of their partners affected their ability to recover and care for their baby, increasing feelings of overwhelm and a loss of control. Restricted overnight presence left mothers and birthing people managing recovery and newborn care alone:

> *"As it was 2022 and still living in post covid times, my husband wasn't able to stay overnight which meant if I needed to get to the toilet or change or feed my baby and I couldn't get hold of anyone I just felt completely out of control and useless."* (Woman/birthing person)

Communication from staff

There were accounts where women and birthing people described interactions with staff that made them felt dismissed or treated as "*an inconvenience*". There were more extreme examples of being criticised or shouted at by staff, leaving women and birthing people feeling humiliated and upset:

> *"The initial postnatal ward HCA screamed at me "that baby needs feeding!!" I was humiliated, degraded and felt invisible when my baby and I almost died. No compassion, no care...I overheard them in handover describing me as "hysterical" [...] I felt like I was a criminal in jail, not a new mother."* (Woman/birthing person)

Communication of key information by staff to women and birthing people, such as any complications that had happened, did not always occur or were not clearly explained:

> *"...they failed to tell me they had bothered the bowel during surgery. It was only my partner, who had had stomach surgery himself previously, who told me to stop eating. As such I was in agony from eating when my bowels were not working."* (Woman/birthing person)

Support partners highlighted that the communication and treatment of the women and birthing people varied considerably, with some responses describing the communication as being delivered "*brutally*", while others had a more mixed experience:

> *"Some staff were excellent, caring and sympathetic, genuinely helpful, emotionally understanding. Others were rude, dismissive, and resentful."* (Support partner)

Community postnatal care following discharge

The postnatal care pathway following discharge was viewed by some as "*fragmented and difficult to navigate*". Once women and birthing people were discharged from hospital, they experienced minimal or delayed contact from community services. Some parents received minimal engagement, and as such had to "*chase [them] down.*"

Once contact occurred, care lacked continuity, with different staff at each visit and limited awareness of individual circumstances. This contributed to the perception of fragmented care:

> *"We did not receive any support from the community midwife team, and hardly any contact from them, unless it was for milestone appointments and it was always someone different who didn't know us or our situation."* (Woman/birthing person)

Some respondents reported being dissatisfied with the care they received during their GP check-ups, reporting that *"the GP doesn't check anything"*. There were suggestions for the 'six-week check' to be reviewed due to being insufficient:

> *"I think I was sat in the waiting room longer than the doctor's office for my appointment. I went for my check without my baby as she was still in hospital. I remember briefly being asked about my mental health and contraception, but minimal else."* (Woman/birthing person)

Issues with the transfer of women and birthing people's medical records between community/primary care and the hospital impacted the care received following their hospital stay:

> *"My notes were never shared correctly. The community midwife and health visitor claimed they had not received my notes. The notes the GP received from the hospital were incomplete."* (Woman/birthing person)

Support partners similarly described uncertainty about who was responsible for care and how to access help. Families reported conflicting information and felt that different healthcare teams did not communicate with each other:

> *"Lots of being bounced from pillar to post. Was sent to A&E as 'a precaution'. Three hours later the doctor says `not sure why you're here but everything is okay'. No communication between teams."* (Support partner)

Variation in experiences of community based postnatal care often depended on an individual's ability to navigate the system and the resources they had available. Responses suggested that those who had more knowledge and resources sought external support from private services, while others potentially face barriers:

> *"To support my own physical health and wellbeing, I paid privately for a pelvic floor assessment and full-body physio and massage. Access to these types of services should not depend on personal financial means; there should be more structured and accessible post-pregnancy support available through the NHS. For many women, especially those without the same resources or awareness, this lack of clear, joined-up support could be a significant barrier."* (Woman/birthing person)

Generally, the support received from non-specialist services was found to be not useful and highlighted gaps in knowledge:

> *"I received visits from the health visitor once we were back home but I didn't feel that these were particularly useful as she didn't seem to have much specialist knowledge about preterm babies, however we were visited weekly for a couple of months by neonatal nurses when my baby was discharged who were wonderful and so caring and compassionate."* (Woman/birthing person)

Physical recovery

Women and birthing people described limited guidance on how to recover after birth, including lack of information about mobility, pelvic health, or preventing complications. Often advice received was generic, leaving them to manage pain or mobility limitations on their own:

> *"Access to postnatal physical recovery support needs to be strengthened. Services such as pelvic floor assessments, rehabilitation guidance, and physical therapies [...] should be available through the NHS, rather than requiring individuals to seek private care."* (Woman/birthing person)

Support partners highlighted that it was sometimes difficult for women and birthing people to access the care they needed to help with their physical recovery. For some, it felt like they "*had to beg for basic care*". For others, they had to advocate for women and birthing people to ensure that they received the care they needed:

> *"...we needed to rely on our GP a LOT for the first few months because my wife was so ill. Trying to get appointments to be seen for the numerous infections my wife experienced over months was very difficult, and we really need to be extremely assertive to get anywhere."* (Support partner)

Feeding support

Women and birthing people described difficulty accessing practical breastfeeding support, especially immediately after birth. Some reported that their repeated requests for support were ignored, leaving women and birthing people unable to initiate breastfeeding. In some cases, formula was given to their baby without consent or explanation:

> *"She did not help me with breastfeeding (despite me asking for help) [...] But my requests for help breastfeeding were denied over and over again. My baby was forced fed formula on regular intervals. The feeding plan was never explained or agreed. I had no access or help pumping."* (Woman/birthing person)

Support partners also described ineffective or fragmented support, with different staff offering conflicting guidance. In some cases, breastfeeding was strongly encouraged despite signs of difficulty, with intensive feeding routines being prescribed:

> *"Breastfeeding was pushed and pushed and pushed, to the detrimental health of our son who was losing weight and my wife was put on regime of breast feeding, then pumping and then feeding our son the expressed milk which crippled her and drove her to burnout and exhaustion."* (Support partner)

For some, messaging around feeding sometimes involved pressure or blame:

> *"Pressure to breast feed and being told stats and outcomes about breast feeding being positive, without balanced discussion of the negatives [...] I was so unhappy with the way the postnatal care approached this topic and was so sexist about it that it actually put me off even though I was feeding fine!"* (Woman/birthing person)

Conflicting advice and a lack of practical guidance often created confusion and feelings of uncertainty:

> *"After discharge I felt well supported [...] but I felt confused about feeding and had conflicting advice regarding my son's feeding plan."* (Woman/birthing person)

In terms of community-based feeding support, variation in experiences could depend on an individual's ability to navigate the system - those with more knowledge or resources sought external support, while others faced barriers:

> *"While I was proactive and able to access support through the Breastfeeding Network and a private lactation consultant [...] For many women [...] this lack of clear, joined-up support could be a significant barrier."* (Woman/birthing person)

For those who had difficulties feeding because of complications, such as tongue tie, their early concerns were frequently dismissed or not investigated. Sometimes, the issue was only resolved because they accessed private services:

> *"...I raised my concerns about tongue tie there but they again dismissed it, and said it was either my supply or my hold and told express and top-up by bottle [...] At 16 weeks we ended up seeing a specialist privately who confirmed that my baby did have severe tongue tie and snipped it."* (Woman/birthing person)

Some responses across both surveys did share positive experiences of breastfeeding support: "*My daughter received excellent breastfeeding support*" (Support partner). Support partners who were involved in, or witnessed, the feeding support given to parents with babies in the Neonatal Intensive Care Unit (NICU) reported that the support was excellent

while they were in hospital. However, the feeding support available once their baby was discharged was limited:

> *"[Parents' names] were shown how to care for [baby name] in hospital while he was in the incubator, how to tube and bottle feed him, the support there was great for them. For us to help them, when they came home there was nothing!"* (Support partner)

Responses show a variation in the consistency and quality of the breastfeeding support they received during postnatal care.

Mental health and emotional support

Mental health needs were often unrecognised by staff or not sufficiently addressed. Many reported an absence of mental health care, even after they had experienced trauma or distressed:

> *"Mental health aspects were non-existent and meant that trauma symptoms/PTSD due to my traumatic birth went undiagnosed and developed into a much bigger issue than was necessary."* (Woman/birthing person)

Respondents also reported that their mental health concerns and symptoms had been dismissed or normalised, such as feelings of anxiety or sleep disturbance:

> *"I stated I was very anxious and starting to hallucinate, I was told it was normal and to go to my GP if it did not improve by 6 weeks. I didn't think I would make it to six weeks by that point."* (Woman/birthing person)

Support partners shared similar responses that there *"is no support at any level for mental health"* for them or their partners following the birth. Responses described how the lack of mental health support could also impact relationships:

> *"...it is likely we will get divorced as a result of the issues it has caused. The GPs send referrals, the referrals get rejected, the system spits you out and you're left on your own."* (Support partner)

Responses specifically from fathers highlighted that there is a lack of mental health care for the partners beyond "*a tokenistic question about "how are you?*" being occasionally asked:

> *"There was no support and information offered for dads [...] there is no support signposted. There is little support for mothers let alone fathers."*
> (Support partner)

Neonatal care

This section brings together the experiences of women, birthing people and support partners whose babies received neonatal care, drawing on accounts of parental involvement, access to babies, clinical care, communication, and emotional support. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Neonatal care refers to the specialist care provided to babies who require additional medical support after birth, often within neonatal units (NNUs) which are designated as special care baby units (SCBU), local neonatal units (LNUs) or neonatal intensive care units (NICU). This may include monitoring, treatment, and support for babies born prematurely or with medical or surgical conditions, alongside support for parents during this period. Care can involve interactions with neonatal nurses, doctors, midwives, and other specialist healthcare staff.

Approximately 1,500 women and birthing people and 100 support partners responded to the neonatal care closed questions. 67% of women and birthing people and 54% of support partners were confident that their baby was being well cared for by staff (see Appendix B). 72% of pregnancy responses agreed that staff supported them to hold, touch, and care for their baby and 62% reported that staff kept them informed about their baby's condition and treatment.

Thematic narrative

A total of 1,188 women and birthing people (12% of pregnancy survey respondents) and 71 support partners (11% of support partner responses) completed the free text question on experiences of neonatal care. Experiences of neonatal care are reflected across five key themes:

1. Being involved in neonatal care
2. Ability to access babies in neonatal care
3. Variation and trust in clinical care
4. Communication and information
5. Emotional impact of neonatal care and being treated as a parent.

The accounts highlighted differences in how care was delivered, particularly in relation to communication, parental involvement, access, and the consistency of clinical care. They also captured how these factors influenced parents' understanding, confidence, and sense of inclusion, as well as their ability to care for and bond with their baby during a highly complex and emotionally demanding period.

Being involved in neonatal care

Parents described variation in how they felt during their interactions with the neonatal care teams. Some felt actively supported to take part in decisions and caregiving whilst others felt excluded, judged, or unable to contribute: "*…told me I was making him more sick by trying to comfort him*". (Woman/birthing person)

At times women and birthing people felt they were not openly involved in care. Responses described waiting for permission to interact with their baby, or being corrected when attempting to help, which reduced confidence: "*I don't feel like the main carer for my baby [...] I waited until staff members offered for me to hold my baby".* Women and birthing people were also unaware of the care level the baby needed, or kept informed about the situation at all:

> *"I had no input into the care my baby received on NICU, I wasn't updated and only knew what was happening when I wanted to self-discharge to be with the baby and the baby was already sedated and tubed ready to be moved to a different hospital."* (Support partner)

This lack of support increased isolation, particularly for those unfamiliar with neonatal care or parenting:

> *"There was no support whatsoever. At one point a midwife asked if the formula I was using was warm and I said I hadn't warmed it up (I didn't realise you needed to) and she laughed at me. I told her that her support would be appreciated rather than being laughed at."* (Woman/birthing person)

Women and birthing people also described positive experiences within family-integrated care settings, where they were invited to ward rounds, encouraged to provide care, and supported to build confidence in feeding and routine tasks: "*We learnt so much; from changing nappies to changing monitors to tube feeding."*

Another person reported excellent experiences with communication in NICU:

> *"When we got the NICU [...] They explained everything so clearly and helped us to understand. Exceptional people. In our experience the staff in and connected to NICU were amazing."* (Woman/birthing person)

Some support partners felt involved in decision-making and that care was clearly explained to them: *"The nurses regularly checked to see how my baby was doing, how we all were, and treated us as normal parents, despite the circumstances".* Practical teaching by staff and regular check-ins with the parents were welcomed and helped families feel they had the ability to care for their baby: *"They were wonderful with the parents, explaining, teaching, assisting".*

However, other support partners described feeling that their views were not incorporated into decisions or that some interactions were impersonal: *"There were many things that upset us about neonatal care. The manner of 90% of the midwives was dismissive and bullish."*

Both groups highlighted the importance of being heard. Women and birthing people described needing to repeatedly raise concerns before being taken seriously, and some felt their observations were dismissed: *"…my intuition that my baby was seriously unwell; but this was played down".* Support partners also reported feeling unable to question staff, particularly where behaviours were perceived as dismissive or where fear of consequences limited speaking up:

> *"Other staff threw their weight around with one threatening me with safeguarding if I told her senior that she had not put my child's medication on properly."* (Support partner)

Being involved in neonatal care was important for families who were adjusting to, and recovering from, unforeseen events. Where staff were approachable and responsive, they felt able to ask questions and engage in care. This, in turn, contributed to a positive experience. However, where interactions were dismissive or controlling, families felt excluded from the care of their babies:

> *"I missed their first bath, their nappy changes - I was just a passenger who'd given birth to them, I wasn't included in any decisions or any care. Yes I was quite sick at the time, but no photos were taken, no bonding was facilitated and no information was given unless I pushed for it."* (Woman/birthing person)

Ability to access babies in neonatal care

Women, birthing people and support partners described how their ability to physically be with their baby depended on visiting policies, availability of accommodation, and other practical arrangements. Access was sometimes continuous and supported, but when it wasn't this led to increased anxiety and stress for those families.

> *"I wasn't able to stay with my baby only the last two nights before they discharged us. I was coming every [morning] at 8am and leaving at 11pm. This was the hardest part not being able to be 24/7 there but I had trust in the doctors and nurses."* (Woman/birthing person)

Families found themselves separated from their babies due to lack of suitable accommodation: "*…was discharged after two days as nowhere available to stay near baby*".

Where on-site accommodation or nearby housing was available, women and birthing people were able to stay closer to their babies, and this increased caregiving and bonding opportunities which were greatly appreciated: "*Facilities including the accommodation available for parents who lived far from the hospital were amazing."*

Physical recovery from labour and birth was a factor in some women and birthing people not being able to be present on neonatal wards and this had an emotional impact on those affected: "*The first day was hard as I was unable to get to the NICU to see my baby*". Furthermore, the impact of hospital policies caused additional distress at these difficult times: "*We waited over 11 hours for a porter to be identified who could wheel me to meet my baby*."

