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Feedback in maternity services

National Report

Ipsos MORI

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1. Introduction

This report presents the findings of a research project undertaken by Ipsos MORI, with input from Dan Wellings at The King's Fund, on behalf of NHS England, exploring the opportunities for the collection of digital feedback in maternity services.

1.1 Background to the research

The National Maternity Review report Better Births sets out the importance of data and asserts that if teams, organisations and systems are to improve, they must know where they are, how they compare to others and to the best, and how they are improving over time. As part of its examination of data and information sharing, Better Births finds that the appropriate, regular and accurate capturing of outcomes of care reported by women and families is currently proving to be a challenge.

The Data and Information Sharing work stream of the Maternity Transformation Programme (MTP) is responsible for implementing the data and information related recommendations of the National Maternity Review. The aim of the work stream is to improve data collection, quality and sharing to drive maternity service improvement at local, regional and national levels. The work stream is exploring what improvements can be made to existing data collections as well as what new work can be done to get a better understanding of women's experiences of using maternity services and in particular how digital technology can be leveraged to capture this.

1.2 Objectives of the research

In line with the work of the Data and Information Sharing work stream of the MTP, Ipsos MORI was commissioned to deliver two key objectives:

- To provide recommendations that will improve the digital collection of data on women's experiences of using maternity services, by exploring the feasibility of a data collection that provides local services with rapid quantitative 'real time' feedback from women and their families on how they are performing to drive continuous improvement in care.
- To assess how national organisations will be able to use this experience data to perform national benchmarking.

These two key objectives are underpinned by a series of research questions:

- Assess local data collections of patient experiences that are currently being conducted within the NHS using digital technology, primarily within a maternity setting but also gathering learning from other digital collections of experience data.
- Use the market assessment of current examples of digital data collection to determine good practice examples of real time digital experience data collection and how such a collection could be done in the context of maternity care.

- Investigate whether user experience data could be gathered using a single set of questions and a real time digital methodology for local service improvement as well as national benchmarking, to drive continuous improvement in maternity services.
- Draft potential solutions for a data collection methodology.
- Investigate whether and how real-time feedback could be integrated with other digital approaches, for example apps.

Please note that this report presents the overall findings of the research for national purposes. A further report will be produced for use by Local Maternity Systems which refers more to the research questions around best practice.

1.3 Key information on other developments

Other developments underway at present have a bearing on the findings and potential solutions generated from this research. This section of the proposal provides context about these developments to support understanding of the report's conclusions and implications.

The Care Quality Commission (CQC) National Maternity Survey

The CQC runs the NHS Patient Survey Programme that includes a National Maternity Survey aimed at women who have given birth within a given time period. Most trusts providing maternity services implement the survey with a specified cohort of women via a small number of approved contractors and according to a specific set of instructions. A small number of trusts opt to implement the survey in-house, but must similar adhere to published guidance materials. This means that the survey data can be compared across trusts. Findings are reported back to individual trusts with benchmarking data. The survey is conducted at a minimum every two years and will be conducted annually from 2017-2019. years to an annual survey. It is currently conducted as a paper survey, with initial questionnaires sent to women's homes approximately six weeks after birth. The most recently published survey – 2017 – received responses from 18,426 women who gave birth during February 2017. More details can be found here: https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2017

At present, CQC is investigating the possibility of transitioning the NHS Patient Survey Programme – including the National Maternity Survey – from a wholly paper approach to a mixed methodology approach potentially utilising digital and paper questionnaires. CQC is investigating the feasibility of a mixed methods approach and will be piloting different options for taking the survey forwards digitally.

The Friends and Family Test (FFT)

The FFT is a feedback mechanism that asks patients if they would recommend the service or ward they have used and offers a range of responses. This is combined with a supplementary follow-up question allowing patients to give feedback in their own words. Since it was initially launched in April 2013, the FFT has been rolled out in phases to most NHS-funded services in England, including maternity services, giving all patients the opportunity to leave feedback on their care and treatment. So far, the FFT has produced more than 48 million pieces of feedback so far – and the total rises by around 1.2 million more every month. At present, trusts are able to decide how to implement the FFT and a range of different methodologies are used, both digital and non-digital. There are three touchpoints at which the FFT is asked:

- Antenatal care – at the 36-week antenatal appointment.
- Birth and care on the postnatal ward (two questions, one about the labour ward/birthing unit/homebirth service and one about the postnatal ward) – at discharge from the ward/birth unit/following a home birth.
- Postnatal community care – at discharge from the care of the community midwifery team to the care of the health visitor/GP (usually at 10 days postnatal)

NHS England is currently carrying out a project to improve some areas of the way the Friends and Family Test works across the country. The project will focus on a number of key areas where the FFT could be more effective:

- Explore a more effective question.
- Supporting services to make the most of what it can give them as a local service improvement tool.
- Removing the burden in meeting some of the specifics in the guidance (for example, the reviewing the fixed "touchpoints" within maternity FFT).
- Supporting the best possible use of the data.

The development project will result in publications of refreshed FFT Guidance by April 2019.

Maternity Transformation Programme Work Stream 7: "harnessing digital technology"

Work Stream 7 of the MTP is focusing on harnessing digital technology within maternity services. One project within this is the development of electronic Personal Health Records (ePHRs). An ePHR is a personal digital space for health and care that enables members of the public to take greater control of their health by accessing a range of information, also enabling people to add information and share it. For example, ePHR users may choose to:

- Communicate with care professionals through secure messaging.
- Share regular information about their condition.
- Capture and share images or video of symptoms or changes in their condition.
- Complete pre-consultation questionnaires to make best use of face-to-face time.

NHS England, in partnership with NHS Digital, has set up a programme of maternity ePHR 'accelerators', involving suppliers who have developed ePHRs. Through this, 17 adoption areas have been selected, covering potentially 130,000 women. This could take maternity ePHR usage from less than 0.1% up to 20% of women in England who give birth. There is then the potential to share learning and expand the use of ePHRs to benefit more women across England. The development and roll-out of ePHRs is currently at an early stage but is expected to accelerate in the coming years.

Maternity Voices Partnerships (MVPs)

The Better Births report recommended that in order to ensure effective service user co-production, independent formal multidisciplinary committees known as Maternity Voices Partnerships, or MVPs, should be established in order to influence and share in local decision-making. A Maternity Voices Partnership (MVP) is a team of women and their families,

commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. MVPs involve service user representatives working in local areas collecting feedback from women using maternity services. An aim of this research was to better understand MVP involvement in the feedback collection process.

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2. Methodology

To meet the research aims, the project comprised a mixed methods approach with five different strands: desk research; case studies with trusts; focus groups with women; an online survey of trusts; and a workshop with stakeholders.

2.1 Desk research

Ipsos MORI initially carried out desk research to identify different data collection tools and services available to trusts. Through existing knowledge and online searches Ipsos MORI established what apps and digital tools are available to women who use maternity services. This immersive phase of the project was later used to inform case study choices.

2.2 Focus groups with women

Four focus groups were held – two in London on 4th April 2018 and two in Long Eaton on 5th April 2018 – with women who were currently pregnant (25 weeks to full term) or had recently given birth (up to a year ago). These groups explored women's views on giving feedback about health services and maternity services in particular, their preferred methods of providing feedback, what topics they wanted to give feedback on, and how often. They were intended to ensure that women's perspectives were taken into account in any recommendations.

Each focus group was attended by eight to ten women and lasted around 90 minutes. Participants were recruited to ensure that a range of demographic characteristics were represented within each group including digital engagement and social grade, with quotas set as per the following table. Participants were offered a financial incentive as a thank you for taking part.

Table 1: Focus Group Quota

Quota	Group 1 participants	Group 2 participants	Group 3 participants	Group 4 participants
Location	London	London	Outside London	Outside London
Stage in maternity pathway				
Women between 25 weeks pregnant and full-term	0	8-10	0	8-10
Women who have given birth up to a year ago	8-10	0	8-10	0
Digital activity				
Digitally active (regularly download use digital apps)	At least 3	At least 3	At least 3	At least 3
Non digitally active (do not regularly download and use digital apps)	At least 3	At least 3	At least 3	At least 3
Ethnicity				
White	At least 4	At least 4	7-8	7-8

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BME	At least 4	At least 4	1-2	1-2
Social Grade				
A, B, C1	8-10	0	0	8-10
C2, D, E	0	8-10	8-10	0

After the focus groups participants were asked to complete a post-task questionnaire which allowed them to reflect on the discussions, provide any feedback which they didn't manage to in the focus groups, and discuss the topic with their partners. In total 14 post-task questionnaires were returned to Ipsos MORI.

2.3 Case studies

Case studies were conducted in order to deliver a detailed and in-depth understanding of how feedback is collected and used, notably within trusts. A case study approach had the advantage of enabling an in-depth 360° understanding of the collection and use of feedback, ensuring that a range of different perspectives were included and triangulated, and that practice within other services outside maternity could also be compared.

Case study trusts were purposively selected to ensure that a range of different approaches to collecting feedback were included. A specific case study for Maternity Voices Partnerships (MVPs) was included to better understand their role and activities in the collection of patient feedback. The table below shows the case studies selected, their method of data collection, and why they were selected.

Table 2: Case Studies

Trust	Data collection method	Reason for selection
Luton and Dunstable University Hospital NHS Foundation Trust	Collecting maternity FFT via electronic tablets at the point of discharge.	A potential digital method that could be widely used, so interviews to find out more about how it has been implemented and its advantages/disadvantages.
Ipswich Hospital NHS Trust	Collects feedback by using a mixture of paper postcards and tablets/iPads to collect FFT. Has also developed an app which could potentially be used for feedback.	Using both paper and digital methods so important to find out how this is working and any potential benefits or drawbacks. Also have experience of developing a digital app.

Southampton University Hospital NHS Foundation Trust	Collecting maternity FFT through paper postcards but also offer the option of using an online survey.	To get a better understanding of how they are using digital data collection methods and the uptake from women using maternity services.
University College London Hospitals NHS Foundation Trust	Collecting maternity FFT via paper postcards but inpatient FFT through a range of different methods including digital.	An opportunity to explore the potential barriers to using digital data collection methods in maternity services.
Birmingham Women's NHS Foundation Trust	Developed an app for collecting maternity experience data.	Explore how the app was developed, any challenges encountered, how they have been overcome and how women have found using the app.
Ashford and St Peter's NHS Foundation Trust	Using BadgerNet – an ePHR allowing women real time access to their maternity records and collecting feedback.	Explore how the app has been developed, any challenges encountered and how they have been overcome. Also explore who is using the feedback collected.
Gloucestershire Hospitals NHS Foundation Trust	Currently using an online survey accessed through a digital letter, which in turn was accessed via text message to collect feedback from women, including FFT.	A potential digital method that could be rolled out, so interviews to find out more about how it has been implemented and advantages/disadvantages.
Milton Keynes University Hospital NHS Foundation Trust	Collecting maternity FFT through paper postcards but also offer the option of using an online survey.	To get a better understanding of how they are using digital data collection methods and the uptake from women using maternity services.

Additional MVP case study		
MVPs	MVPs across the country are collecting feedback from women and potentially using digital data collection methods.	Understand the role MVPs are playing – or could play – and gather examples of best practice.

Please note that this purposive selection means that findings from the case studies cannot be considered representative of all trusts. In total 25 interviews were completed covering nine case studies. In some instances, interviews were carried out with trusts but a full case study was not completed as their method of data collection was different from the one originally identified.

For each case study Ipsos MORI interviewed members of staff, and where appropriate, suppliers of digital data collection tools. Participants included Heads of Patient Experience, Heads of Midwifery or their deputies / other senior midwives, and Heads of Quality and Governance among other roles. Participants were invited to take part in in-depth telephone interviews, lasting around one hour. Having completed an initial interview within a case study, participants were asked to put us in touch with other people within trusts or suppliers. Interviews took place between 9th April and 11th June 2018.

2.4 Online survey with trusts

The online survey aimed to explore how trusts are currently collecting feedback from women using maternity services. More specifically, the survey sought to gain a broad understanding of how participants are selected and encouraged to give feedback, how and when feedback is collected, how these mechanisms are inclusive and gather a variety of women's experiences, and how feedback is used by the trust.

An open link to the survey was sent to Heads of Patient Experience at 135 NHS trusts providing maternity services. NHS England and MVP contacts also encouraged colleagues to complete the survey through their networks. Participants were asked to consult with other colleagues, members of maternity services, and MVP user chairs before submitting their answers, with one response anticipated per trust. Initial emails were sent out on 29 May 2018 and the survey closed on 3 July 2018. A total of 27 responses were received, representing a response rate of 20%.

