LLAIS

Eich llais chi mewn iechyd a gofal | Your voice in health and social care

Having a baby in Neath Port Talbot and Swansea

Experiences of maternity and neonatal services in Swansea Bay University Health Board

May 2025

Trigger warning: Please note that the following accounts are upsetting and there is reference to baby loss.

For those affected by the issues raised in this report, there is support available here: https://www.nicheconsult.co.uk/swansea-maternity-and-neonatal-review/#help

If you have accessed maternity or neonatal care at Swansea Bay University Health Board and have concerns about your care, you can refer your case to the midwifery team for a clinical case review. If you received care within the last 12 months, more information can be found at https://sbuhb.nhs.wales/about-us/feedback/

If you are currently receiving maternity services and have any questions or concerns after reading this report, the health board advises that you speak to your midwife.

The mental health charity **Mind** suggest several voluntary organisations and charities that support families and new parents:

- Family Action offers specialist support services for parents with a mental health problem. This includes services during pregnancy and after giving birth.
- **Home-Start** has a service that pairs you with a volunteer who can visit you to offer practical and emotional support.
- **NCT** runs a range of courses for new parents and has a membership that runs activities and social groups.
- The **Association for Post Natal Illness (APNI)** offers information and support about postnatal depression. This includes information for partners and carers.
- The **Breastfeeding Network** offers nationwide support about breastfeeding when you have a mental health problem.

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About Llais

We believe in a healthier Wales where people get the health and social care services they need in a way that works best for them.

We are here to understand your views and experiences of health and social care, and to make sure your feedback is used by decision-makers to shape your services.

We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong we support you to make complaints.

There are 7 Llais Regions in Wales.

Each one represents the "patient and public" voice in different parts of Wales.

Having a baby in Neath Port Talbot and Swansea

Overview of maternity services provided by Swansea Bay University Health Board

Swansea Bay University Health Board currently provides the following regional maternity services where about 3,400 babies are delivered each year:

- Labour Ward (Singleton Hospital)
- The Bay Birth Unit (Singleton Hospital)
- Neath Port Talbot Hospital Birth Centre
- Community midwife team

The health board also provides neonatal services at Singleton Hospital, in Swansea. Neonatal services are there for those babies who need additional support and care after their birth.

Until October 2024 all of the Health Board's maternity services were being delivered from Singleton Hospital. The options for mothers to have a midwife led birth at Neath Port Talbot Hospital or a home birth were not available for several years because of the changes required during Covid and due to staffing issues, which presented a risk to the safety of services.

The Neath Port Talbot Birthing Centre reopened in September 2024 alongside the reintroduction of the home birthing service.

The women and families we heard from in this report used the maternity services before these changes were made. This means that the experiences we collected reflect a time, both during and since Covid, when birth options for women have been restricted, which may have impacted on their experiences.

Like many of you, in 2023 we heard growing concerns about some maternity and neonatal services across Wales and the UK through the press, our complaints advocacy service and our engagement activities.

Then, Healthcare Inspectorate Wales (HIW) published a report[1] in December 2023, following an inspection of the maternity unit at Singleton Hospital in Swansea, in September 2023. The report found areas where maternity services needed immediate improvement.

Healthcare Inspectorate Wales did another inspection in April 2024. It's report, published in July 2024[2] found that whilst improvements had been made, there were still challenges and further improvements needed.

These reports looked at how services were performing against professional quality standards, highlighting procedural gaps, leadership issues, and staff shortages, as well as patient experience.

We felt it was important that mothers and families had more opportunities to share their experiences, good and bad with decision-makers so they, too, could influence decisions on how to improve future services. So, we included a project in our annual plan designed to do that.

This report reflects the experiences shared by people who told us about their use of Swansea Bay University Health Board maternity services.

1. HIW 2023 Report
2. HIW 2024 Report

Overview

In the past year, Llais' Neath Port Talbot and Swansea region has focussed on hearing from people about their experiences of having a baby.

The project was carried out over several months and ended in early Winter 2024. Since then, we have continued to listen to people who want to share their experience with us.

We find that people generally share their experiences when their experience has had a big impact on them; good or bad.

Good maternity care is not just about clinical treatment – it's also about how people are treated. For many, this is a life-changing experience, full of emotions, new challenges, and many different interactions with many staff.

While giving birth happens every day in the health service, for the person going through it, it can feel overwhelming, unfamiliar, and sometimes frightening - especially if it's their first time. That's why the relationship with midwives, doctors, and other staff really matters. Feeling listened to, respected, and supported can make a huge difference to someone's experience, both at the time and long after.

We heard a wide range of experiences from 515 people. Some had good experiences, but many described significant challenges in their care. None of them told us they had a fully positive experience from start to finish.

What we heard shows that services have not met all the needs and expectations of those who shared their story with us. People who gave their feedback to us also described how it had affected their lives in lots of ways. For some, they felt their experiences had a lasting impact on their health and wellbeing. Most people who shared their story with us told us that they had, during their whole experience, received some great care.

They also told us about the difficulties they faced getting the help they needed when they needed it.

Many of the stories shared with us described serious challenges related to communication, quality of care, respect for people giving birth, and support.

Some people told us of very distressing experiences that they had. These experiences involved mental or physical harm to themselves or their babies as a result and had a devastating impact on their lives.

Many people told us they experienced unnecessary stress, lack of dignity, and barriers to good care.

We took time to review the responses we received as thoroughly as possible before sharing what we had heard.

Where we identified issues that couldn't wait until the end of the project, we brought this to the attention of the Health Board immediately.

What we heard was consistent with the concerns that had already been identified through the HIW report and through our work in the region. It highlighted the need for immediate action to improve maternity services, so that everyone receives safe, respectful, and compassionate care.

It has taken too long for some of the improvements needed to be put in place, but changes have been made since the experiences we collected happened.

Swansea Bay University Health Board has taken steps to respond to the HIW inspection and improve clinical safety and patient experience, including:

- commissioning an independent review (details below)
- introducing a patient experience group
- establishing a maternity 'Gold Command' to oversee the action plan and reporting progress to the Health Board Quality and Patient Safety Committee
- addressing staff shortages, and
- reopening the Birthing Unit, giving more choice to mothers and families

A Welsh Government oversight group has also been established and meets members of the Maternity Gold Command from Swansea Bay monthly.

We also wanted Swansea Bay University Health Board to have a chance to consider the insights and experience in this report and to let us know what they have done or will do as a result.