Some policy decisions were also found to add to tension at these times and parents felt unnecessary rules and restrictions impacted on their ability to be present with their babies on neonatal care units:

> *"I was allowed to accompany baby for admission to NICU, then asked to leave. 'Visiting hours over' directed at Dad. We did not want to go."* (Support partner)

Beyond formal rules, environmental factors such as crowded bays, limited space, and lack of privacy reduced opportunities to fully bond with the baby, even when parents were present: "*Baby was in [an] eight bedded bay, was noisy, wasn't enough room to get them out and cuddle them."* (Support partner).

The structure of postnatal wards contributed to feelings of distress and exclusion for those whose babies were being cared for in neonatal units because women and birthing people were often placed on general postnatal wards without their babies:

> *"After my baby was taken away to be stabilised in the NICU […], I was placed in a recovery bay with women and babies, where I spent the afternoon listening to them cry and bonding with their mums meanwhile I didn't have my own."* (Woman/birthing person)

For those who were placed in single rooms or higher dependency placements, they felt more supported and comfortable:

> *"I was allocated a HDU room due to my blood loss. I was grateful for this as I did not want to be on the postnatal ward without my baby who was in NICU."* (Woman/birthing person)

Variation and trust in clinical care

Parents described a wide range of experiences in clinical care, from attentive and effective treatment to missed signs, delays, and errors that raised concerns about safety:

> *"Care was pretty variable. Some doctors were sensible and competent, others seemed confused and insisted on unnecessary caution."* (Support partner)

Women and birthing people described concerns over delays in recognising deterioration or responding to alarms. In some cases, parents intervened themselves to alert staff:

> *"Overall, the care of my daughter was good. However, we noticed a pattern of some nurses becoming too used to the sound of machine alarms, on more than one occasion my daughter [desaturated] to the point of turning blue and needing oxygen and staff in charge did not notice her oxygen stats on the large screen despite saying this was monitored constantly. I had to shout for help on more than one occasion."* (Woman/birthing person)

Women and birthing people also felt the need to advocate for their babies when staff missed warning signs: "*They nearly discharged my son with sepsis. The only reason they didn't was because I fought for him."* Trusting staff also became extremely difficult when errors were made which affected babies' treatment: *"…my daughter was given light therapy when this was not required as a nurse had plotted it wrong on a chart".*

Women and birthing people also reported concerns over medication administration and issues with procedures being complete too late or incorrectly:

> *"Procedures delayed by over three hours [...] Delayed antibiotics."*
> (Woman/birthing person)

> *"My baby was very well cared for except at some point a miscommunication among staff due to a language barrier resulted in my baby receiving 4x the prescribed dose of antibiotics."*
> (Woman/birthing person)

Some women and birthing people linked these issues to deterioration or harm:

> *"...errors with intravenous fluids (not connected and discovered hours later) were likely to have contributed to the blindness that my baby then suffered."* (Woman/birthing person)

Equipment problems, including unavailable or incorrectly set-up devices, contributed to severe concerns over babies' safety and were also reported to contribute to loss and ongoing trauma for parents:

> *"...however at seven weeks old she was transferred to a NICU closer to home, however the two units did not have compatible equipment, such as feeding tubes etc. so on transfer all of these had to be changed. With a very fragile baby who died only hours after transfer when the equipment was changed surely continuity of care, including equipment would be of the utmost importance."* (Support partner)

Support partners also described how some staff were observed as confident, skilled, and reassuring, while others appeared uncertain: *"...clear differences in the knowledge and competency of the staff caring for him"*. Care was experienced as dependent on who was on shift, with differences in decision-making and responsiveness: *"The level of care varied greatly depending on which members of staff were allocated"*.

Issues around leadership and staff handovers, especially between shifts, was seen as a key component in respondents experiencing co-ordinated, consistent and safe care for babies:

> *"It would have been better if there was one senior doctor in charge of care, which would allow joined up thinking. There were a lot of factors to consider which needed an overall view, care, monitoring, and*

interventions all felt a bit random as each new doctor/nurse came on shift." (Support partner)

Communication and information

Experiences of communication ranged from clear, timely explanations that supported understanding and reassurance, to gaps, conflicting messages, and inaccuracies that created confusion and reduced trust: *"Better communication would have helped."* (Woman/birthing person)

When staff explained care in a structured manner and checked understanding, parents felt reassured and more confident in what was happening:

"The NICU team were generally kind, efficient and communicative about what was happening/going to happen." (Support partner)

"When I came to the neonatal [unit] at the middle of the night to provide milk the nurse told me how my daughter was doing in simple terms and made me feel reassured about leaving her." (Woman/birthing person)

During acute situations, women and birthing people reported not understanding what was happening to them or their child, leaving them confused and distressed:

"My son was sent to the NICU still for reasons unclear to me. They were not honest with me about what happened to him or why he was in there." (Woman/birthing person)

This distress was compounded by difficulties obtaining clear information and regular updates:

"…found it very difficult being separated from baby whilst in NICU and receiving up to date information on his condition." (Woman/birthing person)

Women, birthing people and their partners even report being left with no information in critical situations, one father recounts that: *"Whilst our baby fought for his life for 78 minutes and lay dying we were not told".* Another said: *"I only knew my son had a seizure when I called my husband who was with him. No communication was shared".*

Support partners said plans changed without explanation, leaving them unsure about what was happening or how best to support their partner. In both groups, participants

described needing to ask repeatedly for information, sometimes without receiving clear answers. One father stated:

> *"I was given no information, not kept informed of any progress with regard to my wife, and when I was asked to leave the room right before the birth I feel I was deceived in to thinking I'd be allowed back in to support my wife in a few minutes. This didn't happen."* (Support partner)

Conflicting messages were also common: **"***My family member was told completely different things by different staff and it was very confusing.***"** (Support partner). This led to confusion and uncertainty about who and which information to trust:

> *"One of the doctors seemed to change their mind as to what they thought the problem was based on who they were speaking to at the time. This was quite frustrating and made it hard to take their opinion seriously. It honestly felt like they didn't know what they were doing and were trying to cover their own back/trying not to make any mistakes."* (Support partner)

Confidence in staff was also lost when written reports appeared not to be consistent with what parents heard or understood to be happening:

> *"They constantly moved my baby to different places on the ward without telling me. They wrote in notes that I hadn't made any contact overnight when I always did. When I called they'd say `he's fine' no other info."* (Woman/birthing person)

Additionally, when decisions were taken without the parent's consent or knowledge, trust with staff eroded even further:

> *"Baby given dummies and formula without our knowledge or consent."* (Woman/birthing person).

Support partners recalled situations where information shared gave them false expectations about how care would be administered and that when these situations did not materialise, for whatever circumstances, they felt let down by the staff:

> *"With [the] volume of babies on [the] ward, our baby certainly did not get [a] nurse at the end of bed as was assured. [The] Registrar did not see baby again until in significant failure (over five hours)."* (Support partner)

When the communication, documentation, and observed care did not align, this reduced trust between families and staff at a very complex time, and worsened families' experiences of care:

> *"However, important information about her condition was not communicated to us at the time. We were not told that she had been described as being born in 'poor condition' or that she had taken 10 minutes to breathe properly and unassisted; we only discovered this later in her notes, without context […] clearer communication and more reliable follow-up processes would have improved our experience of neonatal care."* (Woman/birthing person)

Emotional impact of neonatal care and being treated as a parent

The experience of neonatal care was described as emotionally intense: *"No one supports you through the trauma of neonatal care."* (Woman/birthing person)

Families described a range of emotional experiences. Consistent, compassionate care helped them feel reassured and built trust in the staff and support available from the unit: "*They were so supportive of us as parents and we felt comfortable […] leaving our baby in* hospital overnight." (Woman/birthing person) This increased confidence in their own roles as parents and helped them feel more like a caregiver and less like an observer:

> *"Staff [were] so supportive of us as parents, encouraged us to be involved, provided excellent care for our baby and communication with us about her care, included us in decision making."* (Woman/birthing person)

Parents' ability to cope was also shaped by the support, communication, and the behaviours of others who shared their experiences:

> *"Support from other neonatal parents was invaluable."* (Support partner)

Whilst parents understood the primary role of neonatal care was for the baby, they often felt that their needs, especially emotionally, were not considered by staff:

> *"I did not feel that well emotionally supported on a day-to-day basis by the staff in the NICU - in particular by the nurses who I would see all day, every day. It sounds obvious but it was very clear they were there to look after the babies, not the parents. This left us feeling very lonely and isolated at a very difficult time."* (Woman/birthing person)

Both groups felt that the emotional experience of neonatal care lasted beyond the time they actually spent on the unit. However, some parents felt that follow up support was missing:

> *"Psychological support should be available post NICU."*
> (Woman/birthing person)

Being able to access follow up support or peer support alongside supportive staff behaviours helped families mitigate emotional strain in the longer term. However, when this level of support was inconsistent or absent parents found it harder to cope:

> *"Our experience of the care and support we received in neonatal care was emotionally complex and, at times, overwhelming. While we are grateful for the medical care that kept our babies safe, there were significant challenges in communication, parental involvement, and emotional support that had a lasting impact on us as a family."*
> (Support partner)

Experiences of Loss

This section brings together the experiences of women, birthing people and support partners following pregnancy loss, stillbirth, neonatal loss, and, in some cases, maternal death. It draws on accounts of communication, clinical care, support provided before and after loss, and interactions with healthcare staff during this period. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Care following loss refers to the support provided to families experiencing the death of a baby at any stage of pregnancy or shortly after birth. This may include clinical care, bereavement support, communication about what has happened, and guidance on next steps, including memory-making, registration, and ongoing emotional support. Care

during this period can involve midwives, obstetricians, neonatal staff, bereavement teams, and other healthcare professionals across hospital and community services.

Pregnancy and baby loss

Approximately 1,000 women and birthing people and 100 support partners answered the closed questions on pregnancy and baby loss. Only one in five felt the bereavement support they received met their needs (see Appendix B). 54% of pregnancy responses disagreed that they felt informed of the bereavement support available to them and 60% disagreed that they were supported to get relevant mental health support. A minority across both pregnancy and support partner surveys reported that staff treated them with compassion and sensitivity.

Postnatal care following a pregnancy or baby loss

Women, birthing people and support partners were asked specifically about their experiences of the postnatal care that they received following their pregnancy or baby loss.

Approximately 1,000 women and birthing people and 60 support partners responded to the closed questions on postnatal care following a pregnancy or baby loss. Most responses to the pregnancy survey reported disagreement across all postnatal care following a loss questions. Over two thirds of pregnancy responses disagreed that they had received information on how to manage the physical and mental health changes they may experience following their loss. 70% of pregnancy responses disagreed that they received the support they needed for their mental health and emotions. 66% disagreed that the mental health and bereavement support met their needs and 62% disagreed that staff helped them to understand what had happened and why.

Death related to pregnancy, birth or post-partum, and experiences of caring for a baby following the death of a woman or birthing person

This section was only included in the support partner survey. There was a very small number of responses to these questions (<50 responses), therefore all findings should be treated with caution and are for *illustrative purposes only.*

29% of responses reported that staff treated them with compassion and sensitivity, while 38% disagreed with this statement. There was a similar pattern for whether staff communicated clearly and sensitively with them – 26% of support partners agreed, while 43% disagreed.

Less than a quarter agreed that staff kept them informed about what was happening. 26% agreed that staff gave them the opportunity to ask questions.

43% disagreed and 26% agreed that staff informed them of the NHS bereavement support available to them. While 41% agreed that they had access to bereavement support (and 45% disagreed), only 5% agreed that the bereavement support met their needs.

A small number of responses to the questions about caring for the baby after the death of the mother or birthing person were received (<50 responses). For all questions at least 40% of responses reported a positive experience of care, including being able to contact staff when they needed and being supported by staff to bond with, and care for, the baby.

Thematic narrative

A total of 2,243 women and birthing people (22% of pregnancy survey respondents) and 181 support partners (29% of support partner respondents) completed the free text question on experiences of loss.

Experiences of loss are reflected across six key themes:

1. Impact of clear information on how families understood events
2. Staff and system response to concerns and risks
3. Staff and system perceived errors and failings
4. Impact of compassion following loss
5. Impact of the environment and procedures following loss
6. Access to post loss support and follow up.

These experiences reflected differences in how care was delivered at a time of significant vulnerability, particularly in relation to communication, responsiveness, compassion, and continuity of support. The questions in this section also explored how these factors influenced families' understanding of what had happened, their ability to process the loss, and their longer-term emotional wellbeing.

Common themes were identified around compassion, dignity, response to concerns and risk and ongoing inclusion and support across all types of loss by all of those involved:

> *"Grief is only one small aspect of the death of a neonate or of a baby in utero. The death of a baby is one of the most profound experiences that a woman will have and the effects will remain with her for her entire life."* (Support partner)

Impact of clear information on how families understood events

Information about care decisions, loss, and next steps were often reported as being incomplete, delayed, or difficult to absorb in the moment. This left families feeling uncertain about what had happened and what choices were available to them:

> *"I have never given any of my losses a dignified resting place as I haven't had the support."* (Woman/birthing person).

Women and birthing people described not being given clear explanations about what was happening, particularly at key decision points. Many felt unprepared for decisions about care or procedures and described being expected to make decisions quickly without fully understanding their options:

> *"...although I was given all the information in regards to my baby's complications at first, I felt like all my 'options' weren't explained to me in full, and felt pressured in to making a decision right away."* (Woman/birthing person)

Even when written information was provided it sometimes felt too generic which made it feel not applicable or, conversely, it was too complex to be absorbed at once. It was also often delivered at a time when women and birthing people were in shock or affected by medication, limiting their ability to process it:

> *"In the days immediately following my son's death I was also very confused and disorientated due to the shock of what had happened and the effects of strong pain medication. I struggled to understand what practical steps needed to be taken, such as registering the birth and organising a funeral. Information was given to me, but I found it very difficult to process at the time. I wish that this information had been repeated clearly and gently over time, as I was simply not able to absorb everything in those first hours and days."* (Woman/birthing person)

Some women and birthing people reported regret about missed opportunities, such as spending more time with their baby, because they had not been told or had misunderstood what was possible: *"I wish I had spent more time with our son. Very little was explained to me"*. Many did not have clarity on memory making opportunities or funeral arrangements. Additionally, absorbing any details at such a distressing time was almost impossible for many families:

> *"When my son died at 38 weeks after no heartbeat being found at my 38 week appointment it was so unexpected and I was in so much shock. Within what felt like no time at all being told the options I had for delivery and then about funerals and post mortems and then I was sent away with only a (big) leaflet from Sands that I couldn't [bear] to look at the time as I couldn't accept what was happening."* (Woman/birthing person)

In some cases, partners described not being clearly told that the baby had died, or receiving conflicting information about signs of life. These inconsistencies left families unsure about what had happened and prolonged distress:

> *"We only found out from the report [Baby's name] was alive for 90 mins after being told he `Never took his first breath'."* (Support partner)

Information shared after the loss was also problematic, with partners describing receiving reports or official documents without explanation, support or the thoughtfulness expected: *"Birth certificate was provided in a "congratulations on your baby" folder and the death certificate provided in a tax form folder"*. Additionally, families were sometimes alone when receiving information which further added to the distress:

> *"…lack of compassion when she received the investigative report into her son's death, to read it on her own."* (Support partner).

