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Maternity & Neonatal Voices

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What Women and Families Told Us

Local responses to the 2026 National Maternity and Neonatal Investigation

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About the Maternity and Neonatal Voices Partnership

The Maternity and Neonatal Voices Partnership (MNVP) works across Tower Hamlets, Waltham Forest and Newham to ensure that the voices of women, birthing people and families shape maternity and neonatal care. By bringing service users, clinicians, commissioners and community partners together, MNVP supports co-production with Barts Health NHS Trust and helps address local health inequalities through lived experience.

This report shares what local women and families told us about the National Maternity and Neonatal Investigation, published in June 2026 (Access here) , and whether its findings reflected their own experiences of maternity and neonatal care across Barts Health NHS Trust.

We gathered feedback through an anonymous online survey, which received 37 responses, and an online focus group with five service users on September 2026. The report presents the survey findings, respondent demographics and hospital-specific comments, followed by the focus group findings and recommendations.

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What Did the National Investigation Find?

In June 2026, Baroness Valerie Amos published the final report of the National Maternity and Neonatal Investigation, highlighting concerns about the safety, quality and consistency of maternity and neonatal care across England.

Key themes included:

- **Not being listened to:** Women and families described concerns being dismissed or not taken seriously.
- **Communication and involvement:** Families reported unclear explanations and not always being involved in decisions about their care.
- **Respect, dignity and inequalities:** Experiences of discrimination, a lack of compassion and care that did not always meet individual needs.
- **Staffing and capacity pressures:** Workforce shortages, delays and pressure on available facilities affecting care.
- **Continuity and coordination**: Gaps in communication and support between maternity, neonatal, community and postnatal services.
- **Accountability and learning:** Families described difficulties obtaining explanations and meaningful responses when something went wrong.

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Key Survey Findings

MNVP wanted to understand whether these national findings reflected the experiences of women and families using maternity and neonatal services across Barts Health NHS Trust.
Through our survey and focus group, we explored what was working well, where improvements were needed and what changes mattered most to local families.

The anonymous online survey received 37 responses, covering all three main Barts Health maternity hospital sites.

How Closely the Report Reflected Experience

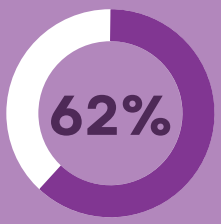
- 16% said it reflected their experience very well
- 46% said it reflected some of their experience
- 11% said very little
- 11% said not at all
- 16% were not familiar with the report

Confidence When Raising Concerns

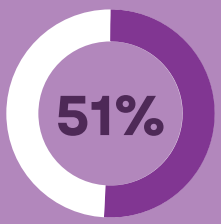
Among the 31 respondents familiar with the report, 74% said it reflected at least some of their experience.

When concerns were raised, 69% of those respondents were not very confident or not at all confident that staff responded appropriately (22 of 32 respondents).