Their response and various initiatives and improvements are included further on in this report.

Purpose and Approach

Our role at Llais is to provide everyone with an opportunity to share their views and experiences of our NHS and social care services – so their views and experiences are listened and responded to by those responsible for planning and delivering services.

This project was designed to amplify people's voices and represent the best interests of the people and communities who received maternity and neonatal services provided by or on behalf of Swansea Bay University Health Board. Our role is not to conduct academic or clinical research.

The insights shared here reflect the real-life experiences of those who took up our general invitation to take part.

Overall, we heard directly from 515 people about their journey through pregnancy, birth, and postnatal care. We heard through in-person and online focus groups (64 people), interviews (4 people), and a survey that was available online and as hard copy (447 people).

We hosted 3 in-person focus groups in accessible community locations: at the YMCA in Neath, at the LC2 leisure centre in Swansea and at the Leisure Centre at Aberavon Beach. This provided a spread of locations for people to attend across the Health Board area.

Each session used the same set of semi-structured interview questions covering the maternity journey, from pregnancy through to birth and then onto aftercare. Everyone who attended was also offered the option of a follow-up interview, although no participant followed this up.

Each person who took part was provided with an information pack to take away from the sessions, containing useful information from Llais and other organisations about counselling and how to raise concerns.

We also arranged 2 online focus groups so we could hear from people who may have found it difficult to share their experiences with us in other ways.

Where we saw gaps in who we were hearing from at our focus groups, we went to where people were. We held conversations with people from minority ethnic communities in local mother and toddler groups.

Most of the questions in our survey invited people to share their experiences in their own words, rather than ticking boxes or choosing from set answers like "yes" or "no".

We wanted people to have the freedom to describe their experience in their own way. They could tell us what went well, what helped and why it mattered and what didn't go well. Many used this space to tell us deeply personal stories that gave important insight into how care was experienced.

This also meant the analysis was more complex. We received 447 free-text responses, and most were not simple or one-sided.

For example, someone might describe a part of their care that was positive like how a midwife made them feel safe. But in the same answer, they might also say that something else like poor communication or pain relief left them feeling distressed or unsupported.

Many people shared mixed experiences, even within the same answer to a single question. Some told us about things that went well and things that didn't, all in the same sentence. Because of this, sometimes the numbers and percentages don't always line up neatly with the stories.

That might seem contradictory, but it tells us something important: the quality of care reported in the feedback to us wasn't consistent. It varied not just from person to person but sometimes from moment to moment, even for the same person on the same day.

We've reflected this complexity in the report.

Nearly half of those who completed our survey had given birth in the 12 months before they provided their stories and feedback. Everyone who took part in our focus groups had given birth within the previous 5 years and around a quarter had done so during 2024.

While the project used a structured approach, it was not intended to be representative of everyone's experience, nor was it statistically weighted. These stories matter because of their human impact, and because every story matters – and not because of how many people shared them.

That said, we did see common themes in the 500+ responses which should be used to continue to drive improvements.

We always keep people anonymous in our work, unless there is a reason to be concerned for the welfare of a person in a vulnerable situation then that information must be shared with someone who is able to act or responsibility. That's because we want people to feel safe and comfortable sharing their experiences – this is what matters most and not the person's name. Some people told us they didn't want services to know they had given feedback, especially if their experience wasn't good.

Because of this, it's possible that someone could have told us about their experience more than once. For example, by joining a focus group, filling out our online survey, or having an interview. While we think this is unlikely, we can't rule it out completely.

What we can say for sure is that every piece of feedback we received came from someone who wanted to be heard, and who took time to share what happened to them, often in the hope that it would lead to change. Whether we heard from them once or more than once, their voices are real and important, and they should be listened to.

The details of the types of questions we asked, the number of people who answered them, and the responses to our equality and diversity monitoring questions are in the appendix.

Independent review of Swansea Bay University Health Board

Separate to Llais' regional project, there is also an independent review into maternity services[3], commissioned by Swansea Bay University Health Board (SBUHB).

Throughout the review, Llais has continued to speak up for families.

Llais is not a part of the review team, we take part in the review's Family and Community Voices Steering Group. We do this, alongside other organisations, to help make sure the review team listens to women and families in a way that meets their needs.

What we have heard through our activities has been shared with the review team, and form part of the evidence to inform its findings and recommendations.

The latest update from the independent review can be found on the website that has been set up to share progress: https://www.nicheconsult.co.uk/swansea-maternity-and-neonatal-review/

3. HSBUHB Independent Review

So why do we still need this report?

Because these experiences matter.

These experiences are not just stories from the past; they are evidence of where things worked well or where they fell short. They deserve to be heard, respected and acted on.

These are self-reported experiences shared through voluntary participation and are not clinical investigations. This report is here:

- To inform future decisions — helping shape improvements that are meaningful and lasting
- To strengthen the changes already underway — grounding them in lived reality
- To serve as a reminder that the poor experiences **must never be repeated**
- To support and encourage the staff working so hard every day to provide care, who would never want anyone to feel the way some people in this report have described.

We know that behind every difficult experience is a team of professionals doing their best in a pressurised environment. This report is not a critique of individuals, it's an opportunity to create a culture together where safe, respectful, compassionate care is always the standard.

The people we spoke to want their stories to lead to better services.

That's what this report is here to help deliver.

What we learned

Quality of care

While just over half (54%) of the people who completed our survey told us their care during pregnancy was *'good or better'*, they often described a quality of care that was often less than positive, and, on many occasions, people described their care as inadequate or inconsistent.

Just over three quarters (76%) of the people we heard from reported a negative experience or identified failures in their care. This shows that even when some parts of care were okay, the overall experience often didn't feel joined-up.

Many told us they wanted to see a better quality and level of care provided in everything from consistency, compassion, information, hygiene, pain relief, and monitoring throughout the different stages of the journey to parenthood.

A number of people described their experience of maternity services as feeling like a *'conveyor belt'* where their individual needs were overlooked. Just under half the people we heard from (48%) told us they felt involved in decisions about their care.

Experiences varied widely, suggesting a lack of consistency in care quality across different teams. Several described repeating their history or feeling lost in a system that didn't seem to talk to itself. One person explained:

"They don't talk... the consultants don't seem to talk to each other. If you have pregnancy-related complications, it's a lot of legwork to chase all these people and it's exhausting."

As a result, this led to time being spent retelling medical history and reading notes with different advice being given. This led to people feeling confused and unsure as to what advice to follow. We also heard examples of notes being shared with the wrong people, breaching confidentiality.