However, where staff explained processes step by step, repeated information, and gave time for questions, families felt more able to understand and engage with care, which helped reduce confusion and supported decision-making directly, impacting their understanding of events and ability to process them:

> *"At week 6 there was a heartbeat but the growth looked smaller than expected, and at week 7 there wasn't a heartbeat - a missed miscarriage, so I needed management. A nurse took us into a room and walked us through what had happened, the options for everything and where to go for more support. I wasn't pressured into any decisions, but when I came to the decision of wanting surgical management later that evening and called the unit, they fitted my surgery in the next day. I always say that I had a positive experience of a dreadful thing."*
> (Woman/birthing person)

Staff and system response to concerns and risks

Some women and birthing people felt they were treated as an inconvenience while experiencing pain or distress. Some described being left to manage heavy bleeding or complications without support:

> *"I was heavily encouraged to medically manage the pregnancy but given how far along I was, I do not think this was safe. I miscarried overnight in the most agony I have ever felt with more blood than I*

could have possibly expected. Clots got stuck leaving me in agony. 999 wouldn't help; the hospital EPU was closed so there was no support available and the MFAU would not help given the stage of my pregnancy." (Woman/birthing person)

These concerns extended beyond clinical symptoms to emotional needs, with some feeling that their worries were not acknowledged or validated: ***"…did not care for my emotional needs as a pregnant woman who was experiencing a miscarriage."***

"The first time I was told they thought I was having a miscarriage, the male dr told me to go home and enjoy my Friday night and to come back in 2 days to confirm it was a miscarriage." (Woman/birthing person)

Additionally, women and birthing people felt they were discharged and dismissed without full information of the stage of their miscarriage and what else would still happen. It was often felt that additional time or support could have helped at this time:

"…was very ill once the baby passed, lost a lot of blood. Was […] scanned and told all tissue had passed (but it hadn't) and was kicked out of the room, still bleeding." (Woman/birthing person)

Women and birthing people also described additional concerns about fairness and consistency with some reported variations in approaches feeling linked to racialised treatment:

"Black and Asian women are known to be higher-risk patients in pregnancy. Despite this, my concerns were repeatedly dismissed. I am a mixed-race woman and a high-risk patient. I felt unheard, disregarded, and treated as a clinical experiment." (Woman/birthing person)

Support partners recalled instances where concerns such as reduced movements or general unease and anxiety were not taken seriously:

"Not once after the three times of her expressing concerns of reduced movements in those last weeks and days did anyone follow up with her at all, make an appointment for her to see her consultant, or advise her of induction at the earliest possible stage, in order to get her baby out. My niece would be here today if this had happened." (Support partner)

> *"Our daughter [...] and our unborn granddaughter [...] died [...], two days before a planned caesarean at 39+4 weeks [...] [Woman's name]'s first pregnancy [...] was complicated [...] She required emergency surgery and multiple blood transfusions. Because of this traumatic experience, [Woman's name] expressed anxiety from her very first midwife appointment during her second pregnancy and advocated for a caesarean delivery. It took considerable persuasion before a caesarean was agreed. We observed a culture that appeared resistant to caesareans generally, and even more resistant to scheduling one before 39 weeks, regardless of individual risk factors and the mother's own concerns about her history[...]The lesson we feel should be learned is that when a mother has a history of serious complications and is expressing genuine anxiety, her concerns should carry real weight in decisions about timing of delivery, rather than being managed within rigid adherence to standard timelines."* (Support partner)

Some partners also questioned the meaning of being labelled "high risk" when this did not lead to increased monitoring or changes in care. *"What is the point in labelling someone as high risk if there are no extra precautions taken?"*

Across all families it was clear there was a wide range of experiences but often they felt dismissed and minimised with significant events being missed. Families linked this to worsening outcomes and ongoing uncertainty about whether the loss could have been prevented:

> *"My daughter could still beautiful [sic] alive if they had all listened to my concerns and believed in my motherly instinct."* (Woman/birthing person)

Staff and system perceived errors and failings

Families often felt let down by staff and the systems which they expected to support them. This resulted in feelings that opportunities were missed or mistakes made that could have contributed to the loss or made the process even harder to cope with:

> *"Had the maternity unit competently followed hospital protocols (there were six separate opportunities identified where both lives would have been saved) we would still have our daughter and granddaughter alive."* (Support partner)

Ineffective use of scans was also highlighted by women and birthing people who felt that, if the scan information had been fully interpreted and utilised, then they would have had a different outcome:

> *"Scan results are not explained - it should be mandatory to highlight anything abnormal such as off the scale measurements and potential issues."* (Woman/birthing person)

Families also found that, once significant events had happened, staff often seemed unable or unwilling to fully account for what had happened. They described situations where they found it difficult to obtain clear explanations about the circumstances of death: *"They will not share information and either they can't or they won't answer our questions."* They reported repeated attempts to ask questions that were only partially answered or not answered at all and unacceptably long waits for reports, which increased feelings of distrust:

> *"There was a cover up in the Trust to the highest level. The Trust did not ensure involved doctors wrote their action in medical notes. [The] Trust did not interview key staff involved until at least three months after death."* (Support partner)

> *"As soon as our daughter was pronounced with no heartbeat, the consultant started to suggest obscure medical reasons for her death, even before she was born. The reality, we have since found out after eight years of fighting for the truth, was failure of the basic level of care."* (Woman/birthing person)

Women, birthing people and support partners reported multiple instances of feeling let down by the systems at a time when support was most needed. Dealing with a loss and additionally dealing with perceived errors or failings leaves families tackling multiple traumas at the same time, and this can have a significant impact on their experience, outcomes and healing:

> *"They gave her the wrong advice and told her to stay home. Our baby [...] died later that day."* (Support partner)

Impact of compassion following loss

Being in receipt of compassionate care from staff at the time of loss had an impact on the experiences of women, birthing people and their support partners: *"Staff gave me 5-star treatment to get through such a horrible time in our lives."* (Woman/birthing person)

Sadly, such behaviour is not consistently available to all, and a wide variety of both positive and negative experiences were described in the responses.

Women and birthing people recalled individual staff who stayed with them, offered reassurance or returned to check on them, sometimes going beyond their formal role: "*[staff member] stayed past the end of her shift to care for [baby name] and created precious keepsakes for us to treasure forever. She promised us that she would not leave [baby name]'s side and she remained with her until she was taken to the Chapel of Rest.*"

Support partners also valued staff who remained present, explained next steps and provided structure at this time: *"[the] bereavement team were all really kind and explained the whole process."* The actions of compassionate staff helped families feel cared for, recognised and supported:

> *"When the medical team first realised our daughter's heart had stopped, they took us into a discrete room for more monitoring. From that point onwards, I can only say the care that we received was exemplary. The team that was brought in to support the delivery of my daughter and look after us post-birth were clearly well trained and sensitive to us as parents. We, at no point, were made to feel that we didn't matter and they made it clear that I and my health was the priority - both in the immediate aftermath but also longer term."* (Woman/birthing person)

Where compassion was found to be absent, the experiences of women, birthing people and support partners were described as confusing and isolating and led to intensified distress in some instances: *"Awful. Truly awful. Even after 25+ years the matter of factness haunts me."* (Support partner)

Reports of being left alone for long periods of time after receiving devasting news were reported by women, birthing people and their support partners:

> *"[We were] told the bad news, given the scan photo and left in the corridor."* (Support partner).

Other women and birthing people described more subtle forms of absence which included where interactions felt rushed and significant events were handled in a procedural way by emotionally disengaged staff:

> *"I was spoken over by ward staff and left alone for hours. The whole experience was made worse by the people who were meant to help. I*

> *was made to feel like an inconvenience by the consultant and spoken to like I had no understanding."* (Woman/birthing person)

Support partners also reported feeling unsupported and uninformed after significant events: "*Left with dead baby. No idea what to do.*"

Across all responses, the differences in compassion received and the subsequent impact on experience was often attributed to individual staff rather than consistent practice: *"I don't believe the level of care and compassion is the same at every hospital."* (Woman/birthing person) Where staff were able to combine emotional presence with clear explanation, families were grateful and care was experienced as supportive even in traumatic circumstances.

Impact of the environment and procedures following loss

Support partners described the impact of physical environments on their experience. Being placed on wards alongside ongoing pregnancies and births was described as distressing:

> *"There should have been a room offered knowing what the outcome was going to be as baby was born at 20 weeks and not viable, instead of having to stay for three days on the labour ward, hearing other women giving birth."* (Support partner)

In contrast, access to bereavement suites or separate spaces provided privacy and reduced exposure to triggers, allowing families to spend time with their baby in a more supportive setting:

> *"The kindness shown to them by all medical staff involved was heart-warming. As a family we were able to spend a precious few hours with our grandson. The hospital that he was born in is fortunate to have a Baby Bereavement Suite [...] Her and her husband were able to remain in the bereavement suite for the duration of their hospital stay which really helped them."* (Support partner)

Experiences of the care of a baby who had died were particularly significant. Support partners described distressing experiences where handling or communication felt insensitive:

> *"The midwife was very abrupt. My daughter did not want at the delivery [...] to see her baby. The midwife was trying to insist she did, even saying that my granddaughter was in a sluice because there was nowhere else*

> *to put her! […] The midwife also misinformed us regarding the crematorium we could use as only certain ones accommodate baby cremations."* (Support partner)

Women, birthing people and support partners felt that their need to care for a baby who had died was often not supported by the staff who left them feeling unheard and dismissed:

> *"We asked if we could keep the remains but [were] told no - in a way that suggested that it was a bit disgusting. I just wanted to bury it. This then gave us the impression that it would just be treated like medical waste."* (Woman/birthing person)

A lack of clear information about where babies were or how they were cared for created ongoing uncertainty: *"We were told our twin's remains would be buried in a plot on the hospital grounds as they were not formed enough for our own burial. We weren't then given any more information as to where they were."* (Support partner)

Whilst families recognised the complexity of arrangements at such times, there was clear evidence that opportunities to provide better support were often missed:

> *"Our funeral director was amazing but he also informed us that he had only been at the labour ward the previous month to explain all the funeral arrangements and registration of the deaths to the midwives. I appreciate not all staff would be there, but this should have been relayed to everyone to save more heartache to add to the already bereaved family."* (Support partner)

Access to post loss support and follow up

Families had varied experiences of support after loss, these ranged from coordinated care to minimal follow-up and difficulty accessing appropriate help. This left families dealing with significant emotional and psychological impacts of the loss, and support partners felt the extra burden of care for the bereaved woman or birthing person as well:

> *"To refuse a woman in need of support, [in need] of therapy, the opportunity to talk to some in [a] professional capacity for eight months is utterly shocking."* (Support partner)

Both groups described inconsistency in follow up care, but some families did receive structured contact, including check-ins and continued involvement from bereavement staff:

> *"The bereavement team at both my local hospital and the children's hospital where my son died were incredible. I felt very supported by the staff who made [a] clear effort to help us following our son's death."* (Woman/birthing person)

Others described an abrupt end to care after discharge, with no follow-up on their wellbeing or the loss: *"Mental health checks should have been offered. Guidance on how to manage the miscarriage should have been offered."* (Woman/birthing person). This absence left families feeling unsupported at a time when needs were ongoing.

Following a loss, women and birthing people described feeling ongoing grief, which was often combined with anxiety or trauma. Some received counselling through hospital services but, sadly, others reported limited signposting or being given only written information, leaving them unsure how to access help: *"They just hand you a leaflet and off you go. I've had two miscarriages and both were treated the same*." This wide range of service availability had a significant effect on the women and birthing people who were trying to recover and the families supporting them:

> *"Her fiancé and her family took it in turns [...] with her, to write notes, collate memories [...] and process what had happened, but we were not specialists, we had [no] understanding of the loss of a child. This was a lived experience for all of us, but we couldn't properly advise her. Her condition spiralled, she stopped eating, she would have breakdowns in the streets, screaming and wailing at anybody that would listen that her baby had died. She had enough."* (Support partner)

Support partners also described long-term impacts and emphasised the difficulties accessing appropriate support and the need for these to be more readily available:

> *"I was offered no support after my daughter's baby died, ...I was not approached and not contacted about bereavement support, I did not know that it was available to me [...] I was unable to anticipate what help might be available to her nor to ensure that she received it. Navigating 'the system' is unnecessarily distressing."* (Support partner)*)*

Families reported counselling being unavailable, too short or not suited to their needs: *"availability of counselling, the quality of counselling and the duration of counselling is totally inadequate."* (Support partner)

"There is very little support available in terms of counselling following the death of a baby and it would be great to see this become a service provided by the NHS. There is inevitably a hugely negative impact on mental health after a loss of this scale and this quickly becomes dangerous. Trained baby loss counsellors would absolutely make a difference in terms of prevention of worsening mental health and rehabilitation back into work and returning to 'normal' life."
(Woman/birthing person)

In many cases, families relied on charities or private services, which introduces variation in availability and accessibility:

"What did help was my local rainbow clinic referred me to a baby loss psychology support pilot service which was intended for mothers but fathers could also attend." (Woman/birthing person)

"Throughout the whole ordeal of losing my baby I was failed and only received support via a local charity." (Woman/birthing person)

Where bereavement midwives or dedicated staff were involved, care was often described more positively. Support partners highlighted staff who maintained contact, provided guidance and offered continuity, which helped families navigate practical and emotional challenges. Women and birthing people also described these roles as valuable when available:

"We also had a counsellor dedicated to us from the hospital for 12 weeks, but she still made me feel safe and almost distanced herself from the hospital. She gave me a safe space to explore all the complex feelings, including blame and anger directed at her colleagues, without defending them. That in turn, made me trust her and resulted in my healing faster." (Woman/birthing person)

Variation was evident, with access to support feeling dependent on location, service provision and individual staff. Where follow-up was proactive and consistent, families felt supported, but where it was absent, families were left to manage ongoing distress without guidance:

> *"On Mother's Day, I am here filling in this form as a mother trying to support her daughter who lost her baby at 29 weeks gestation just days before Mothering Sunday last year [...] The `triggers' for emotional unravelling for women such as my daughter are endless and the psychological impact is with her, her partner, her family members and all her friends for her entire life. At this time the availability of counselling, the quality of counselling and the duration of counselling is totally inadequate."* (Support partner)

Serious illness because of pregnancy or birth

This section brings together the experiences of women, birthing people and support partners who experienced serious illness during pregnancy, birth or the postnatal period, drawing on accounts of clinical care, responses to symptoms, communication and interactions with healthcare staff. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Serious illness in this context refers to acute or severe health conditions affecting the woman, birthing person or baby that required urgent or complex care, including complications such as haemorrhage, sepsis, pre-eclampsia and significant mental health deterioration. Care during these events may involve midwives, obstetricians, anaesthetists, neonatal teams and specialist services across maternity settings.