2.5 Workshop

In the latter part of the project, Ipsos MORI and NHS England held a workshop with maternity service stakeholders to explore the feasibility and implications of potential solutions for digital data collection which could be used for both national benchmarking and local service improvement. Workshop attendees included representatives from NHS England, CQC, NHS Digital, the third sector, a number of NHS trusts and National Maternity Voices representing MVPs. The workshop consisted of a presentation of the research findings and potential solutions, which were then used as discussion points for smaller break-out groups. At the end of the workshop each group fed back to the wider audience, and the insights gleaned from the workshop have been used to inform this report.

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2.6 Other data

In addition to data collected during this research, the report makes reference to Friends and Family Test (FFT) publication data. These data are NHS England statistics, breaking down the FFT results by a number of different organisational levels and providing details of the methodology used to collect the data. The data used in this report are based on the April 2018 FFT data publication[1].

2.7 Note about presentation and interpretation of the qualitative data

It is important to note that qualitative research is used to explore the range of views and why people hold a particular view, rather than to estimate or quantify how many people hold those views. Therefore, the findings presented here are designed to be illustrative, detailed and exploratory. The samples for the case study interviews and focus groups with women were selected purposively, to ensure specific experiences and attitudes were explored in-depth. As such, the findings are not generalisable to a wider population, but offer insight into the experiences, perceptions, feelings and behaviours of research participants.

Verbatim comments from the interviews have been included in the report. These comments have been selected to provide insight into a particular issue or topic and should not be taken to define the views of all participants.

2.8 Note about presentation and interpretation of the quantitative data

Since it was not possible to construct a sample of patient experience leads within trusts and send them multiple reminders about the survey, the online survey has received a relatively low number of responses (27). For this reason, results from the online survey are presented as numbers of trusts rather than as percentages.

2.9 Structure of the report

The report is structured to inform the reader of what data collection is currently taking place in maternity services and how this can be improved going forward, with a particular focus on digital data collection methods:

1. Current feedback collection within maternity services
2. Considerations when collecting feedback and the potential trade-offs between different approaches
3. How women's feedback is being used (both by women and by maternity services)
4. The collection of data for both national benchmarking and local service improvement
5. Conclusions and implications of the research

[1] https://www.england.nhs.uk/publication/friends-and-family-test-data-april-2018/
Please note that trusts with their results suppressed, due to low numbers of completed FFTs, are excluded from this analysis.

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2.10 Acknowledgements

Ipsos MORI would like to thank the team at NHS England and Dan Wellings from The King's Fund for their help and guidance with this study, as well Julia Holding and Neil Tomlin at NHS Improvement, Chris Sutherland at CQC and Julia Gudgeon at NHS Digital for their help and support. We would also like to thank all of those who participated in the research and shared their views with us.

3. Current feedback collection within maternity services

All trusts providing maternity services collect Friends and Family Test (FFT) data and participate in the Care Quality Commission (CQC) National Maternity Survey. The research found that there was also a wide range of other data being collected by trusts to help them to monitor and improve maternity services. This chapter outlines women's perspectives to providing feedback, how trusts currently approach collecting the FFT and other feedback (both survey-based data and qualitative), the role of MVPs and how they add to this, the topics typically covered in feedback exercises and the perceived benefits and challenges of collecting feedback. Finally, it looks specifically at digital feedback, drawing out its benefits as well as the challenges associated with it.

3.1 Women's perspective of providing feedback

In the focus groups, most women felt that giving feedback was part and parcel of using health services, as it is for other parts of their lives. In their interactions with health services, many participants had experience of providing feedback to their dentist or GP via text message surveys which were sent to them after appointments. They also described a similar way of giving feedback to telephone or broadband providers, as well as other customer service focused organisations. Other ways women had provided feedback to health services included more formal methods such as writing letters of complaint, giving feedback face-to-face, and completing paper surveys.

Although being asked for and giving feedback was expected, some women did not do so if the method of data collection was seen as time consuming or difficult. For example, if they had to post back the survey this was seen as being too time consuming as they would have to find a post box. Women were more likely to give feedback where they perceived it to be quick and easy. Methods such as text messaging were seen to be the most straightforward forms of data collection.

Women also felt that the method of data collection should vary depending on the service used. For instance, after a routine scan women preferred to give brief feedback via text message, but after birth indicated they may want to provide more in-depth qualitative feedback via a survey. This reinforced the broader point of women wanting choice; the more options they have to give feedback and the easier it is to complete, the more likely they are to do so.

The timing of when women are asked for feedback is also an important consideration. Women described feeling pressured to provide feedback just after birth, at a point when they were least engaged. Women would like to have more time after birth before being asked to give their feedback and felt that once they were discharged and had time to rest would be the best time to give feedback.

Overall though, women in the focus groups appreciated the opportunity to provide feedback on services and wanted to see services improve based on this feedback. To most women, providing feedback wasn't about assigning blame to staff but about providing constructive feedback which would help staff and other women. It was this constructive element which women valued most.

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"It's nice for midwives, and well any [member of] staff to feel valued. I think, you know, you hear morale is quite low so when you've had a good experience it's important to say. As equally when you've had a bad experience...you want it to be acted on and improvements to be made."
Long Eaton, Derbyshire, C2DE, recently given birth

3.2 Data collection of the FFT

The following table shows the methods that trusts use to collect FFT in maternity services, based on the April 2018 FFT data publication[2]. It demonstrates that using paper or postcards at the point of discharge is by far the most common methodology employed for each touchpoint, particularly for the question about postnatal care in the community (84% of trusts use this approach). The digital approaches – tablet/kiosk, online survey and SMS/Text/App – are used by much smaller but broadly similar proportions of trusts. Although individual digital methods are used less frequently than paper/ postcard at the point of discharge, around half of trusts are using at least one digital method for the birth (51%) and postnatal on the ward (46%) questions, while digital methods are used less for the antenatal and postnatal in the community questions (36% and 31% respectively use at least one digital method). This is partly because trusts are using multiple methods – for example, for the postnatal question on the ward, around one-quarter of trusts use both a digital and non-digital approach (27%).

Table 3: FFT Data Collection Method

Methodology	% of trusts Antenatal	% of trusts Birth	% of trusts Postnatal ward	% of trusts Postnatal in the community
Electronic tablet / kiosk at point of discharge	15%	19%	18%	8%
Online survey once patient is home	15%	18%	14%	6%
Paper / postcard at point of discharge	73%	78%	71%	84%
Paper survey sent to the patient's home	2%	2%	2%	2%
SMS / Text / Smartphone App	12%	18%	17%	15%
Telephone survey once patient is home	0%	4%	2%	3%
Other	1%	2%	2%	1%
Any digital approach (tablet/kiosk; online survey; SMS/Text/App)	36%	51%	46%	31%

[2] https://www.england.nhs.uk/publication/friends-and-family-test-data-april-2018/
Please note that trusts with their results suppressed due to low numbers of completed FFTs are excluded from this analysis.

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3.3 Other survey-based data collection

Many trusts were collecting other data in addition to the CQC National Maternity Survey and the FFT. In the survey, all 27 trusts responding reported that they did so. From the case studies, some trusts were 'bolting on' questions to the standard FFT questions, and using the fact that the FFT was already being collected to gather additional feedback. This allowed these trusts to collect more detailed data on a range of topics in addition to the FFT. Questions were also sometimes adapted over time depending on the feedback received and the priorities of the trust.

Other examples of additional survey-based data collection included:

- Ad hoc surveys that focused on specific topics that had emerged as being important or requiring improvement via other methods of feedback. For instance, maternity staff may receive feedback through an information or engagement event, and then try to understand how widespread a particular issue is through a survey.

- More frequent ongoing surveys – for example, Luton and Dunstable NHS Foundation Trust run a quarterly survey based on the national CQC National Maternity Survey to monitor the performance of their maternity services over time, again with questions adapted as priorities change.

> ***"Health care assistants go around in the morning, and we do that for about a month. It's on the iPad and they go around with it to all the women on the ward. It's quite labour intensive for the health care assistants. It's quite long, and it's modelled on the CQC survey."***
> *Luton and Dunstable NHS Foundation Trust*

Where trusts were collecting additional survey-based data, this was mostly via paper questionnaires (16 of the 27 trusts responding to the survey). Other approaches included internet surveys open to anyone to complete (six trusts), tablets (five trusts), a telephone survey (five trusts), postcards (five trusts), online surveys sent via email (three trusts) and bedside terminals (two trusts). In no cases was this additional feedback collection gathering solely numerical or quantitative data providing percentages – mostly a combination of quantitative and qualitative data was being used.

A range of staff were involved in collecting the additional feedback. Taking paper questionnaires as an example, midwives and other frontline staff were involved in 12 trusts, volunteers in nine, patient experience staff in eight, MVPs in eight, Patient Advice and Liaison Service staff (PALS) in four.

The survey also asked trusts about when feedback was collected for each stage of the maternity pathway:

- Antenatal care was asked about at all stages of the maternity pathway, but was predominantly collected during the antenatal care itself rather than afterwards. Women were more likely to be asked about antenatal care when they were actually at the service, although some were asked just after they had used a service.

- Those collecting feedback about labour and birth generally did so before discharge to community services while women were actually at the service, although some asked about this in the community either before or after final discharge.

- The timing of feedback collection about postnatal care on the ward was more mixed, with some collecting it while women were at the service before discharge to community services, others collecting it in the community, and a smaller number collecting it after discharge from community services.
- Finally, the collection of feedback about postnatal care in the community was broadly equally likely to be collected before and after discharge. Those collecting feedback via paper (the most common approach) were more likely to collect the feedback while women were still using the service than just after they had used it.

Often, the survey suggested that all women using the maternity service were asked for feedback rather than a sample being selected, although women opting-in was also fairly common. For some feedback collections, a representative sample or all women using a service within a certain time window were selected, but this was less common. In terms of promoting the data collection, most often staff were encouraging women to provide feedback, while poster and leaflets were also placed in a service to encourage them to take part. Those running internet surveys open to anyone to complete tended to advertise them online.

On the whole, trusts in the survey thought that the methodologies they were using to collect patient experience data were working very or fairly well. They highlighted a number of specific benefits and challenges for the methodologies they were using, which have been summarised alongside other elements of the research to provide a list of pros and cons of each methodology in Appendix A.

3.4 Qualitative data collection

Trusts were also conducting a range of qualitative work to gather patient feedback. For instance, Gloucestershire Hospitals NHS Foundation Trust 'shadow' or observe women as they use maternity services to understand the service from the women's perspective. A number of maternity services also run Afterthought programmes in which midwives offer a face-to-face debrief after women have used services, seen as particularly helpful for women who had a traumatic or difficult birth. While the primary purpose of this was to focus on the woman's needs, it did also provide useful feedback for midwives of what could be improved. Other ad hoc qualitative methods included midwives conducting regular 'walk-arounds' to see how women were feeling and how their experience has been. Some maternity services were also holding engagement events with women and staff where women could provide feedback, usually face-to-face or via postcards. Information and engagement events were also used for 'future' planning, with staff asking women their opinions of proposed changes to services and future plans for maternity services.

3.5 How Maternity Voices Partnerships (MVPs) are helping

MVPs were also contributing to the collection of feedback in maternity services. The work MVPs carried out tended to be on a smaller scale and more qualitative in nature, but made a significant contribution to ensuring the perspectives of women and families using maternity services were heard at a local level.

Common initiatives carried out by MVPs included: information and engagement events; 'Walk the Patch' initiatives, where an MVP representative visits the postnatal care ward and speaks briefly to women and their partners about their experiences; the '15 Steps for Maternity', exploring the quality of maternity services from the perspective of people who use it; focus groups with women to explore particular issues in more detail; visits to parent and baby groups; and outreach to more hard to reach populations. In addition, some conducted an ongoing online survey, with details provided to all women at booking-in for example, or ran ad hoc online surveys on specific topics that were advertised via social media.

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These surveys were not representative of the population of women giving birth (for example due to low levels of response and lack of a rigorous sampling approach), but did provide useful feedback for MVPs to be able to identify potential improvements to services. They also provided a mechanism by which MVPs could reach a larger number of women in comparison with other more time intensive initiatives.

There were also examples of MVPs partnering with organisations such as their local Healthwatch to collect feedback and improve services. Tangible changes to local maternity services which were directly related to work of MVPs found through the case studies included partners being able to stay on the ward overnight after women expressed a need for extra support.

However, the effectiveness of MVPs can vary by geographic area, with some being further developed than others.

"I run [two MVPs separately]. For [the first MVP], I chair the meetings and we do surveys among families and we have a large Facebook group where I can instantly access opinions of lots of different women on things that pop up. [The second] MVP I've been running since October, and we do similar things but with a smaller amount of women because obviously I haven't had the time to build up a huge amount of women yet."