"You see different people every time as well. You'd go in and one would be very good. And they explain stuff and they'd be like, oh, but this is what you need to do. And then you go in the next time speaking to a different consultant and you'd be like, "but the last person told me this." And they're like, 'oh, yeah? Well, no, you don't need that.' Then they would dismiss their own colleague to do it their way. And then you'd be just left."

"They read out the wrong notes and I had to say that that's not me, and that was a woman that didn't have a partner."

"So I got told by consultant when I had my low lying placenta to go in. So when I phoned Ward x and they said I was fine and I challenged it because I was like "the consultant said I was to go in and be checked. And you're saying no". and they said "oh, well, you're early on in your pregnancy, and unless you're bleeding, there's no point you coming in. So I told the consultant in the next appointment and they said just to push and try to get in to be examined. And I don't think they understood how hard it is just to try and get past the telephone people."

Some people who had routine check-ups and appointments told us they often had to go to different places, having to travel some way for routine midwife appointments. This impacted work and personal commitments and, for some, made the experience feel disjointed and harder to navigate.

"...no continuity in where appointments are. So far I have been to Singleton, NPT hospital, health centres, and my GP's to see my midwife and have routine check ups."

A few people with pre-existing health conditions told us that their broader needs were sometimes overlooked during pregnancy or postnatal care. They felt that, at times, care was focused solely on their pregnancy or recent birth, rather than taking into account their wider physical and mental health.

"(The) Consultant team (was) dismissive and didn't listen to my concerns as I have a long-term health condition...."

"I saw about 7 or eight different people. I was also under a consultant for my BMI. I saw him once and he said that he didn't need to see me again, but I still had to have growth scans. So in terms of the midwives, there were multiple that I saw, and they spent more time reading through the notes and stuff rather than anything else, really."

Several women told us of being left alone in rooms or not fully monitored and having to push for examinations.

"I was covered in blood and left in it all... I had blood running down my legs which meant the blood went on to the bed."

"I was a slab of meat left on the bed. I had one person taking my clothes off, another inserting a catheter. I was naked and uncovered. My catheter was left in for 26 hours! I had a horrific experience and just left."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken to improve the quality of its maternity care and make its services better. These include:

- Introducing Maternity Early Warnings Scores (MEWS) to identify risks in pregnancy and intervene quickly;
- Introducing additional ultrasound scanning for an extended range of pregnancy risk conditions; and
- Increasing staffing levels and reducing vacant posts.

The introduction of a new all Wales maternity app will also go some way to solving the additional issues with information accessibility and continuity of care. In the interim it may still be necessary to review and streamline the number of different locations women need to go to for care.

Clear information and communication

Out of 447 people who took part in our survey, 274 (61%) said the information they received during pregnancy was clear and understandable. People described being given leaflets, clear explanations from midwives or consultants, and having their questions answered.

"Yes, everything was explained clearly, or questions answered if I wasn't sure."

"Information in various forms was thorough and informative."

"Yes, the information given was clear and understandable and relevant."

103 people (23%) felt the information they were given wasn't good enough, and 70 people (16%) gave mixed or unclear answers.

Issues with a lack of clear information and communication came up often in what people told us in our focus groups.

For many, this impacted their ability to understand procedures and give informed consent, especially during birth or emergencies.

Often, people struggled to communicate with midwives between appointments, leading to unanswered concerns. Others felt they were left without essential information making them feel unprepared.

Some parents told us they received little guidance on pregnancy, birth, and early parenthood, including exercise, birth choices, breastfeeding, and emotional support.

Those with complications described feeling confusion due to poor communication and information from healthcare services.

"I could never get hold of her [midwife]. I'd leave a message but get no response."

"The midwife I had been assigned was off work but no one told me. So when I rang her mobile and left a message, I just got no reply. I didn't know what was happening."

"I was given generic information such as eating and drinking, but nothing specific. If it's your first child you don't know what to ask or what you need to know."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to improve communication and make its services better. These include:

- reviewing maternity information documents with the aim of co-creating new versions with people who use the service.

- improved staffing levels giving more capacity to staff to respond to communications.

As part of these actions, a timeline for publishing updated documents should be made available, with priority given to the information people have highlighted they need most.

Being involved in decision making

When we asked those who took our survey whether they felt involved in decisions about their care, 48% (214 out of 447) said yes, 40% (181) said no, and 12% (52) gave a neutral or mixed answer.

This means that more than half of the people we heard from either didn't feel involved or described inconsistent experiences. This is concerning given the importance of informed consent and shared decision-making, especially during something as significant as having a baby.

Many of the people we spoke to said they felt pressured into induction, often without a full discussion of risks, benefits, or alternatives. Induction during pregnancy is when doctors help to start a woman's labour on purpose, instead of waiting for it to happen naturally. Usually, they might do this if the baby is late or if there's a health reason to have the baby sooner.

One person shared that they wanted *"not to be bullied into an induction,"* while others raised concerns about the timing of care decisions and feeling excluded from the process.

We heard that birth choices were often restricted, with many telling us that they had little say in how they gave birth. For example, a feeling of having birth options that were not actually options – there was Singleton or nothing.

People also spoke about the lack of choice they had within their birthing experience and not receiving any information from healthcare staff around them about what interventions or tests were being undertaken and why.

"If you go to Singleton, you're induced. There's no monitoring and allowing to see what's going on, the slightest risk and they induce it's highly highly clinical."

"I felt forced to have an induction. I didn't want an induction because it wasn't an emergency. I had 4 sweeps. They said it was a 'gentle massage'—it is not! The procedure wasn't explained, the attitude was that 'you have to'. It was that or nothing. I felt almost guilty for asking why."

"Nothing was explained to us. She [my wife] was induced which was unexpected, and her waters broke at home so she already had an infection."

"Choice was not explained, and I felt pushed into not having a C-section (which I wanted). I felt like someone needed to advocate for me, but in my condition, I couldn't voice my views and opinions, and no one was listening to me anyway."

"They don't tell you that you have a choice. They push for you to be induced, you can't have a caesarean if you want to, I wasn't allowed."

On the other hand, there were some examples of positive experiences where people felt included and respected. One person said, *"I was encouraged to write a birthing plan and was supported in following it."* Another shared, *"I felt listened to and included with any decisions made."*

However, these comments were less common, and often tied to specific individuals, rather than the system as a whole.