Approximately, 1,500 women, birthing people and 100 support partners responded to the serious illness closed questions. Over two thirds of responses from women, birthing people and support partners showed that women and birthing people did not feel listened to, informed or confident in the care provided by staff during the serious illness. A total of 61% of pregnancy responses and 56% of support partners did not feel treated with compassion and sensitivity during this time.

Thematic narrative

A total of 1,152 women and birthing people (11% of pregnancy survey respondents) and 84 support partners (13% of support partner respondents) completed the free text question on experiences of care for serious illness because of pregnancy or birth.

Experiences of serious illness because of pregnancy or birth are reflected across six key themes:

1. Responses to symptoms, monitoring and escalation
2. Advocacy and Inclusion
3. Informed choice and shared decision making

4. Professionalism and compassion
5. Staffing levels and ward environment.

These experiences highlighted variation in how care was delivered during periods of acute need, particularly in relation to recognising and responding to deteriorating health, clarity of communication and the extent to which women, birthing people and support partners felt listened to and supported. They also showed how these factors influenced confidence in care, trust in healthcare staff and the longer-term physical and emotional impact of serious illness.

Responses to symptoms, monitoring and escalation

Women and birthing people who described reporting extreme pain, bleeding or illness, felt staff tried to "*normalise and trivialise extremely serious health conditions"* rather than act on their concerns: "*Basics of care were missed."* (Support Partner) Care was described as delayed or ignored right up to the point of it becoming an emergency. One support partner said that the "*sepsis my daughter suffered was completely avoidable had there been adequate post-natal care and support."*

"The constant dismissal of my daughter's continued health issues has also been very difficult – only for the situations to `suddenly' be discovered to be life-threatening – with an emergency operation to remove the retained placenta one month after birth, then the Deep Vein Thrombosis, this also having been dismissed as bruising." (Support partner)

Women and birthing people also described being labelled as first-time parents who were overreacting; this was also felt to have contributed to the development of serious clinical conditions:

"I had undiagnosed pre-eclampsia, despite reporting migraines, nose bleeds, fainting, inflammation, sickness, dizziness, protein in my urine - I was fobbed off as an anxious first-time mum." (Woman/birthing person)

Respondents felt the severity of their illnesses could have been avoided with better monitoring and staff following guidance: One mother said: "*NICE [National Institute for Health and Care Excellence] guidance was not followed from the moment I entered the ward."* Additionally, a support partner said: "*the lack of clinical knowledge amongst every midwife involved in this case was alarming."*

In the worst cases reported, women and birthing people were left with lifelong medical issues because of missed or poor care during a traumatic birth:

> *"As a result of appalling failures in postpartum bladder care my partner now has an irreversible lifelong bladder injury with no native bladder function. This was due to a bladder stretch injury incurred in the initial 18h after the birth and death of our baby. This bladder injury was worsened on two further occasions by the maternity team."* (Support partner)

Advocacy and Inclusion

Repeated experiences of not being listened to resulted in women and birthing people stopping raising concerns altogether. Support partners described having to take on advocacy roles, repeatedly raising concerns or challenging decisions to ensure appropriate care, one stating: "*If I hadn't have pushed, outcome could have been much worse."* One woman/birthing person said: "*We had to massively advocate for our baby and I worry for parents [who] are not in a position to do so."*

> *"Partner was twice given penicillin despite being allergic (in notes), I had to raise voice in theatre to prevent penicillin being administered; was then prescribed as an antibiotic which was intercepted by local pharmacist."* (Support partner)

Women and birthing people described feeling judged due to a protected characteristic or perceived lifestyle choices. One woman/birthing person said that staff: *"made their own assumptions about our life",* whilst a support partner reported that staff: "*felt like they were speaking a different language. I felt that [I] was not heard […] We felt watched and as though we were being problematic."* One woman/birthing person reported that she felt: "*The lack of curiosity to my pain and suffering can only be held to institutional racism."*

Certain conditions such as hyperemesis gravida were often described as not being well understood in hospitals and therefore not taken seriously. This led to women and birthing people needing to strongly advocate for the level of care they required:

> *"I think hyperemesis is misunderstood by even health professionals. It's not just nausea and vomiting it's debilitating and isn't always taken seriously. You have to fight for treatment."* [woman/birthing person]

Another woman/birthing person said she was simply told to ""eat ginger" even though she had lost over 10 per cent of her bodyweight. Another described staff as "dismissive of my neurodiversity and did not adjust accordingly."

Informed choice and shared decision making

Women and birthing people described limited involvement in decisions about their own care. This left them feeling that decisions were made for them rather than with them. As one woman/birthing person explained:

> *"I raised concerns repeatedly and was not listened to. That was awful, I am a direct and confident person, I felt dismissed and then unable to advocate for myself."* (Woman/birthing person)

Support partners also reported a lack of autonomy or involvement in care and excluded from discussions: "*At no point did my daughter feel in control of any decisions, treatment or aspect of her care."* (Support partner)

There were, however, examples of more inclusive care. Some participants described being involved in discussions, having options explained clearly and feeling able to ask questions. In these cases, both women, birthing people and support partners felt more confident and reassured:

> *"My daughter's care and the support her partner and myself received from [Hospital A] was excellent. The medical and midwifery staff acted promptly and efficiently to address her medical complications that were the result of poor and in my opinion negligent care from [Hospital B]."* (Support partner)

Professionalism and compassion

Women, birthing people and support partners reported interactions with rude and unprofessional staff at times when they were vulnerable, and communication was often unclear or absent. This resulted in support partners overhearing staff speaking about them or their partner in ways they found disrespectful. One support partner reported feeling: "*belittled, I heard demeaning jokes about my wife defecating bedsheets by [midwives]."* Others found staff using computers together to look at online shopping whilst they ignored calls for help. One woman/birthing person says she: "*was laughed at in theatre by a member of staff."*

Women, birthing people and support partners highlighted unkind throwaway comments from staff, with one being told: "*you should be grateful you are pregnant and get on with it"* (support partner). Another woman/birthing person said that after breaking down from tiredness, she was told by a staff member to: *"get used to it now that you have a baby."*

These interactions contributed to a lack of trust and women, birthing people and support partners feeling unsafe and uncared for in the hospital environment:

> *"I did not trust staff. I heard them discussing mistakes they had made and I saw the unhygienic conditions under which they operated, including dropping gloves on the floor and then putting them back on before treating patients."* (Woman/birthing person)

There were, however, reports of excellent care, where staff were attentive, considered and showed real compassion. One woman/birthing person described how her attentive midwife prevented a serious condition going unnoticed:

> *"I actually didn't know I was unwell, in a meeting with my consultant midwife she ask me and my partner if I was scratching excessively like this all time, my partner confirmed that I was driving him potty with it, she straight away called someone in for bloods, and within 24 hours I was booked for my C-section as my liver was struggling. The care I received was incredible. She always had my health and wellbeing at the top of her pile."* (Woman/birthing person)

Staffing levels and ward environment

Women and birthing people described needing help on wards but waiting long periods for staff to respond, including when pressing call bells. Some reported not ever being told how to request assistance:

> *"At no time on maternity ward did anyone explain to me how I could summon help (I had had an epidural and then a spinal and couldn't move!)."* (Woman/birthing person)

Staffing constraints were mentioned. As one support partner said, they felt there were: *"not enough staff to care"*, with another saying: *"there seems to be a get them out of here as fast as we can. There's no time to breathe there, you are just on a conveyor belt."*

Women and birthing people described wards where staff appeared overstretched and therefore had limited availability to provide support. Support partners also attributed delays in care to staffing pressures, limited bed availability and busy periods. One woman/birthing person says her mother had to help with care to compensate for lack of available staff:

> *"I collapsed with suspected sepsis and was given IV antibiotics. The medical care was good but there was a shortage of nurses/midwives. I was taken care of by my mum (a former nurse) and a senior midwife*

(she did not normally work directly on the ward) who stayed well beyond the end of her shift." (Woman/birthing person)

There were accounts where care needs were met appropriately. Some participants described receiving timely help and wards where staff were attentive despite pressures. Others reported receiving a mixture of good and bad care during their stay.

Mental Health

This section brings together the experiences of women, birthing people and support partners of psychological distress following pregnancy, birth and postnatal care, including emotional wellbeing, access to support, communication with services and wider factors shaping mental health. This section is drawn from the responses of women, birthing people and support partners to free text and structured scaled (closed) questions.

Mental health refers to emotional and psychological wellbeing during pregnancy, labour and birth, the postnatal period or following pregnancy loss or the death of a baby. This includes experiences such as anxiety, depression, trauma-related distress and other psychological difficulties, which may range from short-term challenges to more severe or long-lasting conditions.

Approximately 4,000 women, birthing people and 150 support partners responded to the closed questions related to mental health. Half of the women, birthing people and support partners felt that staff did not take their mental health concerns seriously during and after pregnancy. Only 11% of support partner responses agreed that they were offered appropriate support for their mental health and only 12% reported that the care they received supported their needs. Roughly one in four pregnancy responses reported that they received appropriate mental health support, but only 1 in 5 reported that the care they received supported their needs.

Thematic narrative

A total of 2,595 women and birthing people (26% of pregnancy survey respondents) and 105 support partners (17% of support partner respondents) completed the free text question on experiences of mental health.

Experiences of mental health during and after pregnancy are reflected across five key themes:

1. Experiences of distress and trauma
2. Accessing care
3. Listening and communication
4. Gaps in support

5. Additional pressures shaping mental health and support needs.

Across these themes, accounts described a wide range of psychological experiences, from short-term distress to long-term trauma. Responses highlighted differences in how quickly support was accessed, whether concerns were recognised and how consistently care was provided over time. They also showed variation in whether individuals felt listened to, supported and included, and how wider factors such as physical recovery, bereavement and previous mental health shaped needs for support.

Experiences of distress and trauma

Women, birthing people and support partners described a wide range of psychological responses following pregnancy, birth and postnatal care; these included anxiety, depression, intrusive memories, panic and loss of confidence. Experiences varied in severity and duration. Some developed rapidly following birth, particularly where care had been difficult or traumatic, and they often had a long-lasting impact:

"Losing my mind after birth was the worst experience of my life. It is over 20 years now and I am writing this in tears. It affected me for several years." (Woman/birthing person)

"I have developed PTSD, experiencing flashbacks, night terrors, panic attacks, and intrusive memories of both births." (Woman/birthing person)

The impact of prolonged pain in labour was also reported to have a significant influence on one woman/birthing person's mental health "*as this was the point [my] wife was suffering mentally and felt she was ready to die."* (Support partner)

Others described a broader sense of emotional overwhelm and difficulty adjusting in the early postnatal period, often combined with physical recovery and the demands of caring for a newborn: *"I did not adjust well to life as a new parent – anxious/upset/crying all the time/ anxious."* (Woman/birthing person)

Some women and birthing people also described challenges in their early relationship with their baby, including difficulties with bonding: *"I didn't bond with the baby for 3 months."* (Woman/birthing person)

Respondents described how these experiences affected their sense of self and ability to function in daily life. Women and birthing people reported reduced confidence, feelings of powerlessness and lasting impacts on work and identity:

"I had a very long recovery. My wound did not heal for a long time, my body did not feel right. I was thoroughly disheartened and unhappy. I was made to feel completely powerless. This traumatic birth experience

> *damaged my self-esteem, confidence, mental health and energy. I tried to go back to work after maternity leave, but I could no longer manage my role as a senior lawyer and felt the need to step down. I consider this was as a direct result of the trauma I had experienced at the [Trust Name].”* (Woman/birthing person)

These experiences illustrate how psychological distress was not limited to a single moment but could affect multiple aspects of life over time.

Support partners described similar patterns of distress, including anxiety, disrupted sleep and intrusive memories following traumatic experiences. In some cases, both members of the couple were affected: “*We both had flashbacks and distressing dreams”.* (Support Partner)

In other cases, partners described managing their own distress while supporting the woman/birthing person, including ongoing anxiety and fear linked to the experience:

> *“After the birth, the emotional strain continued. Watching my partner cope with physical recovery while also experiencing birth trauma, anxiety, postnatal depression, and PTSD was incredibly difficult. It added to my own feelings of stress and helplessness, particularly as she had to ask for help for six months before receiving therapy. During this time, I often put my own emotions aside to support her and our children, which led to me feeling emotionally drained and struggling to process my own experience.”* (Support partner)

Partners also described longer-term mental health impacts, including the need for medication and ongoing symptoms, “*I have since had anxiety and sleep issues requiring medication*.” (Support partner). Some described the cumulative effect on the family unit, where both partners experienced significant mental health difficulties. There were descriptions of how psychological distress affected relationships over time, including emotional strain and changes in intimacy.

Experiences of psychological distress were not uniform. Some participants described severe and ongoing difficulties, while others described gradual improvement over time. In some cases, individuals were able to make sense of their experience or begin to recover, particularly where support was accessed.

Accessing Care

Both women, birthing people and support partners described being referred or actively seeking help but then experiencing prolonged delays before receiving support, during which their mental health often worsened. Several women and birthing people reported

waiting *"months to be assigned a CBT therapist"* or not starting treatment until *"very near [their] due date"*.

Others described seeking help early, but experiencing delays before support was available, contributing to worsening mental health over time: *"so much had happened and worsened by then,"* (Woman/birthing person). In some cases, referrals were not acted on or only progressed after repeated requests, with one woman/birthing person describing how it *"took 3 months to get someone to speak to"* and another waiting *"six months before [accessing] appropriate treatment."* (Woman/birthing person).