Survey Insights



said the national report reflected at least some of their experience



said their care was rarely or never well coordinated

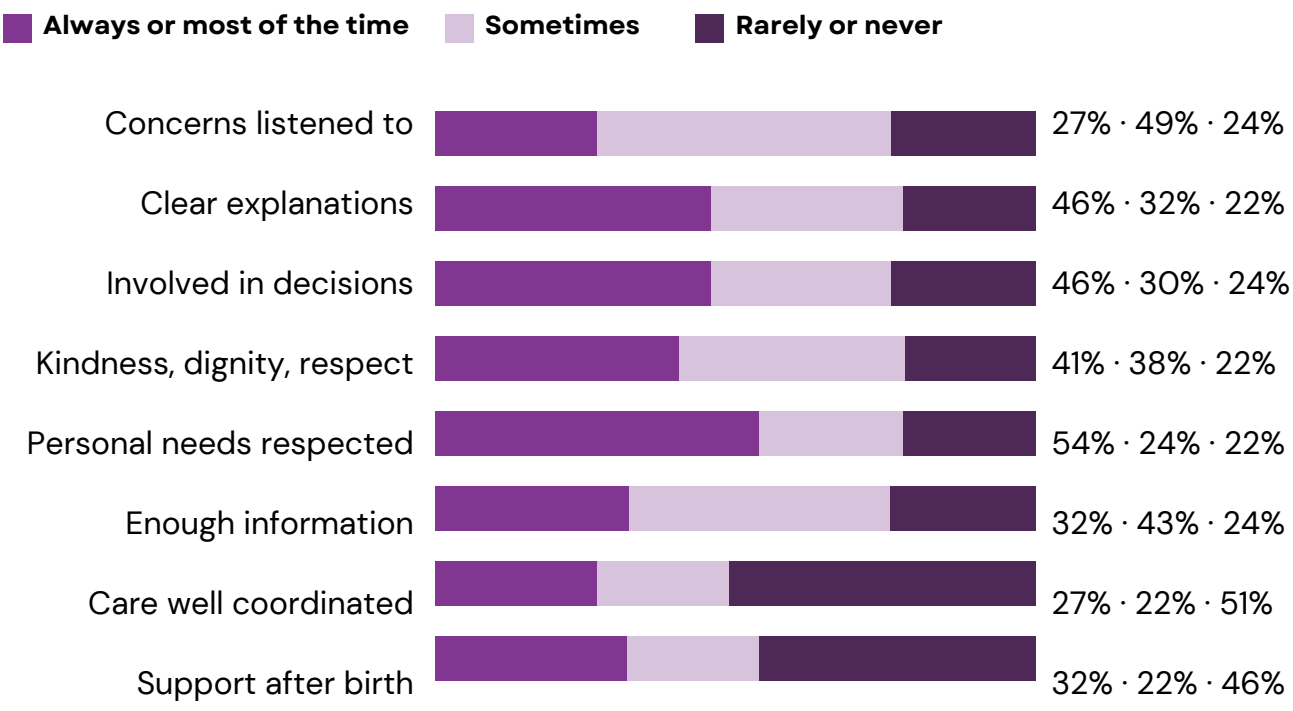


of those who raised concerns were not confident staff responded appropriately

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Experience of Care

Respondents rated eight aspects of their maternity and neonatal care. Care coordination and support after birth were the weakest-rated areas: half of respondents said their care was rarely or never well coordinated, and 46% said they rarely or never received the support they needed after birth.



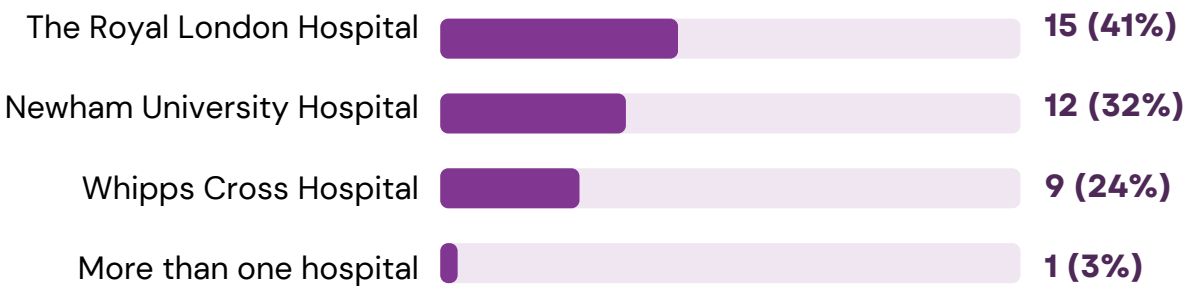
When Concerns Were Raised

69% of respondents who raised concerns were not very confident or not at all confident that staff responded appropriately (22 of 32 respondents).