MVP representative

These differences were largely dependent on a number of factors, with funding a particular issue. The funding available to support MVPs varies considerably as it is mainly determined locally by Clinical Commissioning Groups (CCGs). In some areas, MVPs received enough funding to be able to support data collection activity and wider engagement work. However, other MVPs struggled to receive the funding needed to be able to do this work.

MVPs' success can also depend on the strength of the relationship between the MVP and trust or Local Maternity System (LMS). In areas where MVPs have been established over a considerable period of time (for example, previously as Maternity Services Liaison Committees), they had better relationships and could draw on pre-existing structures and networks to support them. The combination of funding and a strong relationship with the trust could also impact on the ability of MVPs to recruit volunteer user representatives to join the team. In some instances, a lack of engagement made it difficult for MVPs to establish themselves, and could limit how representative MVPs are of different women's experiences.

"In those places [where MVPs are working well], there is an understanding about what an MVP is and what it isn't, and a respect and a collaboration with MVPs. Sometimes some places don't really understand what the role of the MVP is…it's all about relationships and how happy the LMS is to involve the MVP."

MVP representative

3.6 Topics covered in feedback collection

The topics covered by maternity services that were collecting additional data beyond the FFT questions and the CQC National Maternity Survey were quite diverse and depended on the point in the maternity pathway at which women were asked for their feedback. A small number of trusts were collecting feedback focused on antenatal care, for example experience with scan appointments and outpatients

After birth and in the postnatal ward, women were typically asked about their one-to-one care. This included questions such as whether women were treated with kindness and care, given emotional support, shared decision-making, involvement, how much they felt listened to, and if women were offered an explanation in relation to decisions made about her or her baby. Dignity and respect, being treated with compassion and feeling safe were also asked about, along with feeding support or general support to look after the baby. Sometimes more specific questions were asked such as views of visiting hours, whether their partner was able to be with them, and whether they could stay overnight, and experiences of induction. Some trusts also asked about the information that women received. In the postnatal ward, women were also asked about cleanliness and quality of meals.

Once women moved into community based services, topics tended to focus on the provision of information and the support available to them, as well as awareness of local support groups and experiences of health visitors.

"We ask them about their experience of information about screening, feeding support services and the people you've met and an overall view."
University Hospital Southampton NHS Foundation Trust

Some trusts also asked for feedback on specific members of staff, with questions about whether staff went the extra mile, how they could improve, or what they could do to 'wow' women. Other wider questions included what went well, what didn't go well and what could be improved or could have made their experience even better.

When women in the focus groups were asked what topics they would like to provide feedback on, there was a strong emphasis on feeding back on the quality of service and the care and compassion displayed by staff. Other topics considered important included:

- how involved in care women felt;
- the extent to which women felt listened to;
- waiting times; and
- comfort.

3.7 Benefits and challenges of feedback collection

Staff working in maternity services recognised that there are a number of benefits to collecting feedback from women, but also some challenges to doing this.

Case study and survey participants suggested that feedback collection was most useful for the purpose of improving local services. Patient feedback was used to help maternity services build an evidence base which could be used to support changes to services. For example, one case study trust provided additional funding for cleaners after feedback highlighted that hygiene levels on the ward could be improved. Trusts responding to the survey also highlighted the real-time nature of the data, which allowed them to make swift changes.

For trusts that were able to link feedback to individual staff members, the positive feedback staff received was also a major benefit as it helped to boost staff morale and contributed to staff feeling valued, which may have a corresponding impact on the quality of services.

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"It was really positive for the midwives and the staff…the staff really appreciated it."
Gloucestershire Hospitals NHS Foundation Trust

However, there were a number of limitations which affected the ability to adopt different methods of data collection and challenges to how feedback is currently collected. The case studies show that in many instances, staff are making the best of what is available to them, with sometimes only a limited amount of control over the data collection methods being used. For example, staff could be working with data collection methods which were implemented by their predecessors which they had inherited.

"We were already using the iPads when I started and we haven't changed it. I have tried to get the midwives to use them as much as possible."
Luton and Dunstable University Hospital NHS Foundation Trust

In a few case studies, staff were fully aware of the drawbacks of their current data collection method but were unable to change or improve how feedback was collected. This difficulty in changing methods could be attributed to various factors such as a perception that staff would not be open to change and financial constraints. Spending on new methods of data collection was described as a lower priority in comparison to frontline care.

"There are midwifery vacancies nationally…it's important that we know what women are saying but the immediate bedside care and looking after someone in labour unfortunately over-rides that."
University College London Hospitals NHS Foundation Trust

Trusts were also restricted at times by contractual obligations. In some cases, trusts were tied into contracts for data collection services which were also sometimes perceived to be easier to renew, rather than entering a lengthy procurement process. With staff time limited in both maternity services and in-patient experience teams, the procurement process can be seen as time consuming, making staff reluctant to change their approach to data collection. In addition, there could be general organisational or accounting difficulties with moving from the status quo.

Trusts responding to the survey were divided on how well feedback collection of the FFT was working within maternity services. While 13 thought it worked very or fairly well, 12 thought it did not work very well or not well at all. Many trusts explained their response with reference to the response rate they were able to achieve, but a number of other challenges were also mentioned, which corroborated challenges faced by case study trusts.

The size of patient experience teams could also be an issue – generally teams were relatively small, creating difficulties around workload and how to process the volume of feedback collected. For example, in one case study, the patient experience team did not have enough staff to analyse and act on all of the feedback they had collected, meaning that feedback was being collected from women but was going unused.

A number of case study participants commented on how time consuming and labour intensive collecting feedback can be for staff. Staff being involved in collecting feedback (such as using postcards), could also skew the feedback gathered as women might be more likely to give positive feedback when asked by staff directly. In times of heavy workload collecting feedback was often a low priority and could be seen as a burden. Poor engagement and response rates were also a major challenge for all trusts, particularly after birth. For the FFT this could also sometimes mean less feedback in the free text question which was seen as more helpful for trusts.

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Staff could also find it difficult to match up feedback collected from women to specific touchpoints along the maternity pathway, especially if this feedback was being collected via postcards. It could sometimes be difficult for staff to tell from a postcard which service women were referring to, and women may be confused about what part of the maternity service they are being asked to feedback on..

"Knowing whether women have fed back on the right touchpoints. There have been occasions where women have been given the wrong card or they've been given two cards."
University College London Hospitals NHS Foundation Trust

Other methods of data collection also presented some challenges, for example a number of trusts had trialled text messaging but had been unable to move forward with the method as they couldn't find a way to exclude women who may have had a miscarriage or stillbirth.

"We did try the text messages for women, but we couldn't exclude the women who had had a miscarriage which obviously receiving a text about your birth would be very traumatic."
Ashford and St Peters NHS Foundation Trust

From the perspective of staff responsible for patient experience, collecting data which is reflective of all users was also a challenge. Trusts that served diverse local populations could experience challenges including language barriers, limiting who feedback could be received from.

"Our feedback isn't really reflective of the diversity within the hospital. Most of our feedback is from white births but at least half our patients are from BME backgrounds. For a lot of the women English isn't their first language, but we're using the Meridian system on the iPad to translate all our surveys into different languages and that's something we're just going through now."
Luton and Dunstable University Hospital NHS Foundation Trust

3.8 Organisational culture and buy-in

The culture of a service and buy-in from staff is an important factor in how successful maternity services are in collecting and acting upon feedback. The case studies suggest that a positive and constructive feedback culture can have a significant impact on how feedback is treated and how useful it can be across the organisation as a whole.

In some case studies, organisational culture was highlighted as being a positive or negative factor in collecting and using feedback. In cases where staff were more engaged with data collection, they often described a sense of ownership. When they felt they had greater control and could provide input into the way data was collected, they were more engaged with the process. On the other hand, some trusts struggled to get staff to give out FFT cards, which could have a detrimental impact on response rates and the quality of the data.

"It's a cultural challenge – getting clinicians to take responsibility for collecting feedback. Sometimes I have to go on to the ward and do it, but the second I stop the clinicians don't bother and it stops again so the rates fall."
Ashford and St Peters NHS Foundation Trust

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Some trusts were particularly strong at embedding a culture of quality improvement. For example, Gloucestershire Hospitals NHS Foundation Trust train maternity staff to undertake quality improvement projects, which include feedback collection.

"It's based around user feedback and it is about quality improvement based on user feedback and involvement. So, we've got quite a few midwives and teams of midwives going through that [training] programme at the moment."
Gloucestershire Hospitals NHS Foundation Trust

Training and independent improvement projects helped to engrain a culture at Gloucestershire of valuing feedback from women. This included questions being added to the FFT to provide granular, individual-level feedback to members of staff, which boosted morale and helped demonstrate how feedback can be useful.

Generally, across case study trusts a positive feedback culture was also related to how frequently staff would engage in more ad hoc methods such as walk-arounds and face-to-face conversations or reviewing FFT cards before they have been processed. This allowed staff to get a better understanding of current issues in real-time.

3.9 Digital feedback

Digital feedback in maternity services in various forms was not uncommon across NHS trusts in the survey. Excluding 'other' feedback that trusts were collecting outside the list of methodologies specified in the survey, 17 of the 27 trusts were using digital data collection methods to collect maternity FFT, while 12 of the 27 were using forms of digital collection for other feedback (not FFT or the CQC National Maternity Survey). However, nearly all of these trusts were also using postcards or paper questionnaires to collect feedback in conjunction with these digital methods.

In our survey of trusts, of the six trusts responding that were not collecting FFT digitally, three said this was because they did not have the technical capabilities / software / hardware in place to collect this data digitally. One said they had never considered collecting FFT data digitally, one that it was too expensive and the final one saying this was for an 'other' reason.

Seven of the 27 trusts responding used a different data collection method in maternity than for other services when collecting FFT data. For five it was because an alternative approach was more appropriate (for example, given how women are discharged from maternity services, different information systems, Wi-Fi issues, or simply because it works and delivers good response rates), while for two this was (at least partly) because of difficulties excluding women where sending the FFT would not have been sensitive.

Of the 27 trusts, five had previously collected FFT via a digital method that they had since stopped using. In three cases this was due to a change of provider (with one who had been using tablets saying they had reverted to paper because staff had fed back that paper was better), one moved from SMS due to low response rates and one did not know. A number of case study participants were also using digital feedback methods or had previously trialled using them. Where digital feedback was being collected, staff saw value in doing this and believed there were a number of advantages, which are outlined below.

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Perceived advantages of digital data collection

In comparison to paper-based data collection, digital approaches were seen as being faster to collate, process, and report on data. Maternity services and patient experience staff liked having access to real-time feedback and being able to access online dashboards. This allowed staff to monitor feedback being collected from women and to monitor response rates at different points in the maternity pathway.

Digital data collection was also seen as being more stable and reliable compared to paper methods, which often relied on staff to distribute them and encourage women to give feedback.

"If I look at the areas where we are collecting SMS data, there is a sense of stability about it…in outpatients for example, before the introduction of the new system the most data we ever collected was 1200 responses. Out of about a million outpatients - it's not an awful lot…it was something less than 1%. Whereas now we're collecting I would say in between 10 and 15% every month. It's a big shift. And a lot of that was, we were reliant on staff so staff had to do the data collection and hand the cards out - it's a huge burden."
University College London Hospitals NHS Foundation Trust

Not having to rely on staff to collect data also freed up time to focus on patient care, in comparison with an approach like handing out postcards. Among case study participants, digital data collection was also seen as 'the way things are moving'; implementing digital data collection was spoken about as being modern and keeping pace with developments in wider society, which in itself was seen as advantageous.

"It's just the way the world is moving, we need to embrace it and keep pace with the rest of the world."
Luton and Dunstable NHS Foundation Trust

Disadvantages of digital data collection

There were, however, some drawbacks to digital data collection, identified through the case studies and the workshop discussion. During the workshop there was a sense that a move toward digital data collection could exclude socio-economically disadvantaged women and act as a barrier to giving feedback. For example, in order to give feedback via an app a woman would need to be able to afford a smartphone, and pay a monthly bill for data usage. Language barriers were also seen as a potential issue, with the possibility of non-English speakers being excluded from feedback collection (although this would also apply to other non-digital methodologies). This is particularly relevant as there is already an acknowledgment that Black and Minority Ethnic groups, for example, are underrepresented in patient feedback, and any new method of data collection should make every effort to be as inclusive as possible. During the workshop the point was made, however, that digital data collection can be inclusive with technology allowing questions to be easily translated into multiple languages. However, these points were linked to a wider feeling that it was important that the system does not undertake additional data collection that hears the same voices as those who already have a voice and for whom the system is already designed, but that it strives to hear seldom heard voices.