Administrative failures, including incomplete or rejected referrals, further delayed access to care. Participants described instances where referrals were not processed or tracked effectively, resulting in extended periods without support and having to self-refer: *"I found out four months later, after chasing for where the referral was up to, that this was never completed."* (Support partner).

These experiences meant that support often arrived too late, with one woman/birthing person describing periods as *"so awful, so dark, so sad"* and expressing that earlier intervention could have mitigated the severity of their difficulties.

Accessing mental health support was often difficult at a time when women and birthing people felt most vulnerable. This experience reflects how negative responses to seeking help could have perceived consequences including questioning of parenting ability:

> *"I flagged concerns about mental health during the latter stages of my pregnancy and was fobbed off. Later I mistakenly brought it up again only to have it used against me to question my competency as a mother. Despite it being a really hard time of your life it was more dangerous to ask for help than to keep quiet. The 'help' isn't actually help, it's an attempt to undermine you and risk having your children taken away from you."* (Woman/birthing person)

Feelings of vulnerability contributed to women and birthing people delaying help-seeking. One woman/birthing person described being *"so consumed with my son and feeling like a failure that it was a while until I felt confident enough to seek help."* Concerns about not being taken seriously further delayed access to care despite ongoing need: *"it took me forever to seek help as I didn't think I would be taken seriously."* In some cases, perceptions of staff behaviour reinforced these fears, with one woman/birthing person noting, *"doctors' behaviour made me very nervous—they seemed checked out, stressed, and not to care."*

Women, birthing people and support partners described needing to make repeated efforts to access help, with delays, missed follow-up and administrative failures affecting whether support was actually received. Experiences ranged from being seen quickly and helped, *"they sent out an immediate mental health nurse to assess me"* (Woman/birthing

person) to long waits, unanswered contact and needing to chase services or seek help elsewhere.

For women, birthing people and partners, the effort required to access help sometimes led to alternative routes. Some paid privately, used employer-funded services, or accessed charities to receive faster help. These experiences varied by resources: those able to pay described quicker access, while others remained on waiting lists or without support.

Not all experiences were negative. Some participants described being able to access GP care, talking therapies or specialist services in a timely way, where referrals were completed and appointments arranged without repeated follow-up:

"My wife received care from perinatal mental health team and the mother and baby unit. They were understanding and caring and helped my wife get better. It has now been nine months since the birth, and she continues to receive support from perinatal mental health services."
(Support partner)

However, these examples were described alongside more frequent accounts of delays or breakdowns, showing variation in how reliably access pathways worked.

Listening and communication

Women and birthing people described raising concerns about their mental or physical health and not feeling taken seriously. Some reported repeated attempts to seek reassurance that were dismissed or minimised: *"I was told I was lucky that I hadn't experienced anything really all that bad",* particularly where they had prior loss or anxiety. In some cases, no one asked about emotional wellbeing at all, even after difficult births or repeated attendances: *"no one asked or cared about my mental health"*. Others were asked questions, but described them as brief or routine, without follow up or meaningful conversation with those conversations described as *"tick box"* and *"more like chit chat"*.

Support partners described similar experiences when raising concerns on behalf of the woman, birthing person or themselves. Some reported worries being downplayed: *"we were belittled and made to feel foolish"* or ignored: *"I raised my wife's mental health with staff repeatedly and was dismissed"* and in some cases being reassured that help would follow but then receiving no further contact.

Women and birthing people described how repeated dismissal or lack of response contributed to worsening anxiety, distress, and trauma:

"I was clearly suffering with anxiety during my pregnancy. I attended triage multiple times for reduced foetal movements and it was on file as being an IVF pregnancy. But for some reason no conversations were

ever had with me about how I was feeling or coping. By the time I got to the labour, my mental health was hanging on by a thread and the labour itself and the care I received traumatised me so deeply my mental health fell off a cliff. The lasting effects on me and my family have been extreme, my son is three and a half now and I am only just starting to feel more myself though the effects of the postnatal anxiety and PTSD caused by my labour still live with me." (Woman/birthing person)

This highlights how missed opportunities to listen and respond early can contribute to longer-term harm.

Alongside these experiences, women, birthing people and support partners described examples of clear, supportive communication. Women and birthing people highlighted relationships with midwives, GPs or perinatal teams where staff listened, noticed changes in mental health and arranged support. Support partners described professionals who took time to explain situations carefully, spoke directly to both members of the couple and answered questions in a way that reduced anxiety.

Overall, experiences of communication and listening varied widely. Some described feeling consistently listened to and supported, with clear communication throughout care. Others described isolated but significant moments of dismissal.

Gaps in support

This section explores how women, birthing people and support partners experienced gaps in mental health support across pregnancy, birth and the postnatal period. Across both groups, there were recurring themes of support not being provided when needed, ending too early or not continuing as distress persisted.

Support partners described receiving little or no mental health support at any stage, even during periods of significant distress: *"there was no support for [fathers'] mental health."* In some cases, they described feeling overlooked entirely within maternity pathways: *"we were left to fend for ourselves."*

The harm is long lasting:

"After the birth of our daughter a year after the loss of our son, my wife fell into deep postnatal depression, with significant PTSD as well. As the father and husband, I have done what I can without professional assistance/support to manage our family circumstances. I fully put the state of my current mental health, solely down to the lack of care and medical negligence my wife received after the stillbirth of our first born

> *son, and then subsequently down to the lack of postnatal care provided, after the birth of our daughter."* (Support partner)

Women and birthing people similarly described gaps in ongoing support, particularly after leaving hospital: *"support stopped after discharge".* Some reported initial contact or referral but no sustained follow-up. Others described wanting regular check-ins, continuity with one professional and support that extended beyond the immediate postnatal period.

Respondents in both groups described needing help at multiple points over time, rather than at a single moment. This included early pregnancy, after birth and longer-term recovery. Where care did continue, such as ongoing GP support or therapy, it was described as stabilising and helpful. Where it stopped early or was unavailable, people described managing distress without guidance.

There was also variation in the type of support offered. Some partners described generic therapies that did not match trauma or bereavement experiences, while women and birthing people expressed a preference for specialist perinatal or trauma-informed care:

> *"The mental health difficulties I experienced after a traumatic birth sustaining an obstetric anal sphincter injury were misdiagnosed as postnatal depression. There was no targeted mental health support for PTSD after birth, or acknowledgement that a severe birth injury affects you psychologically as well as physically. I felt very judged and discriminated against with my mental health struggles, and the tone seemed to be a judgement on my ability to adjust to motherhood rather than acknowledging my trauma. Mental health concerns were escalated, but not in a way that I felt supported. The way I was treated compounded my trauma and adversely affected my mental health."* (Woman/birthing person)

These experiences led to suggestions for more proactive and routine mental health checks, including support for both parents.

Additional pressures shaping mental health and support needs

Women, birthing people and support partners described how a range of additional factors, including physical health, feeding experiences and bereavement shaped their mental health and influenced the type of support needed. These factors often interacted with care experiences, increasing distress and highlighting gaps in how support was provided.

Women and birthing people described how physical health problems and recovery following birth had a significant impact on their mental health, particularly where pain or

complications were not recognised or treated. There were accounts of how ongoing symptoms and injuries affected both physical and emotional recovery with one account highlighting a gap in this being recognised:

"My mental health challenges arose primarily after the birth, due to the traumatic delivery, ongoing pain, and the physical changes I experienced, including urinary and faecal incontinence and the loss of labial tissue, which went undocumented and untreated for months."
(Woman/birthing person)

Alongside this, some women and birthing people described how previous mental health conditions or trauma were recorded but not meaningfully considered within their care:

"In the immediate aftermath of birth, I was experiencing severe deterioration in my mental state however this was not adequately assessed, recorded or taken into account until I had to be admitted for psychiatric support and medicated. The warning signs should have been recognised much earlier given my medical record and history of complex MH issues. A purple flag on my notes and formal diagnoses of multiple conditions seemed to account for nothing." (Woman/birthing person)

This meant known risks were not always used to guide support or decision making: *"No one asked or cared about my mental health at my antenatal appointments despite having a long history of mental health problems."* Others highlighted how previous experiences, including earlier postnatal depression or loss, were not routinely acknowledged: *"Previous losses should be acknowledged and discussed rather than brushed over."* Where this context was overlooked, participants described missed opportunities for earlier or more tailored support.

Support partners highlighted the impact of bereavement, with many describing ongoing grief following stillbirth or baby loss and its effect on the wider family. One described how *"following the death of our baby, both mine and my partner's mental health declined"*, while another explained:

"I have not had or been offered any mental health help. We are a big family and nobody has been offered any help. I can't come to terms with this and it is affecting my life daily. I am grieving for my daughter and son-in-law and for our first grandson, who will never be. I am not sure

> *how they will ever get over this but it is affecting the whole family, none of whom have been offered any counselling."* (Support partner)

These experiences often extended over time and influenced outlook on the future, including decisions about further pregnancies, with one partner reflecting that it had made them *"very sceptical about having another child."*

Participants also described how aspects of care itself contributed to psychological harm, particularly where communication lacked compassion or where care was perceived as inadequate. Some described a *"lack of compassion and humanity towards the family"*, while others felt their experiences had a lasting impact due to the care they received. However, these experiences were not universal. Some respondents described helpful interventions, including counselling, therapy or support from specialist services and charities, which were experienced as beneficial where available.

Support partners also described significant emotional strain while supporting the woman/birthing person, often without recognition of their own needs. Some felt physically present but not meaningfully included in care: *"I felt completely sidelined and ignored. I was an accessory to all this."* (Support partner) Another described being *"included in everything, but mainly felt like a spare part."* (Support partner). Fathers reported that their mental health was rarely considered, with comments such as *"fathers are not asked how they are at any stage"* and *"there was no support, check-ups or discussions about mental health for the father."*

Conclusion and cross-cutting findings

This report brings together what people chose to share about their experiences of maternity and neonatal care across England. It reflects a wide range of experiences across pregnancy, labour and birth, postnatal care, neonatal care, experiences of loss, serious illness and mental health.

Across the pathway, accounts described both care that felt compassionate, responsive and well-coordinated, and care that felt difficult to navigate, inconsistent or, at times, unsafe. These experiences were often not defined solely by clinical outcomes, but by how care was delivered and how people were treated throughout their journey.

A number of cross-cutting themes can be seen throughout the findings. These themes highlight aspects of care that were consistently important in shaping how people understood and experienced their care.

Consistency and variation in care

Experiences highlighted differences in how care was delivered between services, settings and individual staff. Some people described continuity, clear processes and coordinated care. Others described variation in access, communication and support, with care feeling dependent on the context in which it was received. This variation was evident across all stages of the pathway, from early pregnancy through to postnatal and specialist care.

Listening and responsiveness to concerns

A recurring feature across many accounts was whether people felt their concerns were recognised and acted on. Experiences differed in how concerns were acknowledged, responded to and followed up. In some cases, people described feeling confident that concerns were taken seriously. In others, they described needing to repeat concerns or finding that changes in their condition were not fully recognised at the time.

Communication and information

Communication was central to how care was experienced. Clear, timely, respectful and compassionate communication supported understanding and helped people to feel reassured and involved. Where communication was limited, unkind, discourteous, unclear or inconsistent, people described uncertainty about what was happening, what to expect and what choices were available to them. These experiences were reported across routine care as well as more complex and acute situations.

Involvement in decision-making

Experiences of involvement in decisions about care varied. Some people felt actively involved, with information that supported them to make decisions that reflected their preferences and circumstances. Others described situations where they did not feel fully included or informed, particularly during labour and birth, neonatal care and in situations

involving serious illness. The extent to which people felt able to ask questions and understand decisions was an important part of how these moments were experienced.

Continuity and coordination across services

Many accounts reflected challenges in how care was coordinated between different professionals and services. Breaks in communication and limited continuity were described at multiple points, including transitions between hospital and community care. In some cases, people felt responsible for sharing information between services or managing aspects of their own care. Where continuity was present, it supported trust, understanding and a more joined-up experience.

Staff relationships and behaviours

Interactions with staff were a key part of how care was experienced. Compassion, empathy and respectful treatment were consistently described as important. Positive experiences often centred on staff taking time to listen, explain and provide reassurance. More difficult experiences were linked to limited communications between staff, and mothers and families feeling dismissed, not taken seriously or not treated with sensitivity, particularly during more vulnerable or complex situations.

Access and timeliness of care

Experiences of accessing care included both how quickly care could be reached and how easily support could be obtained when needed. Differences were described in relation to accessing appointments, getting advice and receiving support during and after care. Delays or barriers to access sometimes influenced how confident people felt in the care they were receiving.

Emotional and psychological impact

Across all stages of the pathway, experiences were described as having emotional as well as physical impacts. This included routine care, complications, neonatal admission, serious illness and experiences of loss. For some, these impacts were short-term. For others, they extended beyond the immediate period of care and influenced how they reflected on their experience over time. Support for emotional wellbeing, when present, was a significant part of how these experiences were understood.

Support for partners and families

Support partners, family members and others involved in care also described their experiences of being included or not included. This covered their involvement in communication, decision-making and support during key moments. Their ability to access information, feel recognised as part of the care experience and receive support in their own right influenced how they experienced their role.

Conclusion

Taken together, these findings point to the importance of care that is not only clinically effective but also consistent, well-coordinated and responsive to individual needs. Experiences were closely linked to how people were listened to, how information was shared and how they were involved in decisions about their care.

While the accounts shared in this report do not represent all experiences of maternity and neonatal services in England, they provide detailed insight into what matters to those who chose to respond. They highlight areas where care is experienced positively, as well as areas where it can feel difficult to access, navigate or understand.

Appendix A: Overall respondent demographics

Appendix A shows the breakdown of the survey responses received for both the pregnancy and the support partner survey. It also provides details on the breakdowns of different demographic groups. As the survey was self-selected and not representative of the population who access maternity services, no comparisons with the general population have been made.

An asterisk (*) in the table represents data that has been suppressed because it is below the required threshold of 10 to ensure respondents maintain their anonymity. A dash (-) is for demographic groups that were not represented in the survey responses.

Table 2. Region at the time of pregnancy for both surveys

Region	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
Midlands	1717	19%	93	19%
Southeast	1480	16%	95	20%
Northeast and Yorkshire	1259	14%	56	12%
London	1095	12%	46	9.6%
East of England	1093	12%	60	13%
Northwest	1088	12%	49	10%
Southwest	902	10%	46	9.6%
Unknown region	345	4%	33	7%

A respondent's social economic background (otherwise known as the level of 'deprivation' in the small area in which they lived) has been calculated using the full

postcodes by respondents. Based on the postcode a respondent provided, they have been categorised into one of ten indices of deprivation using the English indices of deprivation 2025 (the index of multiple deprivation 2025).