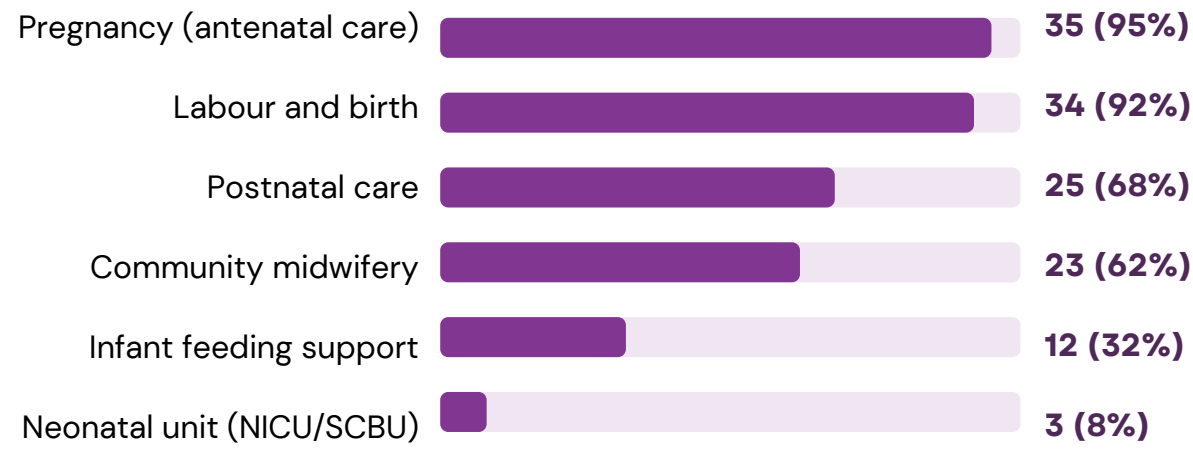
Respondent Profile

Responses covered all three main Barts Health maternity hospital sites. Some respondents had used more than one service.

Main Hospital



Services Used

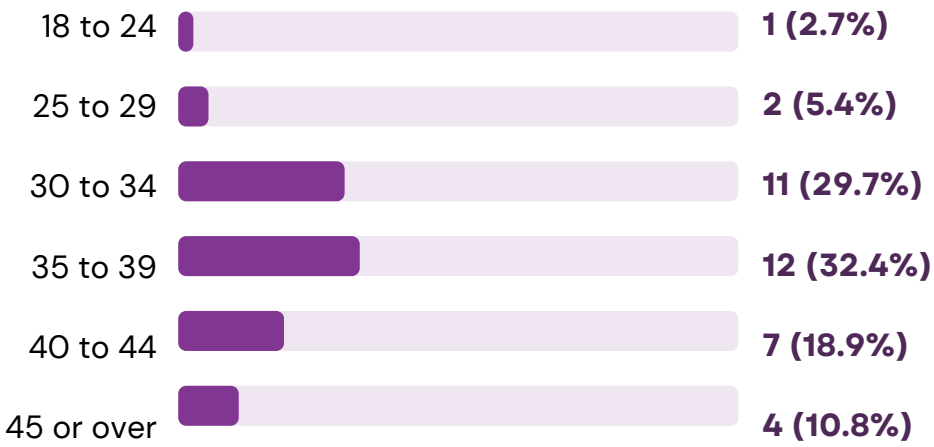


Note: Percentages may not total 100 because of rounding. Service percentages exceed 100 because respondents could select more than one service.

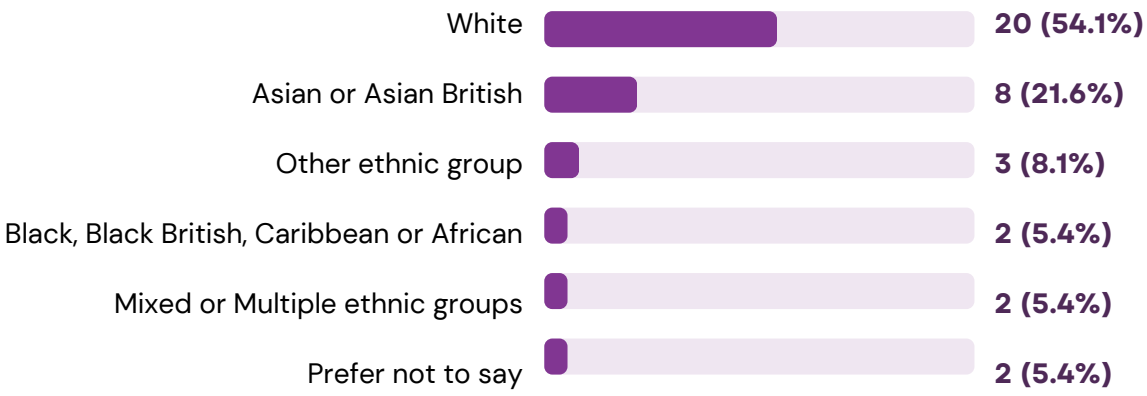
Respondent Demographics

The charts below show the number and percentage of the 37 respondents in each demographic group.