Although digital feedback collection can result in faster collation of data, there was also the issue that digital feedback can limit the ability of staff to identify and resolve issues immediately, depending on how it is done. For instance, some staff

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viewed postcards before they are processed and could identify issues which need immediate attention, whereas waiting for a digital report to be generated may slow down their ability to respond quickly.

There were also teething difficulties when new methods of digital data collection were introduced. For example, Ashford and St Peter's had recently introduced a new electronic Personal Health Record (ePHR) system, which offers the capability for maternity services to collect FFT data through an app. There were some technical issues during implementation and staff confusion around how to use the system and how to explain it to women, although these issues have been worked through.

"There were problems around the android version of the app, the app didn't update when the operating system did which meant the women couldn't use it very well…there are also issues around firewalls."
Ashford and St Peters NHS Foundation Trust

Issues with Wi-Fi connectivity and hardware were also highlighted through the case studies. Inadequate Wi-Fi connectivity at times led to a poor user experience for women and led them to become frustrated and give up with submitting feedback. There were also instances where tablets or iPads were sent to IT services to be fixed or repaired. In the meantime, maternity services reverted to using paper and as result the tablets were used less often and paper data collection methods became the norm again.

Chapter Summary

- **Women felt that providing feedback is part and parcel of using health services and they liked having the opportunity to provide feedback, as long as it is easy and convenient for them. They wanted their feedback to be used to help improve services and this is where they saw its value.**
- **Women wanted to have a range of options for feeding back to maternity services, particularly depending on the type of service used, and the timing of asking for feedback should also be appropriate.**
- **Trusts were carrying out a variety of different data collections, including surveys and more qualitative methods.**
- **MVPs were having an impact and contributing to data collection, especially gathering qualitative feedback, although their effectiveness varied by area. They could be restricted by funding constraints and were dependent on existing relationships with trusts, LMS' and CCGs.**
- **There were a wide variety of topics covered by maternity services when collecting feedback. Trusts appreciated that there are multiple benefits to collecting feedback, such as local service improvement and boosting staff morale.**
- **A service's culture and buy-in from staff was an important factor for the successful collection of feedback. Data collection worked best when staff felt that they had some ownership over the method and it is related to local priorities.**
- **However, there were challenges, mainly around staff time and poor engagement from women. Other limitations included financial constraints, contractual obligations, and the perception that data collection was not a priority.**
- **Digital methods were being used a fair amount, for example with 17 of the 27 trusts responding to the survey using a digital approach for the FFT and 12 for other data collections. However, in nearly all cases these were being used alongside postcards or a paper questionnaire.**
- **Digital data collection was perceived to save staff time and provide more robust, reliable data. However, there were issues around implementation of digital methods and the potential for digital methods to exclude underrepresented groups (a challenge for other data collection methods as well).**

4. Considerations when collecting feedback

This chapter outlines some considerations to take into account when choosing a feedback approach for use in maternity services. Implications of these trade-offs are then outlined. Finally, the possibility of using app based and electronic Personal Health Record (ePHR) based feedback is discussed, as NHS England had identified this as an area of interest and potential.

4.1 How finding an optimal approach involves a series of trade-offs

Different feedback collection approaches each have advantages and disadvantages. Selecting an optimal approach involves considering various trade-offs and will depend on what the purpose of the feedback collection is and how the data are going to be used, which must be the starting point for reviewing the different options. The trade-offs described below outline some of the issues to be weighed up when deciding on an approach to collecting feedback in maternity services. These trade-offs have been constructed from surveys and interviews with trusts and Maternity Voices Partnerships (MVPs), as well as discussions with women themselves. For the pros and cons of specific data collection methods, please refer to appendix A.

1) Level of staff involvement in collecting feedback versus buy-in and speed of action

Some forms of digital feedback collection such as SMS messaging and online surveys would allow staff to be bypassed in data collection, reducing the burden on them. Such forms of data collection typically involve a supplier or specific members of staff (such as patient experience teams) sending out automated surveys to women rather than a paper-based approach that relies on frontline staff to hand out, encourage completion and collect feedback forms. An automated approach also means that feedback collection processes can be administered in a more consistent way. As the process is automated it reduces issues related to feedback collection where staff are involved, such as staff being too busy to administer surveys or forgetting to hand them out.

However, staff not being involved in the data collection element could potentially result in less buy-in and engagement in the feedback and findings, as it is more 'separate' to staff and not something they are intrinsically involved in. It also means that staff are not able to as immediately act upon the feedback received (depending on feedback mechanisms), as may be possible with feedback collected on paper questionnaires or postcards collated within a ward or clinic, or feedback given to staff face-to-face.

"In relation to women who have provided 'real time' feedback and have had a difficult experience, the feedback allows us to address her difficulties and for those to be rectified before she leaves our care. This is beneficial because women feel more listened to and cared for."
Survey participant

This trade-off is not clear-cut because buy-in to feedback could be linked to staff involvement in the collection process but is also linked to how the data are used and shared by the maternity service. Where feedback from women is communicated to staff and shown to have impact, it is more likely to be valued and encourage buy-in. For example, at Gloucestershire Hospitals NHS Foundation Trust although staff were not involved in the collection of FFT data, which included additional questions about specific members of staff (this feedback was collected via an online survey accessed

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via digital letter, the link to which was sent by text message), the feedback was reported back to members of staff at an individual level, having a positive effect on morale.

2) Level of detail that can be collected versus response rates

Response rates will be higher for shorter surveys that women can complete with minimal effort, such as the FFT which is intended to be a quick and easy way of providing feedback. In the focus groups, women said that long and burdensome surveys would put them off giving feedback.

"*If it's* [providing feedback is] *quick and easy I would but if it's long then I don't, I just wouldn't bother.*"
Long Eaton, Derbyshire, C2DE, recently given birth

However, the shorter the survey, the less data are collected. Fewer questions on a survey mean it is less time consuming for women to complete but also means there is less scope to ask questions about specific areas of interest or enough questions to be able to diagnose specific areas of improvement. Keeping a survey short may also mean removing open-ended qualitative questions which are the most time consuming for participants to complete. In the case studies, staff had found in-depth, qualitative feedback from women particularly helpful in making improvements to their services, so excluding this type of question could limit the usefulness of the data collected.

"What we need to know is the actual tangible things on what we need to improve, and some of the automated systems I'm not convinced provide enough of that qualitative information."
Southampton University Hospital NHS Foundation Trust

3) Timing of asking for feedback – response rates versus quality of response

Asking women for feedback while they are at the service is likely to return a higher response rate than once they have returned home. This is because the experience is still very recent and relevant to women, and staff can encourage women to give their feedback so they are less likely to forget to do it.

However, at certain points in the pathway (such as while they are on the ward after birth), women do not feel it is appropriate to be asked for feedback as they are likely to be tired and their priority will be looking after their new-born child. This was reported by women in the focus groups, who mentioned that in such cases while they would not wish to provide feedback at the time, they may be willing to do so after using the maternity service when they had more time. Staff in the case studies also reported that this was not necessarily the right time to ask for feedback. In addition, feedback tends to be more positive when it is collected at the point of service than feedback collected after women have had time to reflect on their experiences. This is partly because they are still at the service and would be nervous of feeding back in a way that could affect their care, and partly due to the proximity of staff which makes completing a survey feel awkward. Feedback collected after women have left a service and had time to reflect may also be more comprehensive than that collected at the time, and can be more constructive for the maternity service in highlighting potential improvements.

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"There is research that suggests that women's responses will change over time and what they might say immediately postnatally is different to what they say when they've processed the birth or six months on."
MVP representative

4) Number of times asked versus linking back to a specific service or individual

Asking women to provide feedback just once at the end of their pathway means less burden on women, who may be more likely to provide more detailed feedback for a one-off data collection than responding to multiple requests for feedback. In the case studies and the online survey there was a perception that women were currently over-surveyed, particularly in relation to the four touchpoints of the FFT.

"I think women are surveyed so often, not just the FFT but there are other surveys occurring and we do worry about survey fatigue."
University College London Hospitals NHS Foundation Trust

However, the maternity pathway is a long process where women are seen by multiple healthcare professionals and use different types of services. Asking for feedback only once at the end of the pathway means the feedback collected could be out-of-date. It can also be difficult to link the feedback back to individual members of staff or specific parts of the service for service improvement. In the focus groups, overall there was a perception among women that collecting feedback just once at the end of the maternity pathway would not be adequate as they wanted the opportunity to feed-back on each of their experiences and encounters with different members of staff throughout the maternity pathway. They thought this would be more useful for the maternity service to be able to practically use the feedback to make improvements.

"I've had such a range of experiences, I couldn't summarise 42 weeks in a two-page document, because I didn't see a single person twice, I went to all sorts of clinics and places."
London, ABC1, recently given birth

4.2 Implications of these trade-offs

With these trade-offs in mind, the points below should be considered when deciding how to collect feedback from women using maternity services.

Using multiple approaches to feedback collection

Different approaches to feedback collection could and should be used within maternity services in order to maximise response rates and the representativeness of the data. A theme from the focus groups was that women did not want to be confined to providing feedback via one method; they were keen to have a choice in how they decided to feed-back about the services they had used. The more options available to women, the more likely they are to give feedback. This also reflects survey literature which recommends using multiple approaches in different forms to encourage participants to

respond, in order to maximise response rates[3], albeit that the use of multiple modes of data collection must be tested and developed to minimise the impact that the mode has on women's responses to the questions.

"Yes some women will respond to an online survey, yes some women will respond via text, it's having different formats I think, and there is nothing like going out to women in a group...and getting actual live feedback from women to help shape your service."
Gloucestershire Hospitals NHS Foundation Trust

"You always sign up for anything and they're like, 'how do you want it, by email, by post'? But ask...because some of us might be like, 'I don't text'."
Long Eaton, Derbyshire, C2DE, recently given birth

The case studies and the online survey provide evidence that maternity services are currently collecting feedback from women through various channels and using different methods. Not including the FFT and CQC surveys, 21 of the 27 participants indicated that they use more than one methodology to collect feedback from women. Responses showed a wide range of collection methods being used, with a mixture of both digital and non-digital methods and often both qualitative and quantitative data is being collected. Looking at the latest published FFT data specifically (April 2018), 37 of the 131 trusts with maternity services had used more than one data collection method to collect FFT data at the postnatal ward touchpoint[4].

Potential for different approaches at different stages in the pathway

It is important to note that there is potential for different feedback collection methods to be used at different stages in the maternity pathway, as the trade-offs described previously will apply differently. For example, short feedback collection exercises could be used earlier in the maternity pathway such as a few key questions sent to women by text message after scans or appointments with the community midwife. In contrast, there is likely to be more detailed feedback following labour and birth, and so this could be a longer, more in-depth feedback collection exercise such as an online survey also gathering qualitative data, sent to women sometime after birth once they have had time to reflect on their experience.

Frequency of collecting feedback

The research suggested that women using maternity services and staff working within maternity services have different views about how frequently women should be asked to provide feedback.

Staff perspective

A theme from the case study interviews and the online survey with staff was the perception that women are currently over-surveyed. Most of the comments on this issue in the case study interviews and online survey related to the FFT, which is typically asked four times of women at four separate touchpoints in the maternity pathway[5]. Staff reported that women being repeatedly given the FFT was having a negative influence on response rates and was causing apathy among women using services, and suggested asking women for this feedback less often. In particular, the second and third

[3] Dillman, Don A., Smyth, Jolene D., Christian, Leah Melani. 2014. Internet, Phone, Mail and Mixed-Mode Surveys: The Tailored Design Method, 4th edition. John Wiley: Hoboken, NJ

[4] https://www.england.nhs.uk/publication/friends-and-family-test-data-april-2018/

[5] https://www.england.nhs.uk/wp-content/uploads/2013/09/fft-mat-guide.pdf

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touchpoints in the maternity pathway (labour ward and post-natal ward) were commented on by staff as being too close together – women could be given the FFT twice in a matter of hours, and this was causing confusion among women, who struggled to distinguish between the two parts of the service.

"Too many touchpoints along the pathway need to be surveyed (patients receive four FFT cards along their journey). Asking a new mother to complete cards after delivery and then post-natal care, when they have bigger things to concern themselves with at that time. It is very difficult for the patient to distinguish which area they should be commenting on as it should all be one continuous journey."
Survey participant

"For women it's seen as one pathway and it's seen as how many times do you want me to feed back? They felt they'd already fed back. I think that was the reason why the response was so poor, they were asked the same question too many times."
Gloucestershire Hospitals NHS Foundation Trust

Women's perspective

Women in the focus groups wanted the opportunity to leave feedback after each contact with their maternity service, as they noted that their experiences could be different each time. They wanted to be able to provide feedback on specific parts of the maternity service, and on particular midwives or other members of staff. This was the only way they could see that their feedback could be used to improve services or provide praise to staff. This is somewhat in contrast with the staff perspective outlined above as it suggests that women did want the opportunity to give feedback at different stages along the maternity pathway.