The Index of multiple deprivation (IMD) measures multiple dimensions of neighbourhood deprivation at a small area level across England. The IMD can then be split into 10 equal-sized groups (the deciles), with rank 1 being the most deprived areas and rank 10 being the least deprived areas. The decile given is relative to the area the respondent lived in at the time of the pregnancy – it does not mean they as an individual were experiencing a defined level of deprivation. The proportion of responses that provided a postcode and fall into one of the 10 deciles can be seen in the table below:

Table 3. Socio economic background at the time of pregnancy for both surveys

Indices of deprivation	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
1	402	5.2%	15	3.7%
2	598	7.7%	31	7.7%
3	661	8.5%	26	6.5%
4	685	8.8%	51	12.7%
5	805	10.4%	32	8.0%
6	843	10.8%	29	7.2%
7	943	12.1%	62	15.4%
8	924	11.9%	54	13.4%
9	922	11.9%	52	12.9%
10	851	11.0%	35	8.7%
Unknown index	140	1.8%	15	3.7%

Table 4. Age band at the time of pregnancy for pregnancy survey

Response	Number of responses	Percentage of responses
Up to 24	718	7%
25 to 34	6353	63%
35 to 44	2824	28%
45 or above	106	1%
Prefer not to say	16	0.2%
Unknown age	24	0.2%

Table 5. Age band at the time of the pregnancy for support survey:

Response	Number of responses	Percentage of responses
Up to 24	27	4%
25 to 34	174	28%
35 to 44	158	25%
45 to 54	58	9%
55 to 64	99	16%
65 or above	31	5%
Prefer not to say	23	4%
Unknown age	53	9%

Table 6. Ethnic Group for responses to both surveys

Response	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
White	8806	88%	501	80%
Asian or British Asian	535	5%	21	3%
Mixed or multiple ethnic groups	295	3%	14	2%
Black, Black British, Caribbean or African	227	2%	17	3%
Other ethnic groups	52	0.5%	*	*
Prefer not to say	-	-	*	*
Unknown ethnic group	126	1%	60	10%

Table 7. Health status at the time of the pregnancy for responses to both surveys

Response	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
Had a physical or mental health condition or illness at the time of pregnancy	2728	27%	80	13%
Did not have a physical or mental health condition or illness at the time of pregnancy	6919	69%	429	69%
Prefer not to say	215	2%	39	6%
Health status unknown	179	1.8%	75	12%

Table 8. Sexual orientation at the time of the pregnancy for responses to both surveys

Response	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
Heterosexual or straight	9294	93%	483	78%
Bisexual	342	3%	*	*
Gay or lesbian	69	1%	12	2%
Other	42	0.4%	*	*
Prefer not to say	138	1%	36	6%
Unknown sexual orientation	156	2%	79	13%

Table 9. Religion or belief at the time of the pregnancy for responses to both surveys

Response	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
No religion	5326	53%	241	39%
Christian	3305	33%	225	36%
Muslim	288	3%	13	2%
Hindu	108	1%	*	*
Sikh	78	0.8%	*	*
Jewish	59	0.6%	*	*
Buddhist	-	-	*	*
Other	149	1%	*	*
Prefer not to say	264	3%	37	6%
Unknown religion or belief	448	4%	89	14%

Table 10. Sex of responses to support partner survey

Response	Number of responses	Percentage of responses
Female	330	53%
Male	248	40%
Other	*	*
Prefer not to say	*	*
Unknown sex	36	6%

Table 11. Whether gender identification was the same at time of pregnancy for both surveys

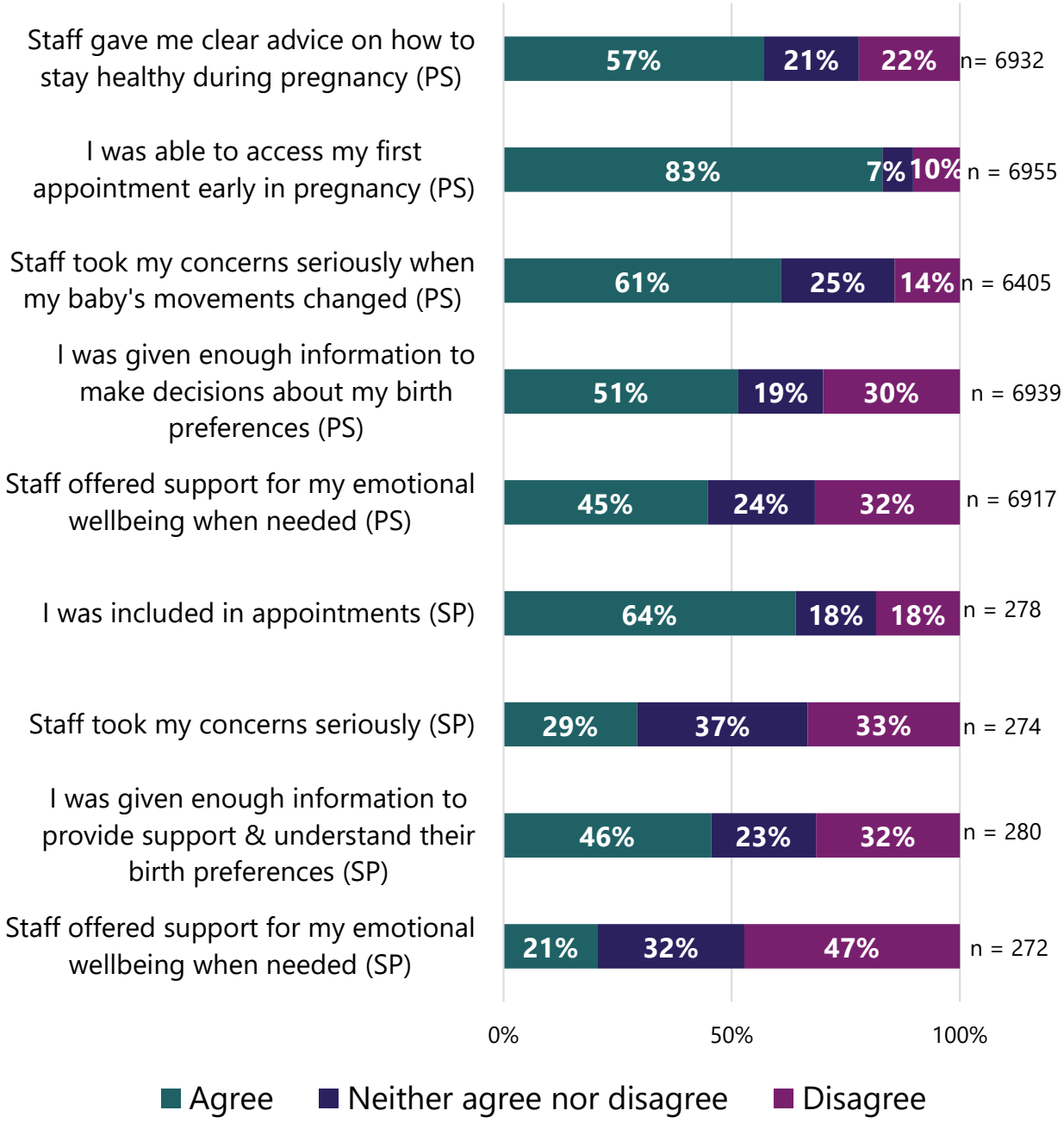
Response	Number of responses (pregnancy survey)	Percentage of responses (pregnancy survey)	Number of responses (Support partner survey)	Percentage of responses (Support partner survey)
Yes	9835	98%	532	39%
No	39	0.4%	85	36%
Unknown response	168	2%	*	*

Appendix B: Additional details for the structured questions

This section shows the range of responses to the structured questions and demographic differences which were found in the responses to the pregnancy survey.

Pregnancy

*Pregnancy question responses for the P*regnancy survey (PS) and the Support partner survey (SP)



Additional demographic differences in the pregnancy survey

Staying healthy during pregnancy

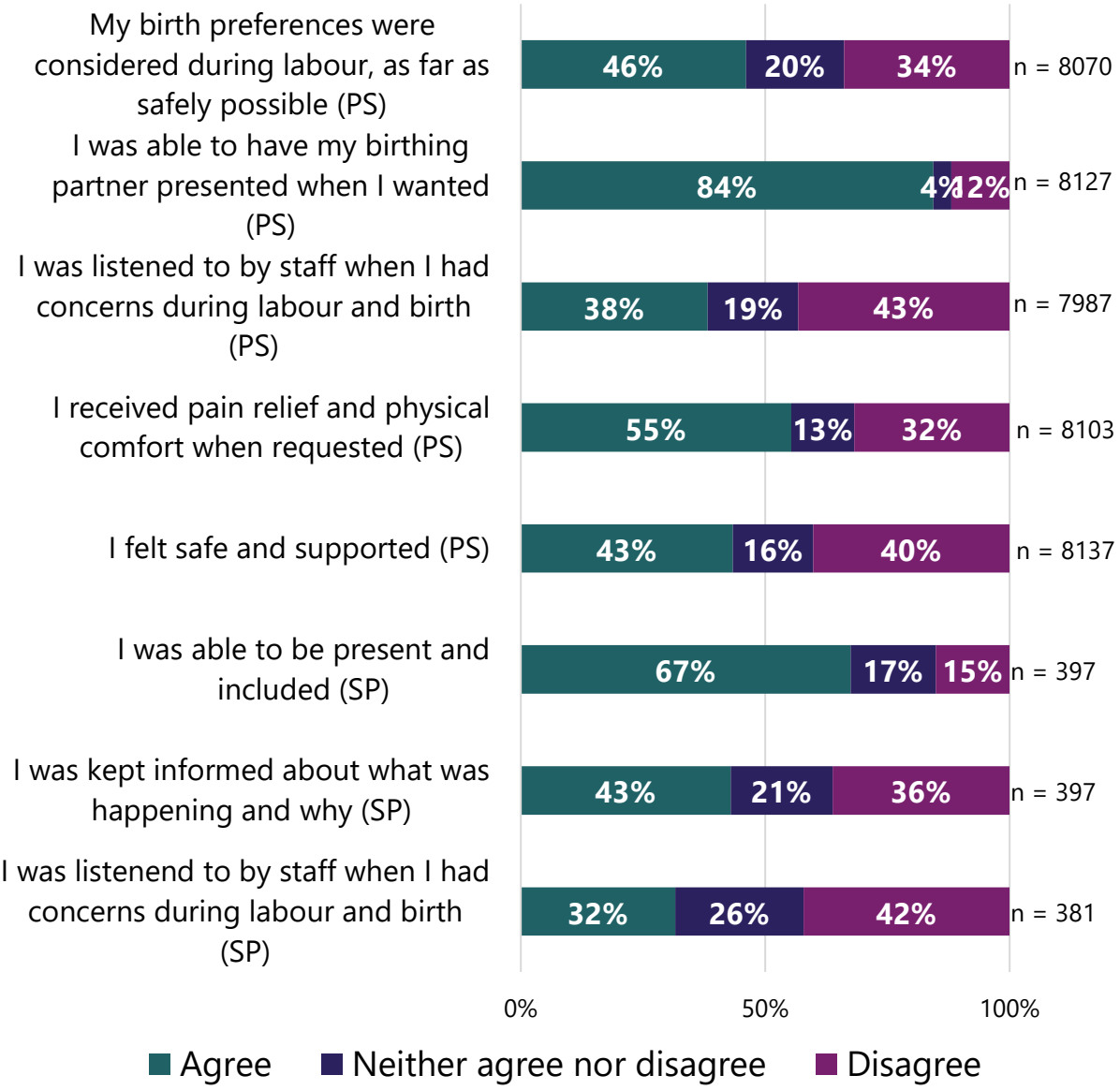
When asked about whether they received clear advice on how to stay healthy during pregnancy from staff, responses varied by ethnicity – 'Asian or British Asian' (45%) and 'Mixed ethnic group' (49%) responses were less likely to agree with the statement than 'White' (58%) or 'Black' (53%) responses.

Information provided to support informed choice

Those aged up to 24 (40%), in the 'Asian or British Asian' ethnic group (39%), in the 'Mixed multiple ethnic groups' (44%), or had a physical or mental health condition (47%) were less likely to agree that they were given enough information to make decisions about their birth preferences. This was compared to those aged 25 to 34 (51%) and 35 to 44 (55%), in the 'White' (52%) or the 'Other Black, Black British, Caribbean or African' (50%) ethnic groups, or did not have a physical or mental condition (54%), who were all more likely to agree with this statement.