Age



Ethnic Background

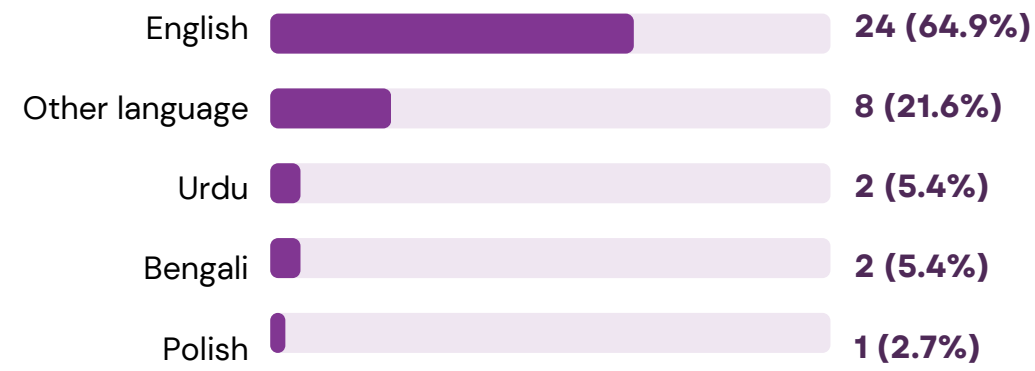


More detailed ethnic background: White respondents included 10 from another White background (27.0%), 9 English, Welsh, Scottish, Northern Irish or British (24.3%) and 1 Irish (2.7%). Asian respondents included 4 Bangladeshi (10.8%), 2 Pakistani (5.4%), 1 Indian (2.7%) and 1 from another Asian background (2.7%). The 2 Black respondents identified as African (5.4%). The Mixed group included 1 White and Asian respondent (2.7%) and 1 from another Mixed background (2.7%). The Other ethnic group included 1 Arab respondent (2.7%) and 2 from another ethnic background (5.4%).

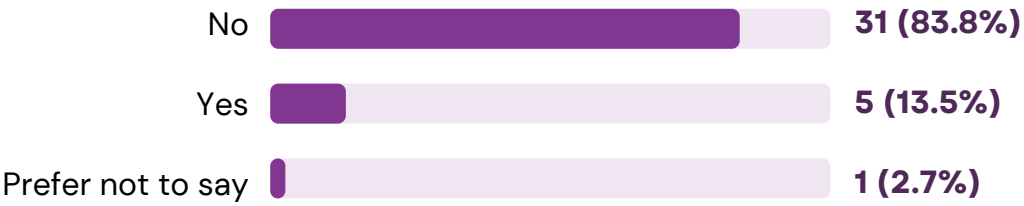
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Language and Support Needs

First Language



Disability and Long-Term Conditions



Interpreter and Communication Support

All 37 respondents (100%) said they did not need an interpreter or communication support during their maternity or neonatal care.

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Main Themes in Written Feedback

Respondents described both positive experiences and areas for improvement in their written survey answers.

What Respondents Said Worked Well

- Kind and supportive care from individual midwives, nurses and doctors, especially during labour and birth.
- Positive experiences with home birth teams, neonatal teams, community midwives and infant feeding support.
- Feeling safe and reassured when staff communicated clearly and responded promptly to clinical concerns.

What Respondents Said Should Improve

- Listening to concerns and treating families with dignity, respect and compassion.
- Clear explanations, informed choice, consent and involvement in decisions.
- Continuity and coordination between teams, with accurate records and consistent information.
- Postnatal support, including basic care, baby feeding help and mental health support.
- Staffing, bed availability, waiting times and access to timely help.
- Recognition of personal, cultural and religious needs.