Why was there a difference in views?

The apparent discrepancy in views between staff and women outlined above may relate to the FFT questions specifically and the timing of the four touchpoints more so than how often women are asked to provide feedback. It may be beneficial to ask different, more specific questions to women depending on their point on the maternity pathway to help them to differentiate between different parts of the maternity pathway. It is also possible that although women in the focus groups said they wanted to provide specific feedback, women would not actually provide the feedback if they were asked multiple times given the daily pressures of life.

4.3 App based approaches & ePHRs

Apps did not seem to be commonly used to collect feedback in maternity services. In the online survey, out of 27 responses there was currently just one maternity service collecting FFT data via an app (alongside postcards and text messages), and one service that formerly collected FFT data using an app but has stopped since it changed supplier. There were no examples of feedback other than FFT being collected by maternity services through apps. Despite no longer collecting data via an app, the survey participant from the trust that formerly collected FFT data this way advocated using an app based approach later on in the survey, saying that it enables feedback to be collected from women in real-time, which their current FFT collection methods were not allowing.

Birmingham Women's NHS Foundation Trust had previously used an app to collect FFT data but this was now effectively dormant, with the majority of data collected by paper and the app no longer being promoted by staff. In this example the app was developed many years ago and had limited functionality and features; it has since been developed further. Another case study site, Ashford and St. Peter's NHS Foundation Trust, had been exploring the idea of collecting FFT data via an app giving access to an electronic Personal Health Record (ePHR), with feedback collection currently in the early stages of development. In 16 of the 27 trusts responding to the online survey, women had access to their personal health records. Only one of these trusts did this via an app, but did not also collect feedback via the app (though they thought they probably would in the future). A third case study, Ipswich Hospital NHS Trust, had also been collecting FFT data through an app. In the past in this maternity service, the FFT data collected through the app had been kept and used separately from FFT data collected via more traditional methods. Ipswich have more recently changed their FFT data collection within the app to make the data comparable to the data collected through their other FFT collection approaches.

Case study participants saw benefits in an app-based approach as it provided data in real-time, although app development did not always fit with current contractual and funding arrangements. A view was expressed that a national app incorporating several features including feedback collection and information provision could be useful for maternity services. Case study participants considered women using maternity services as a demographic who could benefit from an app like this, as many women in this age group are digitally active. Such an app could use the strong branding of the NHS to encourage engagement.

"Two years ago we looked at developing our own app, and then we were aware that the app...was being developed in the north of the country and then that was taken up by the national team under Better Births. And then we were eagerly awaiting the national app, but I think that's now not happening because NHS Choices became NHS UK."
Gloucestershire Hospitals NHS Foundation Trust

In the focus groups, most women were comfortable regularly using digital apps for a variety of purposes. Many of the women in the focus groups had used maternity-based apps in the past such as Baby Buddy to receive information and track their pregnancy. However, the focus groups also suggested that there was a drop-off in maternity app use in later stages of pregnancy and among those who were not first-time mothers.

While apps are rarely currently used by trusts to collect feedback, women were open to providing feedback through an app in theory. However, a key theme was that they would not use an app just to provide feedback. Therefore, an app that incorporated feedback collection would need to include other features such as information provision and access to an electronic Personal Health Record (ePHR). An ePHR, also known as a patient portal, allows for information sharing and/or shared control, access and participation by women and healthcare professionals. The Maternity Transformation Programme is currently working with suppliers across the country to develop ePHRs.

The potential for incorporating feedback collection within an ePHR was viewed positively by both the women in the focus groups and case study participants. This was perceived to have several benefits, including;

- giving women access to a record of their past and future medical appointments;
- removing paper-based processes deemed to be slow and costly, and,

- potentially providing women with a way to communicate with healthcare professionals.

The focus groups suggested that women would be more likely to use an ePHR that provides information about pregnancy and maternity services and incorporates feedback collection. Such an app would encourage mothers having multiple children to continue using it to access their medical record and communicate with midwives, whereas this group might not feel they need to continue using an app that provides information on pregnancy and birth only.

As previously mentioned, one of the case study sites, Ashford and St. Peter's NHS Foundation Trust, is currently trialling collecting feedback through an ePHR. Other case study sites were investigating the ability for including feedback collecting within ePHRs but these were in early stages of development. Despite there being potential for developing apps or ePHRs that collect feedback from women about maternity services, there are currently constraints to this that need to be thought about and worked through:

- Lack of resources in maternity services – in the case studies, some of the NHS trusts had small patient experience teams that are already struggling to collate and use the feedback they are receiving. It is questionable whether NHS trusts would have the resources to be able to deal with feedback collected from an app or an ePHR if one were introduced as another form of mandatory data collection. There are also questions around how such an app would be funded, and if this funding is not available centrally whether individual trusts would have the resources to set one up themselves.

- Processes in trusts would need to be streamlined – alongside resource and funding barriers, there are also practical considerations that would need to be taken into account when introducing an app or ePHR that is capable of collecting feedback. For example, it would need to be compatible with the trust's existing IT infrastructure. Processes would need to be thought through to ensure that women are not asked more than once to provide the same feedback at one time, and potentially filtering out any women who have had a traumatic experience such as a miscarriage if it were deemed inappropriate to seek feedback from them.

- Not all women will own smartphones – despite being considered a digitally active demographic, there will still be some women who would not have access to the app/ePHR. Some groups of women may not be able to afford a smartphone or data to use apps, and these women should not be excluded from opportunities to provide feedback. In the focus groups women also reported that they would not want to download an app if it used up too much space on their phones.

- Not all women will want to provide feedback digitally via an app – while most women in the focus groups were comfortable using apps, there will be some women who are not comfortable with providing feedback digitally. For this reason, it is important that other, non-digital channels of providing feedback remain open to women. As previously mentioned using multiple approaches, both digital and non-digital, is likely to be most beneficial and yield the most feedback.

- Concerns over data security – data collected and used through an app, particularly if linked to an ePHR, would need to be secure to not dissuade women from using it. Access to an ePHR should involve protections such as password protection or fingerprint identification, to ensure that information held digitally is secure.

- Language barriers – national data on births shows that many births in England each year are from mothers who were not born in the UK, who may not speak English as a first language[6]. These women should not be excluded from being able to provide feedback about the maternity services they use. It is therefore ideal that an app collecting feedback would overcome language barriers by being available in multiple languages.

"The con [of using an app] would be if it's only ever provided in English, because we need to ensure that we are not alienating speakers of other languages."
University College London Hospitals NHS Foundation Trust

The practical issues may not be insurmountable barriers to using an app or an ePHR to collect feedback from women. However, they are considerations to be thought through when developing and implementing such an app/ePHR and the findings from the case studies suggest this is a longer term solution. Overall, if maternity services plan to use an app/ePHR to collect feedback from women, it would be sensible to test and pilot this before rolling it out to ensure that the barriers listed above have been overcome, and ensure that groups of women are not excluded from being able to provide feedback. Women should still be offered avenues to provide feedback in non-digital ways alongside any app/ePHR.

Chapter summary

- **Choosing an optimal approach for collecting feedback from women involves a series of trade-offs. Different feedback collection approaches each have their benefits and drawbacks and selecting the optimal approach will depend on the purpose of the data collection.**
- **A range of different approaches to collecting feedback should be used within maternity services to encourage as much feedback as possible from women. This means using both quantitative and qualitative approaches, but also within any single quantitative data collection providing multiple means of responding (assuming that the impact of collecting data via multiple modes can be minimised in terms of women responding differently via different modes).**
- **Women could be given the opportunity to provide feedback at multiple points along the maternity pathway to maximise how data can be used for service improvement. However, the current system of asking the four Friends and Family Test questions at three different touchpoints could possibly be changed to encourage responses and reduce survey fatigue. In addition, different approaches could be used at different stages in the maternity pathway.**
- **App based approaches to collecting feedback, particularly those incorporating access to an electronic Personal Health Record and those providing information to pregnant women, have potential. There are a number of practical considerations that need to be taken into account when developing and implementing such an app, and women should still also be able to provide feedback through alternative means.**

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2016

5. Use of women's feedback

This chapter outlines how maternity services use the feedback that women provide, and how the women themselves use – or would like to be able to use – other women's feedback. It covers who within trusts uses the feedback, how it is communicated, and provides examples of how feedback has been used.

5.1 How feedback is being used by women

Very few women in the focus groups had actively sought out formal feedback that other women had given about maternity services. In general, there were two main reasons for this:

- The women we spoke to in the focus group were not aware that data such as the FFT and the CQC National Maternity Survey are available. While they may have found these data if searching online, few had considered looking for this type of information. The women were largely not aware that they could choose their maternity service, or thought that this choice was very straightforward for them, based on where their closest service was and more historical links to a specific hospital (i.e. where they had been in the past for services not related to maternity).

  "You're going where you're going because it's the NHS, so reviewing it, I wouldn't want to make something worse for someone else because you're going to have to go there."
  London, C2DE, recently given birth

  This meant that these women had not considered looking at feedback data to make comparisons between services or hear more about them from other women, either because they did not realise that they had a choice or simply because they had not thought about choosing their maternity service.

- There was a reluctance to seek out feedback from other women as there was a fear of hearing negative feedback or stories about maternity services that could cause mothers to worry.

  "It depends, you don't want to be about go in to have your baby and worry about what you've seen in a review."
  Long Eaton, Derbyshire, C2DE, recently given birth

  This was particularly relevant given that many of the women we spoke to had not considered multiple services when deciding what to use. They did not realise they had a choice of service – and commonly went to maternity services that were closest to them and/or that they were familiar with without considering others – and this meant that they did not want to hear negative feedback about where they would be going.

  "I didn't really want that much information from people, I didn't want any horror stories."
  Long Eaton, Derbyshire, C2DE, recently given birth

Where women had actively sought out feedback, this tended to be via reviews on online forums rather than more formal feedback, but the perception was that women leaving reviews on internet forums were those who wanted to complain. Some mentioned that they had happened to see (rather than looked for) formal feedback on posters or boards around

their maternity services, in the 'you said, we did' form. However, there was some scepticism about feedback communicated in this way and women would have liked to have seen details of who was giving this feedback and how they gave it, to address their doubt that the findings had been cherry picked from particularly positive women.

"It's on a sign, 'you said we did'…it doesn't say where they gathered the information from."
London, C2DE, recently given birth

If looking at feedback from other people, women generally wanted this to be collected and presented independently of the NHS, or to have some reassurances about who it is based on and that more positive feedback hadn't been selected.

Trusts themselves seemed to question how much women were using the feedback that others provided. For example, nine of the 27 trusts that responded to the survey agreed that the FFT is helping to inform women about the way services are delivered and only six of the 27 agreed it is helping women to choose where to receive their treatment and care (although please note that many trusts also said they did not know).

5.2 How feedback is being used within trusts

Trusts in both the case studies and survey were primarily interested in collecting feedback from women for the purpose of local service improvement activities; staff intention of using feedback for this purpose has also been found in other healthcare areas such as end of life care. Using feedback for local service improvement was particularly the case for the FFT, with trusts responding to the survey saying it was being used to deliver service improvements (20 of the 27 trusts that responded), as a tool to give feedback to staff about their department or ward (20 of the 27), and to improve women's experiences locally (19 of the 27). Similarly, the CQC National Maternity Survey was being used to improve women's experiences locally (21 of the 27), to deliver service improvements (21 of the 27) and as a tool to give feedback to staff about their department (19 of the 27). The National Maternity Survey was also being used by trusts to compare themselves against other trusts or services (22 of the 27 trusts responding). Those collecting other feedback as well as the FFT and the CQC National Maternity Survey also pointed to the key use of the feedback being for local service improvement, including helping to respond to women's feedback real-time (i.e. close in time to their experience), which many trusts said was a use of this additional feedback (for example, 12 of the 16 trusts collecting additional feedback via a paper questionnaire were using it for this).

Women themselves supported this in the focus groups, identifying making improvements to services as the central purpose for which they would like their feedback to be used.

"I'd want it to be acted on. If it's positive I think it should be fed back and if there are elements of negative I'd want improvements to be made unless it was just me."
Long Eaton, Derbyshire, ABC1, currently pregnant

Trusts and MVPs gave multiple examples of where feedback had been used to improve services, including:

- the creation of a dedicated homebirth team and the creation of an induction suite;
- a better toilet/changing facility, and a support group for fathers;
- improvements to the process for inducing labour;

- the provision of wireless monitoring;
- a change to the visiting hours on postnatal care wards
- partners being allowed to stay on the ward overnight; and
- the production of a website aimed at dads.

Please note that further detail is provided in the accompanying report for Local Maternity Systems (LMS).