Labour and birth

Labour and birth question responses for the Pregnancy survey (PS) and the Support partner survey (SP)



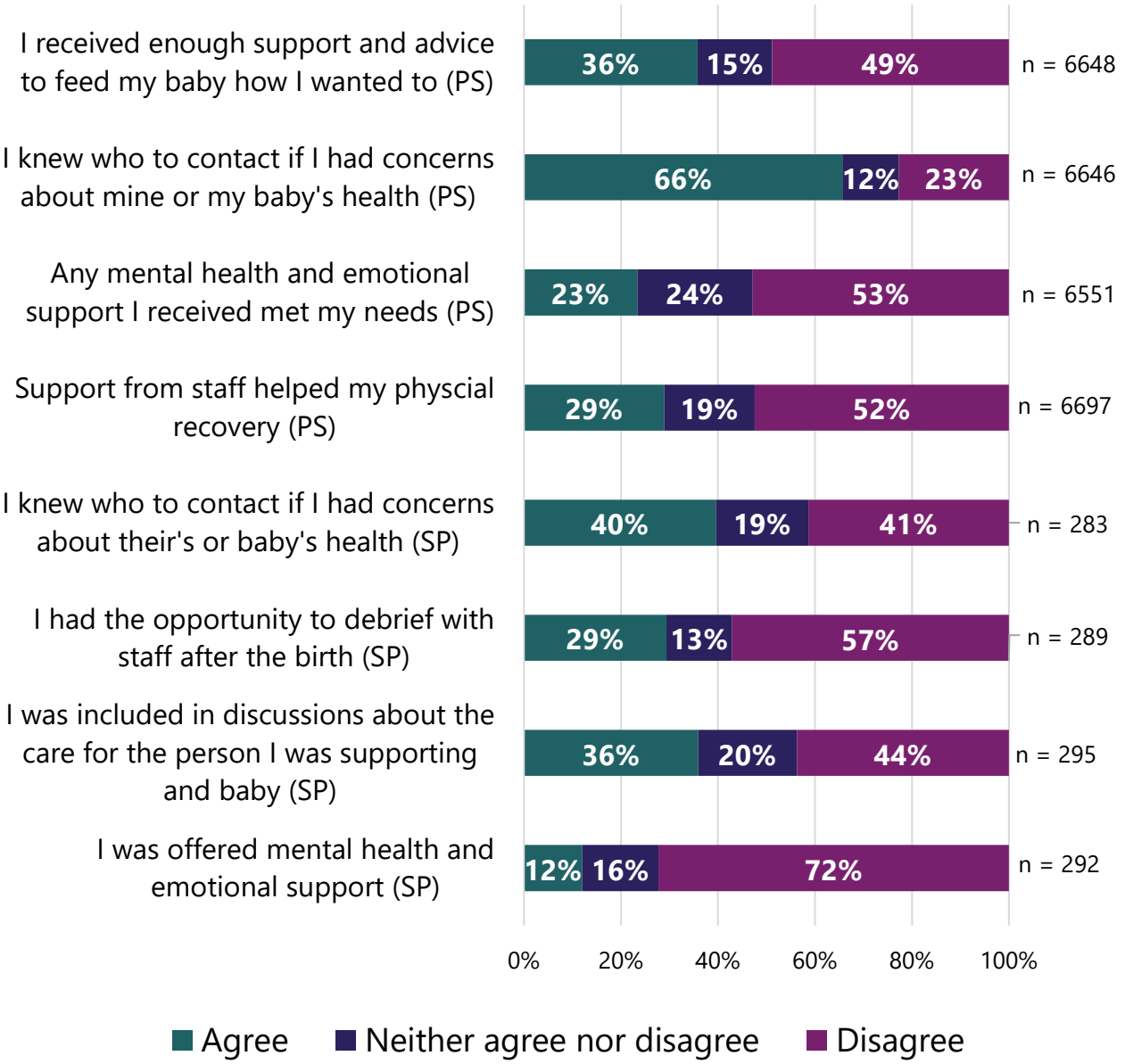
Additional demographic differences in the labour survey

Birth preferences during labour and birth

Responses from the least deprived decile were more likely to agree (52%) that their birth preferences were considered during labour than those in the most deprived decile (42%).

Postnatal Care

Postnatal care question responses for the Pregnancy survey (PS) and the Support partner survey (SP)



Demographic differences in the pregnancy survey

Responses with a physical or mental health condition at the time of pregnancy were more likely to disagree (60%) that any mental health and emotional support they received met their needs compared with those without a condition at the time of pregnancy (49%).

Those aged up to 24 were more likely to disagree (56%) that they received enough support and advice to feed their baby how they wanted to than those aged 25 to 34 (49%) and 35 to 44 (47%).Those from the 'Asian or British' Asian group were more likely to

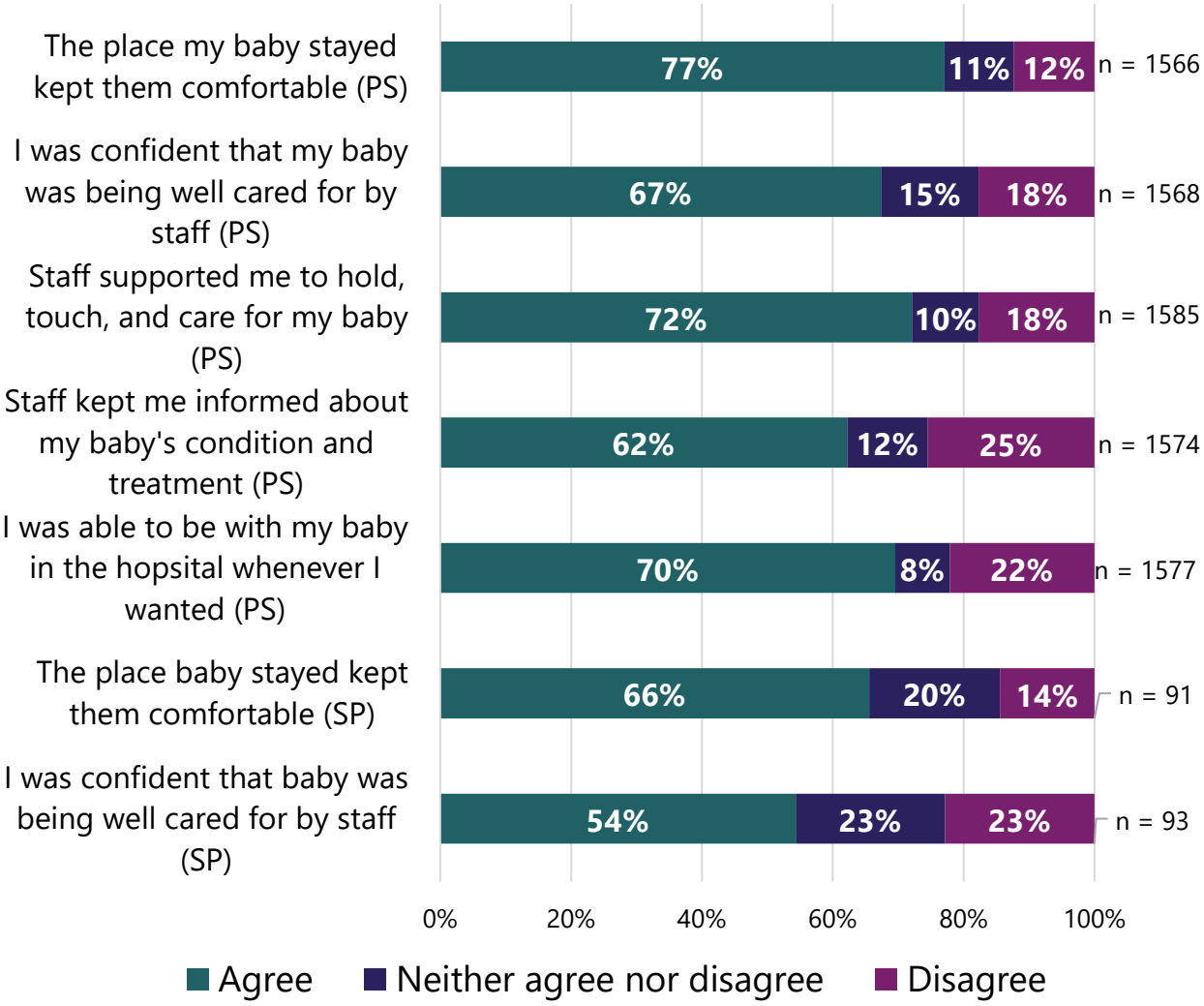
disagree (56%) with this statement than those from the 'Black, Black British, Caribbean or African' (40%) and 'White' (49%) ethnic groups.

There was a similar pattern for those with a physical or mental health condition at the time of pregnancy – 52% of responses with a condition disagreed that they received enough support and advice to feed their baby how they wanted compared with 47% of those without a condition.

Responses from those aged up to 24 (22%) were less likely to agree that the support they received from staff helped their physical recovery than those aged 35 to 44 (31%).

Neonatal Care

Neonatal care responses for the Pregnancy survey (PS) and the Support partner survey (SP)



Demographic differences in the pregnancy survey

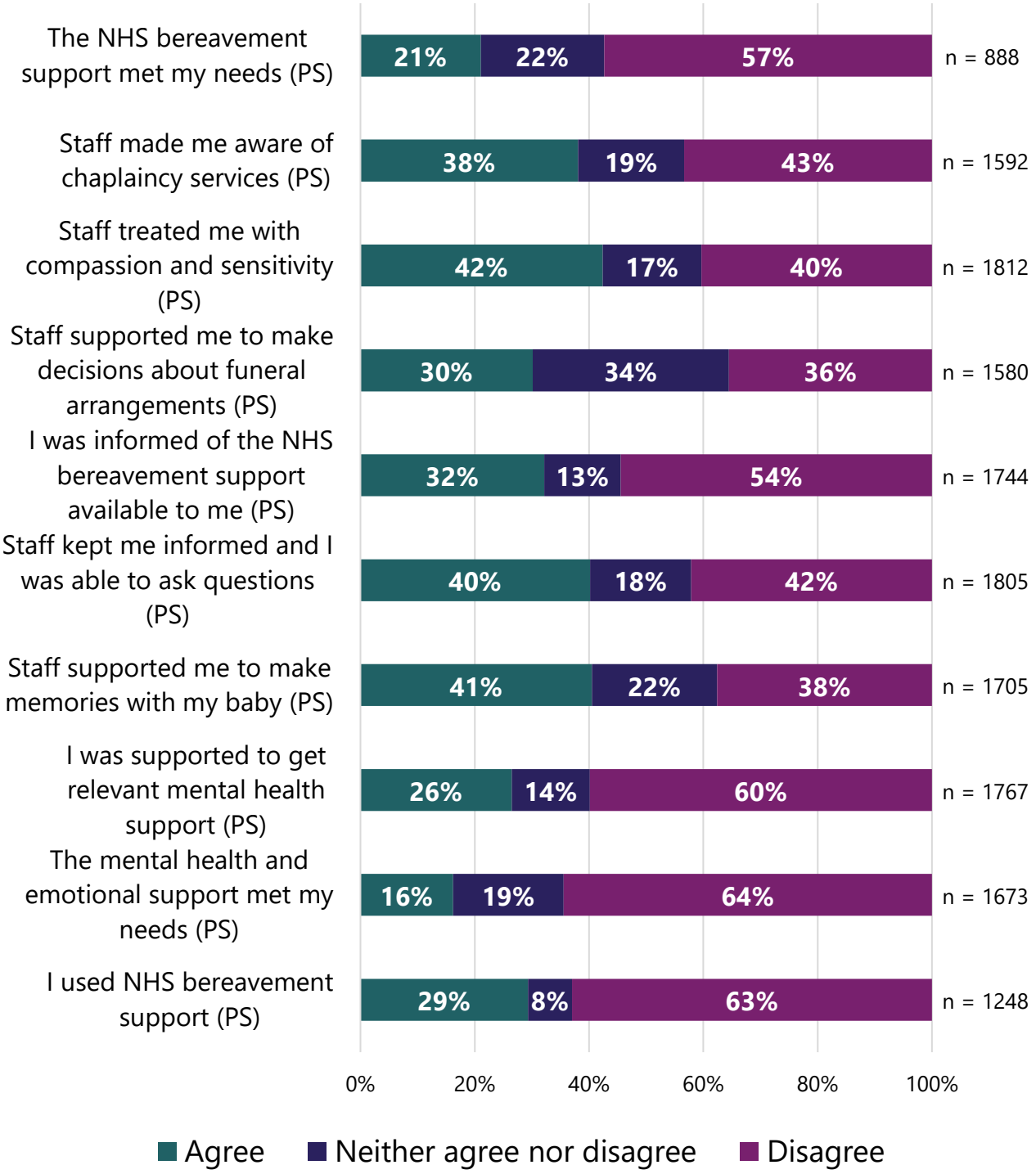
Responses from those aged up to 24 at the time of pregnancy were less likely to agree (48%) that staff kept them informed about their baby's condition and treatment compared to those aged 25 to 34 (65%) and 35 to 44 (62%).

Experiences of loss

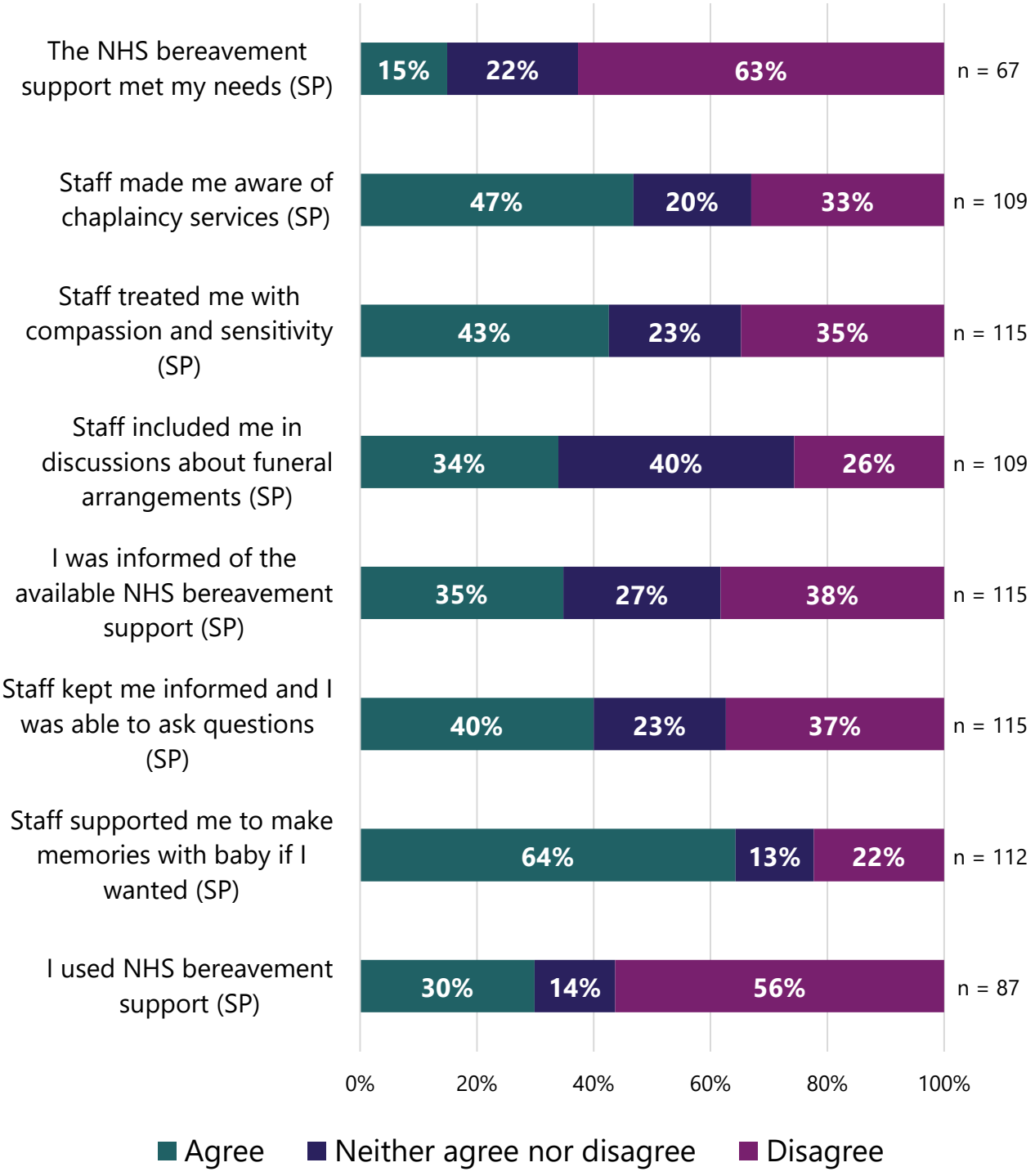
Pregnancy and baby loss responses for the Pregnancy survey (PS) and the Support partner survey (SP)

Due to the number of questions in this section, the support partner and pregnancy survey findings are displayed in two separate graphs.