This all points to a pattern: while some people did feel heard and included, many others described a lack of choice, control, and communication, particularly when it came to decisions around birth and induction.

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to improve birth choices. These include:

- Reopening the Midwifery led Birth Centre at Neath Port Talbot Hospital in September 2024
- Restarting the Home Birth Service in October 2024
- The induction rate is gradually reducing and is now below the national average
- Getting involved in an All-Wales approach to address high induction rates.
- Setting up an Induction of Labour Review Group
- Introducing an induction of labour decision making aid and leaflet, co-produced with people using maternity services and the Maternity Voices Partnership.

Next steps should include monitoring and reporting on the impact of these actions on people's experience based on feedback received.

Respect and compassion

Through our engagement we heard examples shared of staff providing compassionate, professional, and supportive care.

"The midwives were very knowledgeable and had answers to all my questions. They made me feel safe and cared for in any appointment and during the times I visited the antenatal daytime assessment unit due to reduced movements they kept monitoring me until I felt happy and reassured and they never made me feel like I was a burden."

"Community midwife was amazing very person centred. Midwives on labour ward were excellent so caring. They ensured I was listened to and advocated for me to medics."

"My midwife was a true support and not only helped me advocate for myself but also took steps to help ensure I had additional consultant follow ups when I had not been contacted."

"I was treated with dignity, respect and kindness."

People's positive experiences were often tied to specific healthcare staff, or, for a number of women, they expressed 'conditional satisfaction' with their experience, as in *"I was happy with the midwife, but other staff were dismissive."*

We also heard many describing their experience of a more dismissive culture, where people felt their pain and concerns were not taken seriously and staff attitudes varied. We heard some reports described as sarcasm, with a lack of compassion.

"The issue is not a lack of staff. There was no sense of urgency and no kindness. It was patronising."

"One student midwife said to me: 'The staff attitude here is so bad that they're not actually seeing people as people.'"

"The midwife who was monitoring me whilst on the induction drip was extremely unprofessional. She did not speak more than 2 words to me or my partner during the whole 12 hours she was in the room with us. She sat in the corner on her phone unless she was out for breaks. Whenever the heart monitors would lose contact she would huff & puff whilst trying to reconnect them."

"I felt like an inconvenience, patronised, and in the way. I asked for a bath and was judged for it. I asked for a pillow and was told, 'What do you think this is? It isn't the Hilton.'"

There was agreement across all the focus groups that women felt they were shown disrespect through the clinical terms used and attitudes expressed toward them. *'The terms they use are insulting'*; with specific mention of geriatric being used to refer to any woman over the age of 35 and the term *'obese'* being linked with Body Mass Index (calculated using your weight and height).

Some women pointed out that they were classified as *'obese'* due to weight/ height ratios affecting those who work out or do weight training. Women also commented that although they may have been seen as overweight, no one gave them clear information about how to stay active in pregnancy or clear guidance about healthy exercise levels.

One disabled woman gave examples of how she felt a consultant had been rude to her from the start of her pregnancy:

"So when I first went to see him because it was a high risk pregnancy, he was like, 'oh, there's no point telling any of your family because you might lose it.' And so it wasn't even a baby, it was an it. He didn't review my medications that could cause pregnancy loss, and he was dismissive. I knew people, because I have brittle bones, who had fractured hips. And he said, 'I've never seen that in my clinical practice, couldn't possibly happen.'... [my mum] was concerned about my heart because I have cardiac issues and he basically went 'Oh well, if you're not dead at this point, you're not gonna be dead at the end of it. Your heart should be fine'."

The responses we had to our survey suggest that, while inconsistent, many women did experience positive interactions where communication was clear and respectful.

This was echoed in comments from a number of people:

"The staff were incredibly kind and supportive throughout the process."

"The incredible support from the midwives and nursery nurses their compassion and kindness will stay with me forever."

"We had a wonderful midwife caring for us in the post labour ward. I felt very comfortable and she explained everything in detail. I am extremely grateful for her kindness and care."

"True empathy, the doctor was confident and very experienced, he made me feel safe in such a scary situation; but remained honest and realistic through, I had contact details for situations which arose outside of the appointments. Transparency, genuine care, and excellent communication was key."

These examples demonstrate that when care is delivered with compassion and communication is clear, it has a lasting impact. Many people singled out individual midwives or nurses who showed empathy, took time to explain procedures, and helped them feel safe and respected.

These moments of kindness and professionalism provide a model for the kind of care families want and expect.

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to focus on compassionate care. This includes developing a Swansea Bay Maternity Services Charter[4], co-produced with families and staff, and promoting shared expectations and compassionate care.

We think this Charter should be displayed on all wards and included in antenatal packs. Its principles should be part of staff induction, team briefings, and supervision sessions.

Arrangements should be made to monitor whether the Charter's values are being put into practice, using feedback from people and staff involved in services.

4. Swansea Bay Maternity Services Charter

Being heard

Some people told us they felt heard and supported during parts of their maternity journey.

Mums reported *'feeling heard'*, *'listened to'* and being given *'enough time'* by healthcare professionals to discuss their pregnancy and any issues that they had. They described the importance of being given detailed explanations to any queries or concerns that they had. *"I felt listened to and included with any decisions made."*

But for many others, this was not the case. A consistent and deeply concerning theme across both the survey and focus groups was people not being listened to, even when they raised serious concerns about their own health or their baby's wellbeing.

In our survey, almost half (43%) of people said they did not feel that their concerns were listened to and acted on.

The consequences they described of not being heard were, in some cases, devastating.

"I was consultant-led. I had an accident in my car... I phoned them up. I said his movements have reduced. And they said just take paracetamol, rest up, and come back if his movement doesn't return... Then I later found out that an accident is one of the main causes of a placental abruption. Which is how we actually lost our son. They don't listen at all."

Inadequate or no pain relief was a complaint we heard about lots of times in both the survey and the focus groups. Many people reported that they were suffering for long periods of time. Some of those who requested pain relief said that they felt they were dismissed or made to feel as if they were asking needlessly.

Some women told us they left hospital feeling unsure and doubting themselves. At the time, they felt something wasn't right, that they were being brushed off or made to feel silly for raising concerns. It was only afterwards, when they had time to reflect, that they realised how they'd been treated.

Many said they were made to feel like they were overreacting, imagining things, or not to be trusted about what was happening to their own bodies. It left them feeling confused and undermined.