About the Comments

The quotations in this report are anonymised and have been lightly edited for spelling, punctuation and clarity. Where necessary, explanatory words have been added in square brackets to help readers understand the intended meaning. Care has been taken to preserve respondents' original views and experiences. These accounts represent individual experiences and have not been independently verified.

Comments by Hospital

15

respondents mainly received their care at this hospital

The Royal London Hospital

The comments below are selected anonymised excerpts from the survey responses of people who mainly received their care at this hospital.

What Respondents Said Worked Well

Respondents praised individual staff, home birth services, neonatal care and infant feeding support. Several said staff made them feel safe, heard and reassured.

> *"The care that was provided for my son in the neonatal unit was excellent."*
> *"The Homebirth team were absolutely outstanding and made me feel safe and cared for."*
> *"I had 2 anxious pregnancies and was always made to feel my concerns were important."*
> *"The home birth team was amazing and the infant feeding team was also brilliant."*

What Respondents Said Should Improve

Respondents raised concerns about continuity, communication, listening, postnatal support, staffing and bed capacity. Some described traumatic experiences and difficulty obtaining responses through complaints routes.

> *"[They could have] supported me better after birth on the ward. The midwives did not provide good quality postnatal care. It was more like a tick box that they needed to complete"*
> *"Overall, I had no continuity of care, never had an appointment with the same midwife twice."*
> *"I was treated like an inconvenience during my birth; options were not explained to my partner or me, and I feel rushed and unsafe."*
> *"Poor explanation of the induction process and how long it could take. Bad support after birth as I was left on the bed covered in blood for a few hours."*
> *"Treat patients like human beings - don't shout at them or belittle them. Don't dismiss their fears. Ensure there are enough midwives and beds in the labour wards."*

Newham University Hospital

12 respondents mainly received their care at this hospital. The comments below are selected anonymised excerpts from their survey responses.

What Respondents Said Worked Well

Respondents highlighted supportive labour care, attentive clinical responses, miscarriage support and staff who provided good care despite pressure on services.

> *"I felt that they give a brilliant service even though they are very stretched."*
> *"The midwife at labour was kind, respectful and listen to my preferences."*
> *"When I hemorrhaged they all came together and helped me get back to myself in no time so I could breastfeed baby."*
> *"I had 3 miscarriages before and the Hospital really supported me with all the extra care I needed throughout. I felt really safe."*

What Respondents Said Should Improve

Respondents asked for more staff and beds, clearer appointment and induction information, respectful care and stronger postnatal and feeding support. Serious concerns included consent and access to timely help.

> *"I had a terrible experience with a Dr who spoke to me in a very disrespectful way and physically examined me without my consent and without pain relief."*
> *"[The hospital should have ensured] there was space available when booking me in for an induction. I'm sure my baby was in distress due to the stress of hanging about waiting for bed to come available on the ward."*
> *"I was not given any meals, as I wasn't allowed to exit two steps outside the ward area where the meals were served with my baby in my arms."*
> *"The app needs clearer and more comprehensive appointment information. My community midwife appointments were not on there at all."*
> *"[I needed] lactation support. I had significant difficulties with breastfeeding and felt that nobody was able to help me."*

Whipps Cross Hospital

9 respondents mainly received their care at this hospital. The comments below are selected anonymised excerpts from their survey responses.

What Respondents Said Worked Well

Respondents described kind staff, strong community midwifery support and positive care during labour and after birth.

> *"Some midwives went above and beyond to provide good care at a time of high anxiety."*
> *"Treated me with kindness and respect."*
> *"The support I got during my child birth and then after birth was truly exceptional."*
> *"The community midwives were great throughout my pregnancy and the appointments were useful and informative."*

What Respondents Said Should Improve

Respondents raised concerns about being listened to, pain relief, induction information, respect, postnatal bed availability and explanations during care.