Benchmarking, largely undertaken by making comparisons of data such as the CQC National Maternity Survey, sometimes helped trusts to identify areas where – and how – improvements could be made.

"There are two questions [in the National Maternity Survey] on emotional support… and these two questions we want to improve, so we looked up which trusts have scored in the upper 20%, so the team could get in touch and find out what they're doing differently."
Luton and Dunstable University Hospital NHS Foundation Trust

Comparisons tended to be drawn across maternity services rather than with other (non-maternity) services within a trust, as they were seen to be too different for benchmarking to be meaningful. Women also supported this use of their feedback, arguing that comparisons could help to share learning and best practice, and also to promote 'healthy competition' that may also drive standards up.

Another way in which trusts used feedback was to provide individual level feedback for staff. This could either be to highlight specific things that a staff member could do better, or to raise morale by praising individual staff members.

"When they [staff] get great comments from women, it's a really easy route for collecting good feedback for those who are doing really well."
University College London Hospitals NHS Foundation Trust

Again, this coincides with how women would want their feedback to be used, either so that constructive feedback can be provided to staff personally to help them improve, or to thank them and make them feel valued.

"If you did it constructively and just said this didn't feel right for me… not to be horrible but to improve because she might not know she's done it."
Long Eaton, Derbyshire, C2DE, recently given birth

5.3 Who is using the feedback

Trusts reported that a range of different staff were using the various different bits of feedback being collected. In the survey, those identified as using the FFT most included:

- nursing/midwifery staff (20 of the 27 trusts responding said nursing and midwifery staff used it a great deal or a fair amount);
- the trust's patient experience manager(s) (20 of the 27);

- ward managers (19 of the 27); and
- departmental heads (18 of the 27).

Those identified as using the CQC National Maternity Survey most included:

- departmental heads (24 of the 27 trusts responding said departmental heads used it a great deal or a fair amount);
- ward managers (21 of the 27);
- nursing/midwifery staff (20 of the 27);
- the trust Board (20 of the 27); and
- the trust's patient experience manager(s) (20 of the 27).

Where trusts were also collecting other patient experience data from women, similar patterns were seen in the staff using the data.

Women themselves wanted a similar range of staff to have access to the feedback collected. This included:

- Individual members of staff, so that they could be thanked and praised for their work where positive comments were made, or helped to improve where they could have done better.
- Managers, so that they know what is happening in the services and can make changes.
- The Board, particularly for more serious incidents, as they have overall responsibility and budgetary control.

5.4 How feedback is communicated within trusts

The way in which feedback from women was being communicated within trusts varied, but typically utilised multiple channels. The survey of trusts showed that the FFT was mostly presented back to staff through team meetings (20 of the 27 trusts responding) and as a summary report (17 of the 27), with some also using posters on wards or in communal areas (12 of the 27) or as a dashboard (11 of the 27). The CQC National Maternity Survey was generally presented back to staff via a summary report (21 of the 27 trusts responding) and in team meetings (20 of the 27). A similar pattern was found in communications methods for other additional feedback that trusts were collecting.

The case study interviews showed that the frequency of discussion of feedback also varied between trusts, with some covering feedback in weekly team meetings, while others opted to discuss it monthly. Similarly, while some trusts used these more formal mechanisms to summarise feedback, others had individual-level access to the feedback so they could access it directly.

As already noted, some women said they had noticed 'you said, we did' posters and boards around the wards. A few women said they would be happy to provide their feedback in a non-anonymised way, but general agreement was that there should be the option to keep feedback anonymous.

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Chapter summary box

- **Women had generally not actively sought out feedback from other women about maternity services. Reasons for this included: lack of awareness of the availability of these data and a feeling that they did not need to be able to compare hospitals in this way; and fears of hearing negative stories or comments that would worry them. At the same time, they were sceptical of how this feedback would be presented, questioning whether the NHS would cherry pick positive experiences.**
- **Trusts were primarily collecting feedback from women to deliver local service improvements, improve women's experiences and use it as a tool to give feedback to staff about their department or ward. There were multiple examples of where feedback had been used in this way.**
- **In addition, trusts were using the CQC National Maternity Survey to benchmark their service against others nationally to identify areas of improvement and potential solutions.**
- **Other feedback collections outside FFT and the CQC National Maternity Survey also enabled trusts to monitor real-time feedback from women.**
- **Findings were also provided at individual level at times to identify areas for improvement and also to reward staff with praise where they had done well.**
- **Women themselves thought their feedback should be used in these ways.**
- **In general, feedback was being used by nursing and midwifery staff, ward managers and departmental heads, patient experience managers, and – for the National Maternity Survey in particular – the Board.**
- **Women also wanted their feedback to be used at these levels – for individuals, managers and the Board.**
- **Feedback was often communicated within trusts via summary reports and team meetings (of differing frequency). FFT was also communicated via posters on wards and in communal areas, or via dashboards. Women also reported seeing some posters and boards on the wards.**

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6. Collecting feedback for local service improvement and national benchmarking

NHS England is interested in investigating the feasibility of using a single data collection method to collect feedback from women which can be used for both national benchmarking and local service improvement. This chapter outlines the methodological requirements for a data collection exercise to enable data collected to be used for both these purposes, and the inherent tensions between the two.

6.1 Conditions for national benchmarking

There are some prerequisites that a data collection exercise must meet to allow for comparison between providers at a national level. This is because the data needs to be collected in a consistent way across trusts to ensure that any differences measured between trusts are a result of *actual* differences rather than variations in how the data have been collected or who they have been collected from. This section of the report outlines these prerequisites.

Sample selection:

- The population to be surveyed – the cohort of women that the survey is intended to collect feedback from will need to be defined. This may be, for example, all those giving birth in a certain time window.

- The sample frame[7] – i.e. the list of women the sample is drawn from – needs to be put together consistently. Care needs to be taken when deciding on and managing the sample frame to ensure that ineligible women are not included and that eligible women are not excluded, in order to avoid coverage error (ensuring that a sample frame and a sample are representative of the overall population of interest)[8]. The sample frame will reflect the population to be surveyed, and there are two key points here:

    (1) The sample frame needs to match the population to be surveyed as closely as possible. Trusts' systems need to enable them to construct a sample frame that is as comprehensive as possible. For example, if the survey was to be undertaken via email but 50% of women do not provide an email address in a certain trust then an online survey is not a viable approach and would introduce bias. In addition, the sample frame needs to be as consistent as possible across trusts.

    (2) Some women would need to be excluded from the sample frame, such as those who have experienced a stillbirth. This exclusion would need to be implemented consistently across trusts.

- The selection of the sample – having assembled the sample frame, a sample of women will need to be selected from this frame in a consistent way in each trust. This assumes that a census approach is not being taken (which may be more possible using a digital approach as the costs of including additional participants is lower than for paper-based approaches).

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[7] Defined as the 'set of a target population that has a chance to be selected into the survey sample'. Groves, Robert M., Fowler, Floyd J., Couper, Mick P., Lepkowski, James M., Singer, Eleanor, Tourangeau, Roger. 2004. Survey Methodology. Wiley-Interscience: USA, p. 45.

[8] Ibid., p. 54-55.

If the data collection is being managed locally, in order to achieve the above trusts will need to be given a set of instructions for how to select their sample and support in doing so.

Sample size:

The recommended sample size for a survey depends on its purpose and what the data will be used for. There are several factors that would influence the optimal sample size:

- Comparison between trusts: if the data are to be used to compare between trusts on measures included in a survey, a high enough number of responses needs to be achieved from trusts at each question being compared to allow for this.
- Comparison over time: if the data collection is intended to allow trusts to track their progress over time, enough responses need to be achieved at each point of data collection to allow for changes in the data to be measured.
- Sub-group analysis: if the data are to be used to undertake sub-group analysis, for example comparing responses from different groups of women based on ethnicity, age group or other variables, a high enough number of responses needs to be achieved within these sub-groups to ensure the analysis is meaningful. Caution should be taken when attempting to compare results based on low numbers of participants within sub-groups.

Response rates

In general, a good response rate will be required to give confidence in the findings of a national benchmarking exercise. A response rate to aim for cannot be given because, as importantly, the reliability of the survey depends on how different those who respond to the survey are to those who do not respond (non-response bias). When developing a national benchmarking survey, it will be necessary to test how to minimise non-response bias (likely to include maximising response rates and attempting to address differential response rates among different groups within the population).

Methodology:

The same methodology will need be applied for every trust. This means:

- using the same mode or modes to complete the survey;
- implementing the same pattern of reminders to women to take part in the survey; and
- running the survey at the same time – or as similar as possible – for all trusts.

Questionnaire:

If the data collection is being managed locally, trusts should be provided with a standardised set of questions and guidance on how to use these.

- Question standardisation: the questions that are being used for benchmarking need to be exactly the same across trusts. Additional questions tailored by individual trusts could be included in a questionnaire but these should come after the questions to be used for benchmarking, in order to ensure that the other questions do not impact on women's responses to the (earlier) benchmarking questions (as well as encouraging as many responses as

possible to the questions to be used for comparison). The order of the questions to be used for benchmarking should be consistent across trusts.

- Mode of response: the questions for benchmarking need to be answered in the same way across different modes of response. If, for example, the data collection methodology utilises both text message and an online survey, there should not be variance in results because the questions are answered differently on each. This means that questions would need to be designed to work equally across different modes. This will also require testing.

Practical considerations:

There are practical considerations that need to be taken into account when conducting a data collection exercise for the purpose of benchmarking:

- Participants should only be able to respond to a survey once at one time. This means there needs to be management of the sample to ensure that it is possible to monitor who has responded and that no duplicate cases are included.
- Reminders will likely need to be sent to women in order to maximise response rates – again, this means being able to track who has and who has not responded and removing those who have already responded from the sample prior to reminders being sent out.
- Women may have used multiple services across more than one trust, for example giving birth in one trust and then receiving community midwifery services from another trust. Processes would need to be worked out to ensure that women are not asked to complete the same survey more than once in these instances. Ideally the process would be designed in a way to tell which services women are giving feedback about, although this is challenging and does not happen at present with the CQC National Maternity Survey. If the data collection is being undertaken by trusts, a system needs to be worked out to decide which trust is responsible for administering the survey (for example, it could be the trust where the woman has given birth).

Ethical considerations:

There are also ethical considerations to bear in mind. These considerations apply to any survey or data collection among women, but may be more challenging to address with a digital method.

- A process needs to be worked out to ensure that the data collection excludes women who have had a traumatic experience such as a stillbirth or miscarriage, if it were deemed inappropriate to ask this group for feedback or if the questions were not relevant to these women. Surveys that could cause distress and harm to women should be avoided. In the case studies there were examples where certain forms of data collection had been not utilised as processes were not currently in place to ensure such cases were excluded from the data collection. While it remains important to enable these women and their families to provide feedback, alternative more personal approaches will be more appropriate.
- Processes should be in place to enable women to opt-out of the data collection should they choose to at any point, and also women should be able to have their data excluded from the analysis and deleted if they decided they wanted this.

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6.2 The need for a centralised function

If a data collection exercise is being used for benchmarking nationally then some centralised function will necessarily be required in order to ensure consistency in approach. There are three main approaches which could be used:

1. The approach could be led centrally (such as for data analysis and reporting) but have trusts responsible for administering the surveys and collecting the data from women, which would then be collated by the service and sent back to a central team for analysis. Trusts would need to be provided with a set of clear instructions on how to administer the survey, collate the data and send it back to the central team, which would also specify the questions to be asked for benchmarking. This approach would be like that taken for CQC's National Survey Programme, which involves a centralised survey coordination centre providing a specific set of instructions for how to undertake the survey, which are then undertaken by trusts and approved contractors. For the CQC National Maternity Survey, for example, trusts are provided with a set of instructions to follow with the aim of achieving at least 300 survey completes per trust[9]. One advantage to this approach is that it overcomes some data protection issues, with trusts retaining ownership of patient details. In this model, trusts provide the funding for the surveys while the commissioner provides the funding for the central team.

2. The second approach involves the data collection being more heavily reliant on a central team running a national survey. Rather than trusts being responsible for administering the survey and collecting data to send back to a central team, trusts could pull together a sample frame of women using their services and send this to a central survey team. The central team could then undertake the sampling process and send out the surveys via the chosen method. This option bypasses trusts being responsible for data collection and is therefore less prone to error, but would still require them to pull together lists of women who are eligible to provide feedback. Trusts would require clear guidance and instructions on how to undertake this process to ensure that sample frames are drawn in a consistent way. The National Cancer Patient Experience Survey uses this type of approach[10]. With the new General Data Protection Regulations (GDPR) and National Guardian recommendations, this approach may not be possible in future.