Examples described to us included:

- women saying they were in pain and being told they were not
- women in the process of giving birth and being told they were not
- women being questioned as to why they needed pain relief immediately after stitches
- women having infected stitches with the suggestion that it was their fault, even though no one monitored them or told them about wound care
- women complaining because of their treatment and being told that they have a healthy baby so there was no problem.

"I tried to voice concerns …. but felt they were disregarded."

"She said the baby wasn't moving right. Two weeks in hospital telling them the baby wasn't moving. Emergency c-section and they found the cord was wrapped around its neck. They ignored her. They don't think women know their bodies."

"I couldn't get any pain killers and wasn't listened to. I was offered paracetamol and codeine. After 4 hrs they checked on me and said 'you're not in active labour' 'you're not in that much pain' 'I think you're about 4cm'. I asked for a second opinion and was found to be 9cm dilated. It was then too late for pain killers and the baby hadn't been monitored at all."

"'I just thought this is how it is. I assumed it was really painful and that you are not listened to."

"I kept saying I was in pain, but they told me I wasn't."

"I was literally in the process of giving birth, and they told me I wasn't."

"I asked for pain relief after stitches, and they questioned why I even needed it."

"My stitches got infected, and instead of checking on me, they suggested it was my fault."

"It's really all about the baby how you feel and how you're doing just doesn't feature. I was offered a debrief but the doctor was unknown and just read my notes and told me I was cheery and I had a healthy baby so what was the problem."

We also heard from some women that they were being told to bring their notes or 'maternity green book' to each appointment even though it wasn't being referred to.

The maternity green book includes a record of people's health, appointments, test results in pregnancy and any birth plans. They also have useful phone numbers. NHS Wales advises that you should have these notes with you all the time until you have your baby. This is so healthcare staff can read about a person's pregnancy health if they need urgent medical care.

Several people expressed frustration that although they were advised to carry their maternity notes, they felt these were often overlooked.

"I kept writing down my concerns in the book, thinking it would help, but the midwives didn't check it."

"It felt pointless carrying it around when it wasn't being used for anything."

Welsh Government are currently developing a new app to improve maternity care that will be available in all parts of Wales by March 2026. This will make it easier for healthcare professionals to share important information, to make quick, informed decisions, and give women the personalised care they want. Mothers-to-be will be able to access their full maternity records instantly on their phones through a new app.

The app will provide tailored updates after every appointment and timely messages to ensure a healthy pregnancy.

It will replace paper notes and enable women to:

- view booked appointments
- learn more about their baby's development and track progress weekly
- enter blood pressure readings if asked by their midwife
- personalise details and preferences quickly, including where they want to give birth and any allergies they may have

Improvement actions taken by the health board

Swansea Bay Maternity Voices Partnership[5] , provides a number of ways for people to share their feedback and suggestions

A key theme we often hear in our engagement activities is health and social care services not listening to people. The Maternity Voices Partnership will enable people to share their feedback and suggestions after they have received care, but it is the cultural change programme we are asking the health board to commit to (See section: Next steps for Swansea Bay University Health Board) that will need to drive improvement in people's experiences of care.

5. Swansea Bay Maternity Voices Partnership

Being cared for after giving birth

Just over half of the people who responded to our survey (53%) told us their postnatal care was positive.

"The ward that I was in straight after surgery there were excellent midwives and they looked after me and helped a lot with me, the baby and getting me showered and up after the c section."

"Lovely community midwives who offered lots of support and help with breastfeeding and advice with safe sleeping."

When experiences of care after giving birth were negative, they were often described as deeply distressing or traumatic.

Around a fifth (21%) of people who told us through our survey about poor care after birth shared accounts that went far beyond dissatisfaction, highlighting situations where they felt neglected, unsupported, and even unsafe in the days after birth.

"My scar popped open. I was given 3 steri strips to hold myself together and told to wait for 48 hours."

"I had to walk two wards to get to my baby after surgery — (then) I collapsed at the reception desk."

We heard from some women who told us that, after having a caesarean, they were unable to reach their newborns due to lack of assistance. Some said they were unable to pull the emergency cord for attention due to the physical layout of the rooms and wards or due to pain and physical restrictions they faced.

One woman told us that she had to call the ward from her mobile phone to get support and another reported being left alone until her partner arrived the next day.

"I couldn't reach my baby. I was told, 'You're the mum, we don't have to do everything for you'."

"One of the women in front of me opposite me in the Bay, she had an emergency C-section in the middle of the night and her baby laid there screaming because she was so high. She couldn't move and I had to get up. Having just had to see to myself and go and look after her baby because there was no one to do it. And I think that there's no excuse, don't care how busy you are. There's no excuse like that, for a baby not to be fed."

Some people told us they left hospital without having had their wounds checked or being given any advice about how to care for stitches once home. A few described their stitches as coming apart. We also heard from many who said they struggled to get adequate pain relief after the birth, including cases where they had just had major surgery.

"The midwife rolled her eyes when I asked for pain relief. It felt like I was being judged for not being able to handle it."

"My epidural was wearing off. I had stitches and no one checked when I had last had pain relief. I kept asking for something, but they only realised when I was writhing in pain. The consultant was finally called, and it turned out no one had given me anything."

"Just over 12 hours after my C-section, I was told to get up and move. But I was only on paracetamol. I asked for something stronger, and the midwife said, 'Well, why do you want that? You do realise you can't go home if you take that?' I felt like I was being punished for needing it."

Some women with babies in the neonatal intensive care unit told us they often felt unsupported, left to manage their own recovery alone, not being able to get to see their babies because there was no one to take them, and they were unable to walk to the unit after surgery or stitches.

Some of these women reported collapsing trying to get to their babies, particularly when they had not been given pain relief, or feeling *'told off'* for not tending to their babies when they felt stuck in their rooms alone and unable to reach pull cords or move.

"My child was in the ICU. After six hours I didn't see him because no one could take me to him. Eventually a porter took me but no one could come and get me back so I missed dinner. They offered me a pack of biscuits and that was it. My child came back from the ICU and we were put into a watched area. I had to walk 2 lengths of wards to get to my baby and I was told that I had to walk. I got as far as the reception desk [she collapsed]."

"I couldn't get to the ward to see my baby, they said to me 'why aren't you down there feeding your baby, that's your child you know'."

"After that [1st visit to NICU when she was taken with partner] it was like 'You go whenever you want, now it's your problem' sort of thing. You know, I could barely walk, and I had to wait until my partner came in the following day to actually get up and go to the toilet because nobody came to help me."