> *"The induction process was explained poorly and resulted in an 8-day hospital stay plus an emergency c-section."*
> *"[Staff could have] listened to me when I was struggling. I was induced and told that if I had more than three contractions in five minutes, the pessary would need to be removed."*
> *"Not enough beds in the post natal unit, so I spent the night in the recovery room post c section."*
> *"I was not given pain relief when I told staff that I was struggling. Only in the Labour ward was anyone listening to me."*
> *"Midwives need to be trained to listen first and give simple explanations."*

More than one hospital (1 respondent - Whipps Cross Hospital and Newham University Hospital)

This respondent identified labour and delivery as the part of care that went well ("During labor and delivery.") and asked services to respect religious beliefs, values and diversity: "By respecting religion beliefs and values and giving some space to accept the diversity." "Please ensure Muslim women should be treated according to their religion beliefs and they should not feel shame to be in hospital."

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Focus Group Findings

Online focus group, September 2026, with five service users.

Following the anonymous online survey of 37 respondents, MNVP held an online focus group with five service users. Participants had experience of maternity and neonatal care across different localities and all three Barts Health maternity hospitals: the Royal London Hospital, Whipps Cross Hospital and Newham University Hospital.

The discussion explored whether the findings of the Independent National Maternity and Neonatal Investigation, published in June 2026, reflected families' experiences of local services. The findings that follow are organised around the questions asked. Quotations are anonymised and lightly edited for clarity without changing their meaning, and experiences are presented as participants' personal accounts.

Overall, participants felt that many of the national findings were familiar, particularly:

Not Being Listened To

Women and partners did not always feel listened to when raising symptoms or warning signs.

Care Not Personalised

Care did not always feel tailored to the individual and their history.

Inconsistent Communication

Explanations, information and handovers were not always clear or joined up.

Gaps Between Services

Support was not always joined up as care moved between teams and services.

Theme 1: Listening to Women and Families

Thinking about your own experience, did the national finding that some women and families did not always feel listened to feel familiar?

The strongest and most consistent message was that women and partners did not always feel listened to when they raised symptoms, changes or warning signs.

Women experiencing severe pregnancy sickness described being told by NHS 111 and primary care services that vomiting was normal in pregnancy, even when they could not drink water, stand easily or manage basic activities. They did not always receive clear advice about medication, assessment or what to do if they were too unwell to attend in person.

> *"I was told, 'It's normal,' but it wasn't normal for me."*
> *"I couldn't even drink water, but I still felt that my symptoms were not enough for them to help me."*

One partner described repeatedly communicating serious concerns during early labour but feeling that the urgency was not recognised: "I felt that they just didn't want to hear what I was saying."

Another mother described reporting continued bleeding following a caesarean birth. Her concern was initially dismissed after a brief check. Emergency action was taken only after she became dizzy and her partner contacted staff again.

Service-User Message

Concerns raised by women and families should not be dismissed before an appropriate clinical examination or assessment has been completed and serious complications have been ruled out. Participants stressed that delayed recognition can, in some circumstances, place the mother or baby at serious or fatal risk or contribute to a long-term or lifelong condition for the baby. Listening must lead to assessment, documentation, escalation and clear safety-netting advice.

Theme 2: Communication and Joined-Up Care

Were things explained clearly, and did different staff and teams communicate well with the family?

Appointments and Investigations

One participant attended two community midwifery appointments in Newham that had already been cancelled. She was not informed before travelling, resulting in unnecessary travel, lost working time and additional stress.

Another participant was told by her community midwife that she needed a particular blood test. After the test had been completed, a hospital consultant told her that it had not been clinically necessary in her circumstances. She also did not receive direct communication about the result. The conflicting information made her feel that an unnecessary test had been requested simply to complete a standard process.

> *"I took time off work and travelled to the appointment, only to be told that it had been cancelled."*
> *"It felt like ticking boxes. I had an unnecessary blood test, and no one clearly explained why I needed it or gave me the result."*

Communication During and After Emergencies

Participants understood that staff sometimes need to act quickly during emergencies. However, they still wanted staff to respond properly to concerns and provide brief, clear explanations whenever clinically possible.

One participant woke following an emergency caesarean birth and was told that staff had almost lost both her and her baby. She was not given a clear explanation of what had happened or why they had been in such danger, and continued seeking information after leaving hospital. Although her GP understood that the birth had been medically serious, she still did not receive a clear account of what had happened.