3. A potential third approach is similar to the second in that there is a centralised team carrying out the survey on behalf of all trusts, but in this model a central team would be able to use a pre-existing national list to draw sample and administer surveys. If a centralised list of women already existed that could be used as a sampling frame, trusts would then not need to spend time drawing sample frames to send to a central location and the potential for error would be further minimised. An example of this approach would be how the National Survey of Bereaved People (VOICES) runs. For VOICES, the death register, held by the Office for National Statistics, is used as a centrally held sample frame from which a sample is drawn[11]. However, at present there is not a centrally-held list of women.

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[9] https://www.cqc.org.uk/sites/default/files/20180130_mat17_qualitymethodology.pdf

[10] http://www.ncpes.co.uk/index.php

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/previousReleases

6.3 Tension between local service improvement and national benchmarking

When collecting data that are being used for both local service improvement and national benchmarking, there is an inherent tension.

Data that are used for local service improvement, with services adapting over time as feedback is received, tend to be more helpful for trusts when collected through more qualitative methods (including free text questions on a survey). Enabling local service improvement requires trusts to have some degree of ownership over the way data are collected and for their approach to be flexible and reflexive to local circumstances (for example, the timing or topics of a data collection).

However, to produce robust data that can be used for national benchmarking there would need to be a standardised methodology carried out across all NHS trusts at the same time for the data to be reliable and comparable. These data would also need to be to quantitative in nature, which is less useful for service improvement. National benchmarking also requires some degree of central co-ordination to ensure that the data is processed in a consistent way as is the case with the CQC National Maternity Survey.

The need for a standardised method and a central point of data co-ordination limits the ownership trusts would have over data collection and analysis. It may also have implications for how quickly trusts can react to feedback, as in practical terms with this type of national mechanism there is likely to be a delay between feedback being submitted and the trust receiving reports due to the time it takes to assemble samples, give women the time they need to respond and allow for multiple approaches, and to then consistently process the data and report upon it. A lack of ownership may also impact buy-in from staff and attitudes towards data collection generally.

Although these are important points to consider, and the tensions between local service improvement and national benchmarking are clear, it may be possible to have a method of data collection which could achieve both. However, any method would require further thought and rigorous piloting to determine the best methods to use, and ensure consistency across trusts, but also considering how much ownership could be given to trusts while maintaining standardisation and data processing. It is therefore worth considering whether it is preferable to have separate collections for different purposes (i.e. local service improvement and national benchmarking), rather than one collection trying to achieve both.

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Chapter summary box

- **There are a set of conditions that must be met if a survey is to provide data that can be used for national benchmarking purposes. These include:**
    - **Setting a consistent population for the survey, being able to develop a list of eligible women in exactly the same way for each trust, and applying the same approach for selecting a sample.**
    - **Achieving a sample size large enough to allow comparison between trusts.**
    - **Procedures and measures for maximising response rate and minimising non-response bias.**
    - **Employing a consistent methodology.**
    - **Using the same benchmarking questions to be asked up-front in any questionnaire, and with questions whose response is not affected by data collection mode.**
    - **Practical requirements such as being able to track who has and has not responded.**
    - **Ethical issues that may be more challenging to address for digital approaches.**
- **Benchmarking nationally will require some centralised function in order to ensure consistency. There are different approaches to this, one in which trusts administer surveys according to a specific set of instructions outlined by a central team, and one in which a central team administers the survey on behalf of all trusts (likely with trusts each providing sample since a national list of women is not available).**
- **There is an inherent tension between the standardised methodology and centralised function that a survey for national benchmarking would require, and the local ownership, flexibility and more qualitative nature of data collection for local service improvement.**
- **Any data collection to be used for both of these purposes will require a programme of testing and piloting.**

7. Conclusions and implications

This chapter outlines some overall conclusions emerging from the findings, along with their implications for collecting digital feedback from women in the future.

7.1 Conclusions

Overall

- Women were accustomed to providing feedback across a range of services in their lives and were keen to provide feedback on maternity services, as long as this is easy and convenient for them. They were interested in providing constructive feedback that could be used to improve services.

- The research demonstrated that maternity services are currently collecting feedback from women in a wide range of ways. As well as the Friends and Family Test (FFT) and the Care Quality Commission's (CQC's) National Maternity Survey, local maternity services were using a variety of survey-based and more in-depth qualitative approaches to collecting feedback from women about their services.

- Digital methods were being used a fair amount, for example with 17 of the 27 trusts responding to the survey using a digital approach for the FFT and 12 for other data collections. However, in nearly all cases these were being used alongside postcards or a paper questionnaire.

- In some areas, trusts were also working with Maternity Voices Partnerships (MVP) to gather feedback, and MVPs were adding in a number of different ways. However, there is geographical variation, with some MVPs already having better (often historical) relationships in place and differences in funding.

- However, the research also demonstrated that there was limited funding and staff capacity within trusts and MVPs to collect and analyse feedback. This means there was limited appetite for collecting more feedback in addition to what is already being done. There were also barriers to trusts changing how they were currently collecting feedback, even where they wanted to.

Selecting a methodology

- Choosing an optimal approach for collecting feedback from women involves a series of trade-offs. Different feedback collection approaches each have their benefits and drawbacks that have to be thought through depending on the purpose of a specific data collection. For example, a method that works well for performance management may lack the real-time advantage, which means it works less well for service improvement. When selecting a methodology, it is important to identify the purpose of the data collection, and to accept that it may not be possible for one methodology to fulfil multiple purposes.

- The research – and survey literature – shows that any single data collection should use a combination of different approaches to women to collect feedback. Contacting them in multiple ways encourages high response rates (assuming the impact of different modes on the data collection can be mitigated).

- Women could be given the opportunity to provide feedback at multiple points along the maternity pathway as it would be more useful for service improvement to link feedback to a point in the pathway.
- The same methodology does not necessarily need to be used at different stages in the maternity pathway. For example, feedback will be more detailed after labour and birth than after a more standard appointment, so a method that works for a standard appointment may differ to that used for more labour and birth.
- However, asking for feedback multiple times raises concerns about survey fatigue. Mitigations for this may include using different methodologies and different questions, that reflect each stage of the pathway.

Benefits and drawbacks/considerations around collecting feedback digitally

This research suggested that there would be benefits to collecting feedback digitally, including that it:

- Enables automation of data collection and entry (vis-à-vis paper approaches) which can help to improve quality of data and reduce the costs associated with paper-based processes such as printing and postage.
- Enables faster collation and usage of information, reducing the time-lag between data collection and reporting.
- Opens up more convenient ways for women to provide feedback about services and fits with their experiences of providing feedback for other sectors.
- Saves the time and resources of frontline members of staff who may currently be involved in administering surveys or the FFT, for example where a trust is collecting FFT via postcard.
- May enable more complex analysis of data collected, for example if survey results are collected through an electronic Personal Health Record (ePHR) and can be linked to information stored on it.
- Can enable easier analysis and interpretation of data, such as the creation of real-time dashboards for trust staff to access.

However, the research also raised a number of challenges and considerations around extending digital feedback, including:

- Although less of an issue for this user group than many others within the NHS, digital approaches offer potentially lower inclusivity than other types of approaches as some women using services will not be able to or would prefer not to provide feedback on maternity services digitally.
- The feasibility of digital approaches are not known in terms of whether trusts hold sufficient email addresses or mobile phone numbers, for example.
- Some digital methods (for example an SMS survey) have a limited ability to collect more in-depth qualitative feedback that is particularly useful for service improvement.
- Technical issues, such as poor Wi-Fi within some services.

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- Ethical issues may be more difficult to overcome than with other methodologies, for example, ensuring that specific women are excluded from digital surveys where they should not be sent them (such as women who have experienced a stillbirth) may be more difficult for an SMS survey than a postcard approach.
- Resource challenges within trusts and MVPs where data are not currently collected digitally, as funding may not be available to develop a different approach. There would also be challenges in terms of staff capacity if considering the immediate time required from patient experience teams to change approach, and further challenges if this was to be an additional data collection rather than replacing an existing mechanism.

Use of feedback

- Women had generally not actively sought out feedback from other women about maternity services. One reason for this was a lack of awareness of the availability of these data and a feeling that they did not need to be able to compare hospitals in this way as they were more likely to simply use a hospital close to them and/or that they had historic links with. In addition, women had fears about hearing negative stories or comments that would worry them. At the same time, they were sceptical of how this feedback would be presented, questioning whether the NHS would cherry pick positive experiences.
- They saw the primary purpose of collecting data as being for maternity services to use to make improvements (including through making comparisons with other services), but also to reward and praise staff.
- This matched well with how trusts were actually using feedback. They were primarily collecting feedback from women to deliver local service improvements, improve women's experiences and use it as a tool to give feedback to staff about their department or ward.
- In addition, trusts were using the CQC National Maternity Survey to benchmark their service against others nationally to identify areas of improvement and potential solutions. Trusts and MVPs provided multiple examples of where feedback had been used to improve services.

Collecting feedback to be used for both national benchmarking and local service improvement

- In order for data to be used for national benchmarking, a number of conditions must be fulfilled to ensure that survey data are robust enough to be comparable across organisations. This means that a level of central control of the survey would be required, either with a single supplier running a survey for all trusts (as is done for the Cancer Patient Experience Survey, for example), or through providing specific instructions for trusts to follow (as is done for the CQC National Survey Programme). Both options have advantages and challenges, as outlined in this report.
- However, there is an inherent tension between national benchmarking and local service improvement:
  - Local service improvement works best where trusts and MVPs feel ownership of the process and the data, and are able to respond to local issues by tailoring the questionnaire.
  - However, to produce robust data that can be used for national benchmarking, central coordination and a specified methodology and set of questions are required.

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- Any data collection aiming to enable both national benchmarking and local service improvement needs to bear this tension in mind and ask whether it is possible to achieve both or whether having separate collections for different purposes is preferable.

7.2 Implications

1. Introduce digital feedback through existing mechanisms – which can be developed further – rather than adding a new mandatory digital data collection mechanism

A strong theme emerging from the case studies was the limited funding and staff resources that NHS trusts currently have for the collection of feedback, analysis and use of the data. An additional nationally mandated survey that uses a digital methodology, in addition to the FFT and the CQC National Maternity Survey, would require significant investment. Trusts would need investment so that they could work with suppliers and employ staff to analyse and work with the data, and the centrally-run data collection would require funding. Even if the funding challenges can be overcome, maternity staff already consider women to be over-surveyed, and staff themselves are unlikely to be able to absorb another set of data to act upon in addition to FFT, the CQC National Maternity Survey and what they are collecting locally (themselves and via MVPs). This is not necessarily linked to staff resources, it is also about ensuring that staff can focus and are not overwhelmed by volume.

In addition to this, setting up a new mandatory digital feedback mechanism – particularly one that aims to provide data for national benchmarking – is a significant undertaking. It would require extensive development work to establish feasibility (for example, checking that trusts are able to provide consistent sample frames), and then run pilots to test different approaches. In addition to cost implications, this also has implications for timings. Since both the FFT and the CQC National Maternity Survey are already running and have the required infrastructure in place, they provide a good starting point for digital data collection. FFT data are being used for local service improvement and the CQC National Maternity Survey provides benchmarking data that allows services to compare themselves with others. While these two data collections exist and between them allow service improvement and benchmarking, in the short-term, for the reasons outlined, we suggest working with them to improve what they offer and see whether/how they can move towards digitalisation rather than introducing another form of national data collection that tries to do these things.

2. Build on the FFT and CQC National Maternity Survey

CQC National Maternity Survey

The CQC National Maternity Survey is already moving towards digital data collection, with testing being undertaken to investigate different digital approaches, their feasibility, and their effects on response rates to the survey. We suggest that NHS England works with CQC to develop and test a digital approach to the survey. Although the timings may not meet NHS England's ideal requirements, setting up an additional data digital data collection will also require significant time, and would duplicate CQC's work.

Our research also highlighted that a key barrier to using the CQC National Maternity Survey for service improvement is the time lag between collecting the data, dissemination, making appropriate changes to services, and those then being measured in the survey to ensure improvements have been made. There is always likely to be some time lag for a large and robust survey of this nature due to the time it takes to assemble samples, give women the time they need to respond and allow for multiple approaches, and to then consistently process the data and report upon it. However, moving

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towards a digital approach may improve the time lag issue to some extent. Again, we suggest that NHS England works with CQC to address this as far as possible to maximise how useful these data are for service improvement, as well as national benchmarking.

Friends and Family Test

The FFT is already well-embedded within maternity services and they find the free text responses particularly helpful in terms of local service improvement. However, there are two key ways in which the implementation of the FFT could be improved:

- The touchpoints at which the FFT is given to women are considered by maternity staff to be too many and in the case of the questions about labour and the postnatal ward in particular, too close together, resulting in apathy from women and lower response rates. It can also be unclear to women which part of the service they are giving feedback on. Combining the feedback collection for labour and the postnatal ward might help to reduce the burden on staff and women. Alternatively, maternity services could themselves decide at what points they would like to collect feedback.