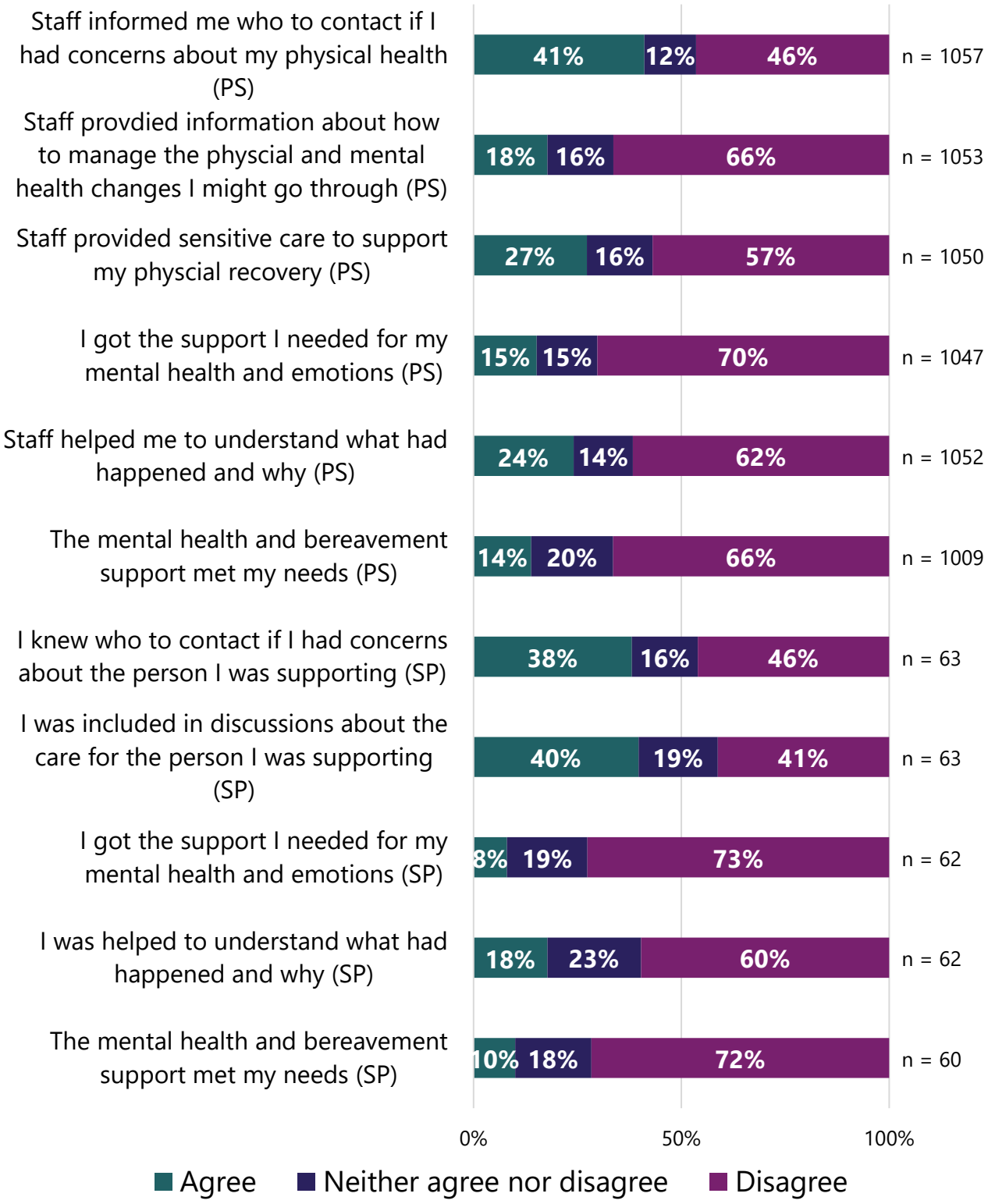
Pregnancy survey – pregnancy and baby loss



Support partner survey – pregnancy and baby loss



Postnatal care following a pregnancy and/or baby loss responses for the Pregnancy survey (PS) and the Support partner survey (SP)



Additional demographic differences in experiences of care following a pregnancy and baby loss in the pregnancy survey.

The findings reported below relate to questions from both the pregnancy and baby loss and postnatal care following a pregnancy and baby loss sections.

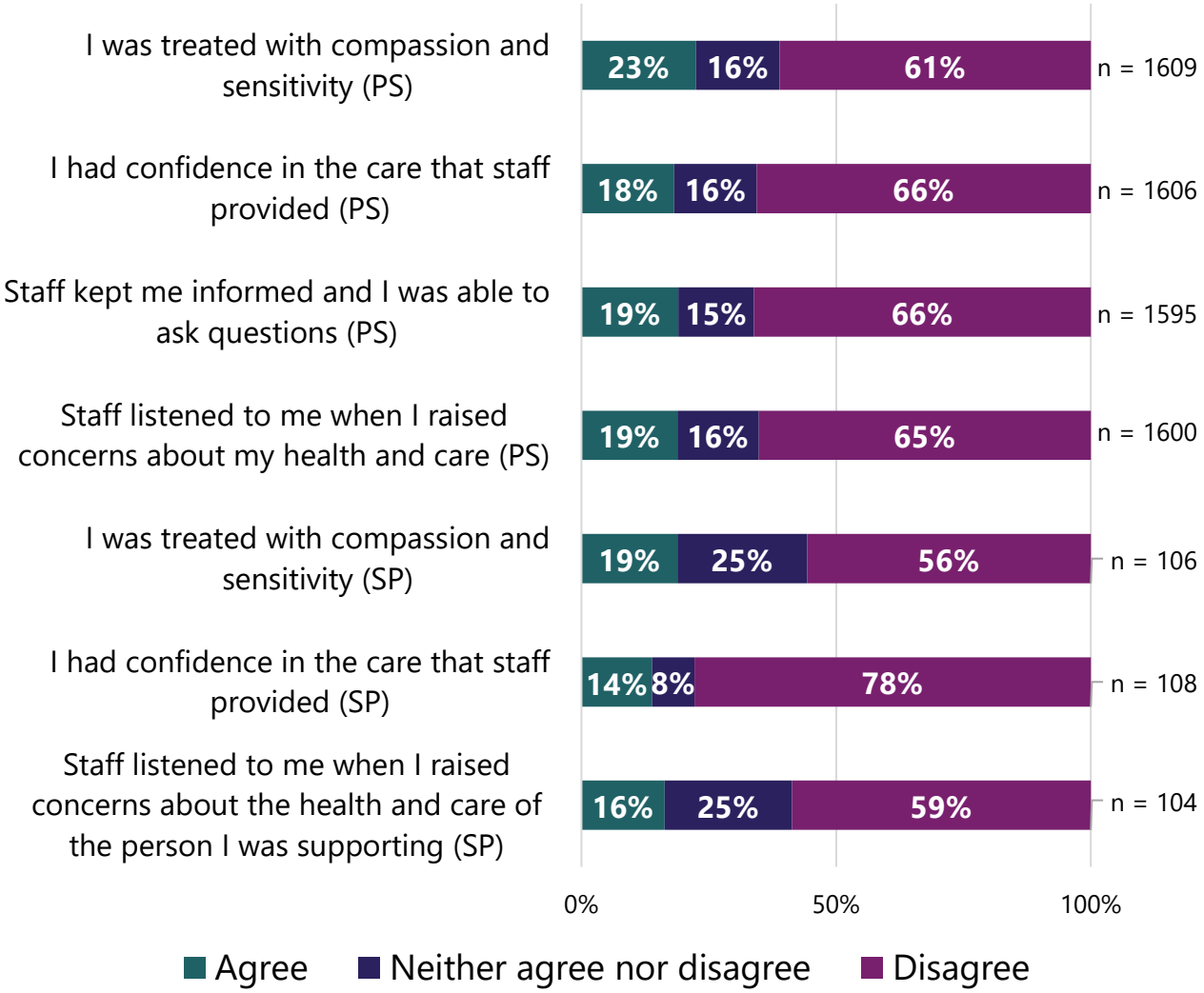
50% of responses that had a physical or mental health condition at the time of pregnancy disagreed that staff made them aware of chaplaincy services available to them. This is compared to 41% of responses from those who did not have a physical or mental health condition at the time of pregnancy.

Responses that reported a physical or mental health condition at the time of pregnancy were less likely to agree (35%) that staff informed them who to contact if they had concerns about their physical health, than those who did not have a condition at the time of pregnancy (44%)

Those aged up to 24 were more likely to *disagree* (52%) that staff treated them with compassion and sensitivity following their pregnancy or baby loss than those aged 25 to 35 (38%) and 35 to 44 (40%).

Serious illness because of pregnancy or birth

Serious illness because of pregnancy or birth responses for the Pregnancy survey (PS) and the Support partner survey (SP)

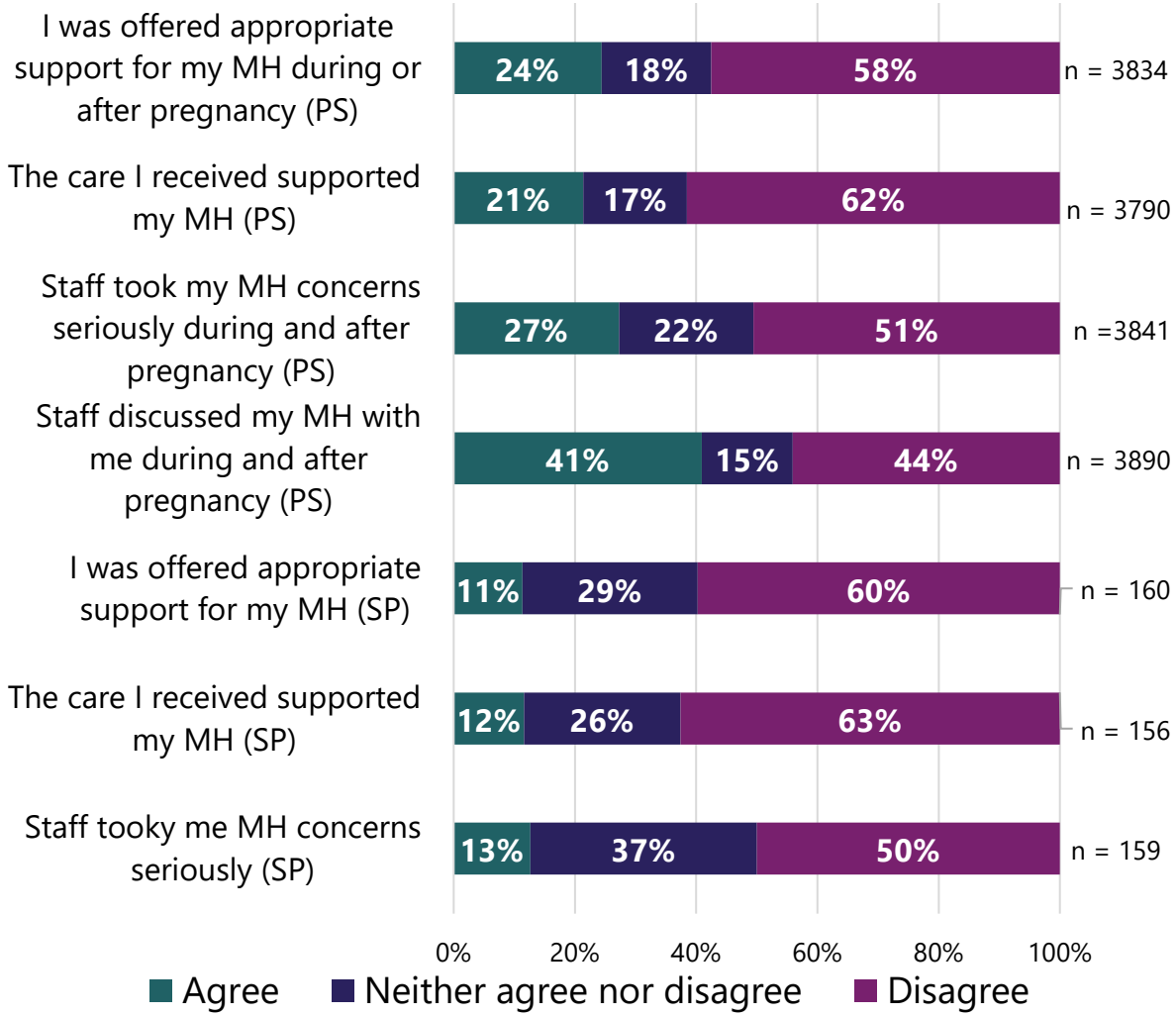


Demographic differences in the pregnancy survey

There were no clear differences in the typical experiences of different demographic groups. Although some variation in responses was observed, all groups reported similarly negative experiences of care during serious illness related to pregnancy or birth.

Mental health

Mental health question responses for the Pregnancy survey (PS) and the Support partner survey (SP)



Demographic differences in the pregnancy survey

Responses from those aged up to 24 were least likely to agree (19%) that staff took their mental health concerns seriously during and after pregnancy, whereas 28% of those aged 25 to 34 and 30% of those aged 35 to 44 agreed.

1 in 5 (20%) responses from the 'Asian or Asian British' ethnic group and less than 1 in 5 (15%) responses from the Black, Black British, Caribbean or African agreed that their mental health concerns were taken seriously by staff compared to nearly 1 in 3 responses from mixed ethnic groups (29%) and the 'White' ethnic group (28%).

There was a clear pattern as well by deprivation – 55% of responses from the most deprived decile disagreed that their mental health concerns were taken seriously compared to 45% of responses from the least deprived decile.

55% of responses from those aged up to 24 disagreed that staff discussed their mental health with them during and after pregnancy. They were more likely to disagree than those aged 25 to 34 (42%) and 35 to 44 (44%).

Those from the Asian or British Asian ethnic group were more likely to disagree with this statement (55%) compared with those from the mixed (46%%) and the 'White' ethnic groups (43%)

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