> *"I was told, 'We almost lost you and your baby,' but no one clearly explained why."*
> *"I feel like I still didn't get closure about what happened during the caesarean section."*

Communication Across Hospitals

One participant received all her antenatal care at Newham University Hospital and was booked for an induction there. When a bed was not available, she was transferred to Whipps Cross Hospital for the induction, which was followed by an emergency caesarean birth in which the mother and baby required urgent care. She felt there was no coordinated follow-up after the birth: "All my care was at one hospital, I gave birth somewhere else, and there was no follow-up afterwards from the second hospital."

Service users wanted reliable appointment reminders, prompt cancellation notices, explanations about why tests are required, communication of all results and a clear clinical handover when care moves between teams or hospitals.

Theme 3: Compassion, Dignity and Individual Needs

Did care feel kind, respectful and personal, and were individual needs understood?

Experiences were mixed. Participants described individual midwives, nurses and neonatal staff who were compassionate, responsive and willing to adapt care. One participant's experience improved significantly after she requested a different community midwife.

Other experiences felt based on completing standard processes rather than understanding the individual. Participants described having to repeat their history, staff not appearing to have read their notes and conflicting advice from different professionals.

One participant made a personal request about the timing of an elective caesarean birth because of its cultural and bereavement significance. She understood that the request might not be possible, but wanted a clear and respectful response. Instead, she felt responsible for repeatedly chasing the service for an answer. Participants felt that good care was too dependent on the individual professional on duty.

> *"After I changed midwife, I received very good care from the midwife who followed me up."*
> *"I don't want to be put into one box because someone else had a similar experience. Everyone has a different body and a different journey."*
> *"Some nurses were really outstanding, and some were not up to the standard we expected."*
> *"It sometimes feels like a lottery whether you get someone who listens and cares."*

Theme 4: Continuity and Support

Where did service users feel well supported, and where was more support needed during pregnancy, after birth or during neonatal care?

Continuity and Follow-Up

Participants described gaps when care moved between community teams, hospitals, neonatal services and primary care. They wanted a named professional or small team to retain oversight, particularly following an induction transfer, emergency birth, neonatal admission or serious complication.

Families also wanted automatic access to a birth-reflection appointment and relevant records after an emergency or traumatic birth, rather than having to identify the service and repeatedly request support themselves.

Emotional and Psychological Support

Some participants felt that care focused mainly on the baby while the mother's physical recovery and the emotional needs of both parents received less attention. One partner described a lack of psychological support following a traumatic birth and neonatal admission; the family eventually arranged and paid for therapy independently.

Participants wanted psychological support to be offered proactively to both mothers and partners, with clear information provided before discharge and again during community follow-up.

Hospital Conditions During Hot Weather

One service user raised concerns about hospital conditions during very hot weather and heatwaves. Air conditioning and other cooling facilities were described as inadequate, making the environment uncomfortable for women, babies and families.

The participant wanted preventative heatwave measures to be in place before temperatures became extreme, including maintained ventilation and air-conditioning systems, safe cooling equipment, temperature monitoring, drinking-water access and clear information for families about how heat-related risks were being managed.

Neonatal Care: Family Involvement and Joined-Up Support

Did parents feel included and supported as partners in their baby's care, and what helped or could have been better?

One participant described the neonatal team at the Royal London Hospital as kind, precise and family-centred. Staff provided regular updates, involved the parents in their baby's care and made telephone support available at any time. A neonatal nurse also recognised that the mother was exhausted and encouraged her to go home, rest and continue her own recovery. Additional neonatal support groups were valued because they helped families meet other parents with similar experiences and receive support outside the clinical environment.

> *"The nurses were outstanding. We felt listened to, and they kept us involved."*

However, communication between hospital and community services was not always joined up. One parent was contacted about a routine home visit even though her premature baby remained in neonatal care. This made her feel that staff had not read the notes or understood the family's circumstances.

Parents wanted neonatal services to continue involving them in decisions while also recognising their own physical and emotional needs. They also wanted community professionals to understand prematurity and receive an accurate handover before contacting the family.