Some people described disjointed services between GP, midwife, health visitor and other health departments within their community after giving birth.

Some described always seeing different midwives, some told us their GP had refused to see them, even in cases of mastitis and for the 6-week post birth checkup, some were left off the list, so they did not have a health visitor until they made multiple phone calls about it, and some did not have their 6-month check-up.

2 people told us they were sent home with needles to self-inject without having been shown how to inject and had no way of disposing of the sharps boxes they had.

Access to mental health support was described as inconsistent. Some people said they were denied help due to delays referring them on to the right service, while others told us they were not offered support even after experiencing a stillbirth.

"There was no mental health support, and I felt overwhelmed."

"I was meant to be referred to PRAMS but no one had actually done it they didn't accept me because a month had gone past but that wasn't my fault."

"We had no counselling. We had no nothing at all. When we left hospital and it was just a case of 'here you go. Here's a box'. They gave us like a memory box and we left hospital. That was was it."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to improve the care provided after birth, including support available to people in pain, who have lost their baby or who need other support after giving birth. These include:

- Introducing Self Administration of Medication (SAM) – pain relief controlled by those in pain and administered automatically.
- Introducing regular medication and observation rounds to improve access to medication.
- Increased availability of drug trolleys for staff to use.
- Providing an education package to improve infection rates. This has been presented to a number of teams and provides resources to make sure staff are up to date and knowledgeable about the process of identifying and managing surgical site infections.
- Introducing specialist bereavement training for nurses and midwives.
- Providing a face-to-face discussion with either the Clinical Risk Specialist Midwife or the Lead Midwife for Quality safety and Risk. All families will be given the PMRT review letter during this discussion.
- All families experiencing a stillbirth will receive a documented discussion regarding the mortality review process and timelines for the availability of the report. They will also receive a named contact from the Governance team along with the details of how to contact should they have any questions regarding their review.
- Increasing breastfeeding support with the introduction of additional support groups and training for staff to Baby Friendly Initiative standards. Early breastmilk use has increased from 47% to 71%, the best rate in Wales.

While many people described challenges after giving birth, we also heard positive experiences through our survey. Some people told us they felt well cared for and supported by attentive and compassionate staff.

"After care was excellent, as baby was prem we had to stay in hospital a little while but everyone we came into contact with were brilliant and couldn't have done enough for us."

They described being regularly checked on, helped with feeding, and offered pain relief promptly. One woman shared, *"All maternity aftercare was fantastic. I struggled with breastfeeding, and they were so helpful,"* while another said, *"I felt cared for, and they were always available to answer my questions."* Others spoke about feeling reassured by the professionalism of staff and appreciated the clear explanations they were given.

"The consultants were professional and made me feel reassured."

Though these positive experiences were much less common from those we heard from, they stood out for the difference kindness, clear communication, and continuity of care made to people's recovery and emotional wellbeing.

The contrast between positive and negative experiences was stark.

When care was good, it made people feel safe, supported and valued. But when care was lacking, people said it left lasting distress, fear, and even trauma.

These accounts show that consistent, respectful, and responsive postnatal care is not a nice to have but a vital part of keeping mothers and babies safe, well, and feeling supported.

Barriers to care for people from ethnic minority backgrounds

Women from African, Bangladeshi, and Pakistani backgrounds described experiences that highlighted extra challenges when accessing maternity services.

Some of these women we heard from felt that stereotypes affected their care. Black women described being perceived as *"aggressive"*, affecting how staff treated them.

Some women we heard from were concerned that they weren't supported to manage their pain due to racial stereotypes relating to pain thresholds. Some talked of feeling *"invisible"* compared to other people being cared for on the ward.

English as a second language made it difficult for some people to understand the information they were given, making it harder to make decisions about their care.

One new mother, who was also a healthcare professional, shared with us that she was warned that complaining about her care could threaten her ability to practice medicine in the UK. She told us that she felt this led to severe postnatal depression and the breakdown of her marriage.

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to better understand and improve the care it provides to people from minority ethnic backgrounds. These include:

- Piloting an All Wales NHS Fast Track service for women with no or limited spoken or understood English (language barriers create a higher risk of not getting the right service, at the right time when pregnant).
- Carrying out outreach activity to engage with minority ethnic groups. Highlighted concerns have been fed into a Service Group and action taken to address the concerns.
- Using the health board's outreach workers to help the Engagement Team of the External Independent Review to further develop links with these communities so that their feedback is more extensive.

The health board must use the new patient feedback system to proactively identify and respond to inequitable experiences.

Unsafe care

Many of those who shared their stories with us said they felt like their safety, or their baby's safety could have been at risk. Serious safety concerns were raised with us across all stages of maternity care. These ranged from hearing about dismissed concerns during pregnancy to poor monitoring in labour, experiences of unsafe practices, degrading treatment and potential neglect in postnatal care.

Among the most distressing stories we heard were cases of women being left alone in labour or giving birth outside of designated areas.

Some told us of failures in recognising and treating infections. Some people told us their experiences had long-lasting impacts including physical and psychological traumas.

Several people shared that they have changed their future family planning decisions; a number of people were delaying having another child until the Neath maternity unit had reopened, and a few women who lived on county borders told us were choosing other health board birthing units rather than Singleton.

"This experience is one of the main reasons I will not have any more children. I cannot go through all of that again."

"I thought I was going to die and my baby was going to die..."

"The room was chaotic, and I didn't feel safe."

"'At birth I wasn't checked for two hours I went to the toilet and rang the emergency cord I gave birth in that toilet cubicle."

"Two midwives tried to check my cervix and couldn't. The consultant came to check. I was given no pain relief, and he actually pulled my cervix down, and me down the bed with it. They called the doctors in there were loads of people there and my bum was showing."

"Yes, poor unpleasant midwifery, horrible rooms, (a) man came and did an internal (examination of me) without introduction."

"I said the baby was coming but the midwife said I was only two centimetres. I was told I wasn't in labour because my contractions weren't every 15 minutes but I had my baby on the toilet in the toilet cubicle in the hospital."

" I was showing signs of bad infection [waters were broken for 24 hours or more] but nothing was ever done. After 40 hours I was taken to theatre, was given an episiotomy. I had an infection but my husband was sent away at 4:00 AM in the morning. I was still in agony, I asked for pain relief from the sister and she said no I was asthmatic. I was told I was asthmatic but I'm not."