- Staff also reported finding the data from the main closed FFT question to be less useful or actionable than the open-ended responses. Options include developing a new question, or a short series of questions that collect more specific responses, and/or to allow different questions for different stages of the pathway.

In addition to this, we suggest that NHS England continue to communicate best practice to trusts about collection of the FFT, including a specific focus on digital data collection, building on what a number of trusts are already doing locally. This could include:

- Encouraging trusts to take more ownership of the FFT, for example using it as a vehicle for also asking some more specific questions that reflect local issues and changing those questions as priorities change.

- Demonstrating how the FFT can be triangulated alongside other feedback and data sources (including qualitative approaches) to provide a more complete picture of services, diagnose issues, develop improvements, and then measure the impact of changes.

- Suggest digital approaches that trusts may wish to consider using, alongside their benefits and drawbacks, to help trusts to consider the different options and learn from what others are doing.

3. Potential longer-term solution for service improvement and benchmarking

For the reasons already outlined, we do not currently recommend implementing another form of data collection in maternity services in addition to the FFT and CQC National Maternity Survey. However, the development of digital approaches may offer longer-term potential for a data collection that allows both local service improvement and national benchmarking. In particular, the timing is currently perfect for considering adding feedback mechanisms into electronic Personal Health Records (ePHRs), as they are being currently developed.

Women reported that they would not download an app purely for the function of providing feedback. Instead, an app would need to provide them with information (which they would particularly trust because of the NHS brand) and information targeted at them personally depending on their stage of pregnancy or their own medical history. An ePHR

would enable this, with women more likely to use it and continue using it throughout pregnancy, regardless of whether or not they are first time mums.

The research suggested that feedback collection is currently seen as an 'add-on' that is not the focus of ePHR development, partly due to low interest from trusts, who have limited resources to act upon another set of feedback data. However, interviews with suppliers developing ePHRs suggest that it would be possible to incorporate feedback elements, with the advantages as outlined at the beginning of this report chapter.

If developing this approach, we recommend incorporating the following elements:

- Using the ePHR to trigger a feedback request being sent to a woman, for example after a scan or midwife appointment, so that feedback can be directly linked to an event and health professional and therefore be more useful for improving services.
- Allowing this feedback request to be completed via the app, SMS, or a link to an online survey, to allow women choice and offer a range of response modes (as women, staff and survey literature all suggest).
- This feedback request could include a small number of short, standardised questions that are easy to complete and likely to bring a higher response rate than a long series of questions. In addition, by standardising these questions and asking them up-front, the findings could potentially be used for national benchmarking (assuming the other conditions outlined in this report are met).
- Following these short, standardised questions, women could be sent a link to an online survey, comprising questions designed at local level to reflect local priorities, including free text questions to gather more qualitative feedback. This may also encourage more local ownership of the data.
- These questions (both the standardised and local) could also be tailored to the specific point on the maternity pathway, since they will be triggered by a specific event. This would also allow more questions for stages of the pathway likely to require more detailed feedback (i.e. labour and birth).
- Incorporate the FFT questions within this approach, so that it is not an additional data collection, but one that delivers the FFT alongside other data that together can be used to improve services and compare trusts.
- Enable data analyses of feedback data alongside demographic and other information already incorporated in the ePHR, such as number and type of appointments attended, to add value to the data collected and how it can be used to improve services.

Considerations around this approach

There are some disadvantages, barriers and considerations to the data collection approach outlined above:

- It would be necessary to select five or so standard questions (potentially varying by stage on the pathway) that could be used for benchmarking, which may be a challenge. In addition, it would mean collecting less data per participant than a mechanism like the CQC National Maternity Survey.
- As the longer online survey would come at the end of the series of short questions, the response rate to this part may be low. This would need testing to measure drop-off and identify the best way of doing this.

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- Work would need to be done to identify at what point(s) of the pathway the questions should be asked, and how often women should be asked for feedback (bearing in mind response rates). Again, this would require testing. It will also be necessary to consider if the questions can be asked at multiple points in the pathway and still be used for national benchmarking, as this would mean collating and processing multiple datasets per trust.

- There are process/practical considerations from the perspective of trusts that need to be taken account of. For example, if the feedback request was being sent out by text messages, are enough mobile phone numbers of women collected and stored by trusts to enable this, or could (and would) this be done through the ePHR?

- Care would need to be taken over ethical implications, such as ensuring women who should not be sent the feedback request are excluded (for example, mothers who experience stillbirth).

- Consideration will also need to be given to interoperability of the data. For example, processes should be in place to ensure that women are not asked to provide the same feedback more than once, if a service is collecting it via multiple approaches.

- If this were a nationally mandated data collection, care would need to be taken not to stifle local innovation by imposing a top-down approach.

- In addition, if it were a nationally mandated data collection, a decision would need to be made about whether to ask all ePHR providers to enable the feedback request in a uniform way, or whether to develop a single national ePHR incorporating this feedback mechanism.

- The ePHR, would need to be designed to be engaging for women and encourage them to use it. It should be designed to not exclude groups of women, for example by being available in multiple languages.

- Not all women would be able to or would want to use an app or an ePHR, or to provide feedback via this mechanism. This would need to be explored during the development of the approach. It is very important to ensure that the views of these women are still collected.

If there is appetite for this type of approach, and if it is to provide national benchmarking as well as local service improvement, it will require significant development work. In addition, ePHRs are themselves at a relatively early stage of development – this provides both opportunities for building feedback into them but also means it is a longer-term solution. Further, if pursuing this, we recommend piloting and testing the approach extensively to ensure it can best deliver what is desired. If, however, this approach was to be used as an optional local feedback mechanism, with trusts themselves determining what and how they want to collect and leaving aside the national benchmarking requirement, this option would be significantly less challenging. It is the requirement for standardisation and centralisation accompanying national benchmarking that adds complexity and the need for extensive testing and piloting.

4. Continue collecting feedback via other approaches, do not solely focus on digital

Collecting feedback digitally has a number of advantages, as outlined earlier. However, it is not a panacea, and should be used as one of a suite of feedback mechanisms, for two main reasons:

- Firstly, not all women will be able to or want to provide feedback digitally and these women should not be excluded from being able to provide feedback. Workshop participants were very clear that it is important not

simply to continue collecting feedback from the same people who already feedback, and who the system is already designed to work for. They pointed to other harder to reach women whose feedback needed to be heard and that a digital approach may not solve this issue, although this assumption would need to be tested. Consequently, trusts would need to continue working with all of their patients to establish what works best for them.

- Secondly, a great deal of useful feedback comes through other (often more qualitative) approaches used by trusts and MVPs, for example through 'Walk the Patch', visiting parent and baby groups, outreach and so on. Feedback collected locally in these ways are useful for making service improvements and it is important not to lose this more in-depth input from women and families.

5. Continuing to use MVPs to collect feedback from women on local issues, and doing anything possible to support them

Where MVPs are working well, they are adding to the collection of feedback collection locally, in particular by:

- Collecting more in-depth feedback from women as an independent body.
- Conducting 'deep dives' to understand issues women are having in depth. For example, they could conduct in-depth qualitative research with women around areas flagged up as issues in the FFT or CQC National Maternity Survey, to understand concerns and diagnose ways of improving services in more detail.
- Providing a crucial link to hard-to-reach women who otherwise might be missed by feedback collection (and potentially particularly digital feedback collection).

The system should look to further support and encourage MVPs in any way possible, including:

- Additional and more consistent funding for MVPs.
- Helping to professionalise them, for example by offering and providing training.
- Assisting trusts with promoting MVPs and encouraging women and families to participate in them – including women from a range of different backgrounds.
- Offering guidance and training for trusts on how to engage and work with MVPs, encouraging trusts to listen to the MVP and facilitate co-production.
- Providing best practice for trusts around how feedback gathered from the FFT, CQC National Maternity Survey, any other local feedback collection exercises and feedback collected by MVPs can be brought together to triangulate findings, and how MVPs may assist this triangulation.
- Providing best practice to encourage and enable MVPs to incorporate digital data collection even further into what they are already doing, if it proves useful – such as using tablets to collect data when speaking to women and families face-to-face about their experiences.

8. Appendices

8.1 Appendix A: Pros and cons of data collection methods

Paper survey completed at the hospital / clinic

Pros:

- Direct way of providing feedback which is given at the time and received immediately by staff.
- Seen as straightforward and in-the-moment.
- Some people find completing on paper easier than digital.
- Staff can engage with women and encourage them to complete feedback.
- Less sample management required by trust.

Cons:

- Relies on staff to collect feedback.
- Takes longer for trusts to collate, process and use.
- Not reassuring that feedback will be escalated.
- May be difficult to provide negative feedback.
- Can be time consuming to complete.
- Women may be tired and find burdensome.
- Creates paper waste.

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Paper survey sent after appointment

Pros:

- Women can complete in their own time and at their convenience.
- Women may be more likely to provide more detailed feedback as completing in their own time.

Cons:

- Women may forget important information/experience (depending on how long after appointment).
- Having to go to a post box and send it back is a burden on women.
- Takes time for the trust to receive, collate and use.
- Costly for the trust – e.g. postage, printing.
- Requires sample management processes, e.g. address database.

18-003043-01 NHS England Digital Maternity Workshop Presentation – V1 – INTERNAL USE 2

Telephone survey after appointment

Pros:

- No paper waste.

Cons:

- Probably the least preferred option in the focus groups.
- Has to be completed there and then, so inconvenient for women.
- Dislike of automated phone calls. If not automated, requires staff time.
- Women said they would prefer a feedback line to call if they wanted to speak to someone.
- More difficult to analyse than other formats (need to transcribe or code).

18-003043-01 NHS England Digital Maternity Workshop Presentation – V1 - INTERNAL USE 3

Being able to speak to staff directly

Pros:

- If positive experience, women were happy to give feedback.
- Easy and quick to give feedback in person.
- Can get resolutions straight away, immediate and personal.
- Morale boost for specific members of staff receiving feedback.

Cons:

- Some may be uncomfortably providing negative feedback this way.
- Negative feedback could be rebutted by staff.
- Concerns that bad feedback wouldn't be passed on to management.
- If in-depth, time consuming to arrange times to meet.
- Time consuming for frontline staff to receive feedback in this way.
- Cannot use for benchmarking.

18-003043-01 NHS England Digital Maternity Workshop Presentation – V1 - INTERNAL USE 4

Online survey sent after appointment / discharge

Pros:

- Women can complete in their own time and at their convenience.
- Quick for the trust / their supplier to receive, collate and use.
- Requires no postage.
- Open survey links are promoted via social media, e.g. Twitter, Facebook.

Cons:

- Women may forget important information/experience (depending on how long after appointment).
- Potential for technical issues, or for survey to be sent to junk mail.
- Women may forget to do it or not bother.
- Unique survey links require trust to manage list of email addresses – using an open link gets around this but means survey responses aren't attributable to individuals.

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Tablet or kiosk provided at the hospital / clinic

Pros:

- Can be quick and easy, especially if done while waiting.
- Feedback provided in the moment (memory is fresh).
- Less sample management required by trust.
- As digital & real-time, data is quick to collate for trust/supplier.

Cons:

- Reports of tablets being stolen in trusts.
- Still requires staff to direct / encourage women to complete feedback.
- Not easy to complete when you have children with you or are busy – burdensome.
- View of a tablet being more impersonal than other methods of collecting feedback.
- Can't tell how long survey is, concerns over how the data would be used.

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SMS / text message survey sent after appointment

Pros:

- Seen as quick and convenient, easy to complete if quantitative responses.
- Can be sent soon after appointment so experience is fresh in mind.
- Can complete 'on the go' at convenience of participant.
- Potential to combine texting with an online link in order to capture more in depth feedback.
- Data received instantly/collated quickly.

Cons:

- Can become repetitive, impersonal & generic.
- Women would not want to be charged for texts.
- Texting not good for collecting in-depth feedback – difficult to write long responses.
- Requires some process/sample management to collect and keep phone numbers up-to-date.

Smartphone app

Pros:

- Can give feedback in your own time, available and accessible anywhere.
- Could get reminder notifications to encourage responses.
- Can include all your data in one place if linked to ePHR.
- Could incorporate information provision.
- Some women already used to using pregnancy related apps.

Cons:

- Women wouldn't download app just to provide feedback – would have to be useful to the user in other ways.
- Concerns with phone memory.
- Some people not good with technology.
- Concerns about security of information on an app.
- Requires maintenance of apps and making sure information is kept up to date – this requires resource.

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