Digital Maternity Records and Data Consent

Participants recognised that a reliable digital maternity record could improve communication, reduce missing information and support continuity. They wanted it to include appointments and cancellations, reasons for investigations, test results, consultation outcomes, care plans, important history and transfers between hospitals: "If there is an app, it needs to be updated with the outcome of each appointment so that you know what is happening throughout your journey."

Participants also raised concerns about who would access, store or process their information. Some referred to public controversy about Palantir's involvement in NHS data systems. They wanted the Trust to identify all organisations involved, explain what would be shared and why, seek meaningful informed consent, offer a clear choice about third-party storage or processing wherever possible, explain how consent could be withdrawn and provide a non-digital option. Digitalisation should improve safety and continuity without reducing privacy, choice or control.

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What Matters Most and What Needs to Change

Which findings felt most important or familiar, and what one change would most improve local maternity or neonatal care?

Consistency for Every Family

The changes that mattered most to participants were consistent listening, continuity, reliable communication and accountability. They wanted good care to be the standard for every family rather than depending on the individual professional, shift or hospital site.

What Participants Want to Change

- Take concerns raised by women and partners seriously and complete an appropriate clinical assessment before ruling out complications.
- Provide clear safety-netting, treatment and medication advice for severe pregnancy sickness.
- Use reliable appointment confirmations, reminders and cancellation notices.
- Explain why tests are required, ensure they are clinically appropriate and communicate the results.
- Improve handovers between community, hospital, neonatal and primary care services.
- Provide clear explanations during and after emergencies and automatically offer birth reflection after a traumatic birth.
- Clarify which team is responsible for follow-up when an induction or birth is transferred to another hospital.
- Offer psychological support proactively to mothers and partners following traumatic births or neonatal admission.
- Develop continuity through a named professional or a small maternity team familiar with the family's history.
- Introduce preventative heatwave measures and maintain adequate cooling facilities in maternity and neonatal areas.

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Key Recommendations

Based on the survey and focus group findings, MNVP recommends:

Ten Priority Actions

1. **Listening to women and families:** Take concerns raised by women and their partners seriously, make sure they receive a proper assessment, and act promptly when further care or escalation is needed.
2. **Support for severe pregnancy sickness:** Improve access to assessment and treatment for women experiencing severe pregnancy sickness, including clear advice on medication, when to seek help and where to go for support.
3. **Better communication and informed consent:** Make sure families receive timely updates about appointments, cancellations and test results. Explain why tests or procedures are needed and ensure consent is obtained before any examinations or treatment.
4. **Induction delays and bed availability:** Review delays caused by limited induction beds and improve communication with families about waiting times. Where transfers to another hospital are needed, make sure care is properly coordinated.
5. **Continuity of care:** Improve communication and handovers between maternity, neonatal, community and primary care teams, particularly when women are transferred between hospitals or following complicated births. Families should know who is responsible for their follow-up care.
6. **Support after emergency or traumatic births:** Make sure women and their families receive clear explanations about what happened during an emergency. Birth reflection and appropriate follow-up support should be offered without families having to repeatedly ask for it.
7. **Better postnatal care and support:** Ensure mothers receive appropriate care and support after giving birth, including access to meals, pain relief, hygiene, help with feeding and support for their own recovery. Emotional and psychological support should also be available to mothers and partners, especially following traumatic births or neonatal admissions.

Key Recommendations

Based on the survey and focus group findings, MNVP recommends:

Ten Priority Actions

8. More personalised and family-centred care: Wherever possible, families should receive care from the same midwife or a small team who understands their history and needs. Care should also respect individual, cultural and religious needs, and parents should be involved in decisions about their baby's neonatal care.
9. Improving hospital conditions during hot weather: Make sure maternity and neonatal wards are prepared for hot weather, with appropriate cooling, ventilation and temperature monitoring to keep women, babies and families comfortable and safe.
10. Improving digital maternity records: Involve service users in improving digital maternity records so that appointments, test results, care plans and other important information are accurate and accessible. Families should also receive clear information about how their personal data is used, stored and shared.

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Contact Us

Thank you to everyone who shared their experiences through the survey and focus group. Your voices and feedback will help shape future maternity and neonatal services across our boroughs.

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