"It was a long time before X could talk again about her experience, which has left her traumatised and caused a period of postpartum depression that she had to receive treatment for. She came out of hospital feeling humiliated and afraid."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to respond to safety concerns. This includes introducing a new monthly safety and performance dashboard, which has been live since 1 April 2025.

Over the past 6 months, the health board has reported that the numbers of incidents have reduced, and the number of incidents being closed has increased. An incident is any matter reported by a patient or a member of staff.

Understaffing and work culture

Across all of our engagement activities people reported staff being *'overrun'* and felt this impacted negatively on their experience. Inconsistencies in care before birth, rushed and unhygienic hospital settings were identified as being because there wasn't enough staff.

"'I think understaffing is another issue and when I went into my delivery room, which obviously I didn't deliver in and she was showing me around and she showed me the bathroom. Where the shower walls and it was blood everywhere, with bloody towels in there. They were not checking these things before. That woman hasn't long given birth in here, and we are being put into this room with blood everywhere to give birth ourselves, that was a bit of a panic for us. Obviously it was cleaned up when I raised it."

All focus groups we held suggested the difficulties people experienced at Singleton hospital, and maternity services more generally, were caused not only due to staffing levels.

Many felt the underlying work culture and attitudes within services also played a significant role. They described a focus on clinical processes that, in their view, came at the expense of personal care and compassion.

"All of the care side of things weren't there. We call it healthcare but health is all there – in a very clinical meaning; but there's absolutely no care."

"They follow the book too much."

"It's robotic so if your body doesn't follow the book you are ignored."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about a range of actions it has taken or is taking to tackle understaffing and create a positive working culture, including recognising and celebrating excellence in its maternity services.

This includes:

- Recruiting nurses, midwives and doctors, strengthening the maternity workforce, and meeting Birthrate Plus[6] standards. Consultant vacancy levels are now at 7%, midwifery vacancies are below 2% in hospital and 4.9% in the community. There are no staff vacancies in neonatal services

- 19 nurses and midwives completing the Royal College of Nursing Wales' Accelerating Excellence Development Programme

- Re-opening of the Midwifery led Birth Unit in Neath Port Talbot

- In the period 2024 – 2025 the Health Board's maternity service and staff won a number of awards
    - Baby Lifeline Mother and Baby charity's Excellence in Neonatal Care Award
    - Royal College of Midwives Perinatal Midwife of the Year
    - Marisopa Awards Midwife special recognition award.

6. Birthrate Plus

Raising concerns

There was confusion regarding how to complain, with some who took part in our focus groups stating they had complained because they had spoken to a member of staff or midwife about their treatment.

Amongst those who shared their experiences, there was very limited awareness of formal complaint procedures.

Less than a quarter (23%) of the people who took our survey said that they were given information about how to raise a concern. Some women had been offered a debrief but were waiting for long periods for one.

Some people felt their complaints didn't lead to action or change, or they didn't feel listened to, even when rules or procedures were in place. This was particularly the case for one participant who had experienced a stillbirth with her first child and the same circumstances led to emergencies when giving birth to her third child. She felt that if her first child had not died, her third child would have died because there had been no learning from the previous mistakes.

"Having had a still born later in my third pregnancy It was following the pattern of the first– my placenta was tapering off. The consultant was very undermining of my knowledge and experience saying I would be fine and it wouldn't happen again. But I was admitted with slow movement, exactly the same as the first. Midwives, ward sisters were saying to get me in for an emergency c section. At the end of his shift he came to say 'you're going in now'. It was appalling."

From what we have heard, there was a clear feeling that even when issues were raised, nothing happened, nothing changed, or no lessons were learned that informed change and delivered improvements.

We heard that while small changes were made, they appeared to have little influence on system change or led to real improvements for the experiences of people having babies and their families.

"A debrief wasn't offered to me you have to ask and you can't ask if you don't know that you can have one."

"I was told 'you're just upset because it didn't work out for you the way you wanted'."

"7 month waiting list for a debrief. I had my baby two months ago. I will either be recovered or in psychiatric unit by then."

"I had a debrief– they were reading my notes and there were inaccuracies and things I wasn't told at the time. Staff at the debrief encourage me to put in a complaint. They said they wanted services to get better too."

Improvement actions taken by the health board

Since we completed our engagement activities, the health board has told us about the action it has taken to capture and respond to people's experiences of care in real time and throughout their pregnancy and after birth.

Since 1 April 2025, the health board has started issuing surveys to all people using maternity services throughout their pregnancy and after birth.

Themes from the outcomes of complaints, and the learning from complaints, need to be made publicly available to restore trust and provide assurance to those using maternity services.

Incorporating information about complaints processes into documents (e.g., pregnancy pack) will help people know how to raise complaints and provide feedback about services received.

It will be important not to rely solely on numerical data to monitor improvements. The health board has shared that from 1 April 2023 to the 31 March 2025 there were 2,266 Friends and Family survey returns (one third of all patients) with an overall satisfaction score of 92.5%. The score remains fairly consistent across this time yet covers the time when we know services were failing people in their care and many were having difficult experiences.

The Friends and Family survey is a quick and anonymous way for people to give their views after receiving care. People may be asked to complete while still on the premises or may be contacted later. People are asked: *"Overall, how was your experience of our service?"* and can rank their answer from *"very good"* to *"very poor"*. They have the opportunity to explain their score by adding comments and may also be asked some follow-up questions.

As we have seen from our own survey as part of this project, the headline numbers don't always tell the full story. It's important that the health board systematically looks beyond the numbers by pulling together and making use of all their patient experience feedback and complaints data to drive improvements.

Our project involved 515 people, but there's still no clear pattern of service in the care they received. If the system was mostly working, we'd expect to see clear pressure points where things go wrong, and clear examples of what works well. If there had been improvements, people's stories would show some progress.

But no one described a fully positive experience from beginning to end, and we did not hear a clear pattern showing that more recent experiences were consistently better than older ones. Many said that any good care they received was because of individual staff members, not because the system worked well.

Next steps

As highlighted above, the health board has taken a number of actions based on feedback received from people who have used their maternity services, Llais and Healthcare Inspectorate Wales (HIW).

Significant investment has been made in maternity services and team leadership to build on improvements, however there is still more to do in response to the issues raised in this report. In some areas there is a lot of activity shown addressing concerns, but in others more is still needed. Action must be taken on all of the points we have highlighted.

The health board will have further information to act on when the Independent Review into Maternity and Neonatal services in Swansea Bay releases its report in the Summer.

The new quality statement on maternity and neonatal care[7] and the perinatal engagement framework[8] has been published since we undertook our project. This sets out how NHS Wales will improve services and what good looks like.

The quality statement has been developed following high-profile reviews of maternity services[9] across the UK, including in Wales.

7. Quality statement on maternity and neonatal care
8. Perinatal engagement framework
9. Ockenden Report

The health board is actively involved in rolling out the new framework that includes a commitment to setting up, or strengthening, local Maternity and Neonatal Voices Partnership (MNVP) forums. These forums bring together women, families, and staff to have their say on how to improve services and help monitor maternity and neonatal care in Wales. The Swansea Bay MNVP is one of the most established in Wales.

Llais will be the 'host agency' for a new national MNVP Cymru Forum, bringing together local forum chairs from across Wales to share experiences, take joint action, and help shape better maternity services.

We will be helping to make sure the MNVPC works well across the country and will also help create a shared MNVP toolkit with a clear job description for the regional lay chairs, so things are more consistent everywhere.

Maternity services will continue to be a priority for Llais. We'll keep talking to people using these services and use what we learn to make representations to decision makers and service providers.

6. Birthrate Plus

Next steps for Swansea Bay University Health Board

On 27 March 2025, the Chief Executive of the health board reiterated her apology on behalf of the Board to those who had poor experiences of maternity and neonatal care. This will be appreciated by many people who feel let down by the service and experience they received.

We ask for a formal acknowledgement from the Board of the scale and nature of the experiences of poor care shared with us, and the impact of those experiences on the people and families who feel so badly let down by their NHS services.

We ask for a commitment to use this report, the findings from the independent review, and the patient experience data it has started to collect to meaningfully scrutinise and report regularly, in public, on people's experiences, and the actions being taken as a result.

Many participants' experiences suggested that a significant cultural shift is needed if maternity care is to be improved for those accessing it.

We ask the health board to commit to a cultural change plan alongside the clinical and patient experience improvements it is making. As part of the cultural change plan, meaningful and appropriate key performance indicators should be identified, monitored and publicly reported on so the public knows what, how and when things will change.

It is positive to see that the health board has introduced more co-production into its ways of working, bringing in the expertise of people with lived experiences into the development of materials, the Maternity Services Charter, and their Maternity Voices Partnership.

This will strengthen and add an important dimension to the quantitative information, such as 'family and friends' data, that has regularly been collected and reviewed.

Given its importance, we are asking the health board to confirm how these patient experiences will be embedded into their formal governance, accountability and key performance frameworks and processes.

We have heard positive reports from people having their babies in the Birth Centre at Neath Port Talbot hospital, which re-opened in September 2024.

There is a good opportunity for the health board to look at what is working well in the Birth Centre and see what principles could be taken and applied across its maternity services to strengthen and speed up improvements.

Listening and responding to the experiences shared in this report, and from other sources, is essential to drive quality improvements to care so that everyone giving birth receives safe, consistently high-quality care and compassionate support at each stage of their care journey.

This report focusses on what we've heard from people receiving services in the Neath Port Talbot and Swansea area.

We know from our wider activities and conversations with people across Wales that mothers, babies, and their families have great experiences of maternity and neonatal care, but there are also times when things don't go as well as they should.

After every report that exposes big failings in maternity services, including Shrewsbury and Telford Hospital NHS Trust[10], that provides care for people living in Powys, and Cwm Taf Morgannwg Health Board[11] **we say never again.**

We want the experiences in this report to help all organisations in Wales delivering maternity and neonatal care to learn lessons and prevent any repeat of the poor experiences we've heard in Neath Port Talbot and Swansea.

10. Ockenden Report
11. Independent Maternity Services Oversight Panel

Next steps for maternity and neonatal services in Wales

Llais will push for the rapid and transparent rollout of the All-Wales Perinatal Engagement Framework. We will make representations to health boards to openly share and promote what they are doing to implement the commitments in the Framework.

We will ask the National Strategic Clinical Network for Maternity and Neonatal Services to reflect on the lived experiences shared within this report and use them to influence change, to improve outcomes and experiences.

We will make representations to Welsh Government to encourage the development of a national approach to supporting those who have been harmed by poor maternity care. We will call for a national trauma support service to be established for people to get the help they need to recover.

Thanks

We thank everyone who took the time to share their very personal and sometimes very traumatic experiences. We know that reliving difficult experiences can be draining, but most people were clear that they were doing it so that others don't have to go through what they did.

We are grateful to you for helping us to understand your experiences of maternity services provided by Swansea Bay University Health Board. We hope that your voices will drive forward continued action to make services better.

Thank you to Swansea Bay University Health Board for facilitating and supporting our work, listening to the feedback that we, and other organisations, have provided, and for acting on this feedback and putting service improvements in place as a result.

Finally, we want to thank **Samaritans Cymru** for providing invaluable support to those who needed it at our focus group sessions.

Share your story about maternity care

If you have an experience of maternity services that you would like to share, you can do so in the following ways:

- Contact Llais: nptandswansea.enquiries@llaiscymru.org 01639 683490
- Share your experience with the independent review: https://www.nicheconsult.co.uk/swansea-maternity-and-neonatal-review/#feedback

Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

Accessible formats

This publication is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us. You can ask for a copy by contacting our office:

Llais
Crown Buildings
Cathays Park
Cardiff
CF10 3NQ

02920 235 558
enquiries@llaiscymru.org
www.llaiswales.org

Appendix 1: Timeline

Date	Event
5–7 Sep 2023	Healthcare Inspectorate Wales (HIW) inspection of maternity services at Singleton Hospital
12 Dec 2023	SBUHB announces independent review into maternity and neonatal services
12 Dec 2023	Maternity and neonatal services escalated to Level 3 (enhanced monitoring) by Welsh Government
15 Dec 2023	HIW report published, identifying urgent issues
Dec 2023	Independent review officially begins
April 2024	Llais launches maternity insight project in Neath Port Talbot and Swansea
Jan 2024	Oversight Panel for the review established; Margaret Bowron KC appointed as Chair
22–24 April 2024	Further HIW inspection conducted
June 2024	Chair of the review resigns; Terms of Reference revised for better family involvement
25 June 2024	Dr Denise Chaffer appointed Interim Chair of the review
31 July 2024	HIW report published, noting improvements but ongoing challenges
Autumn 2024	Neath Port Talbot birthing unit reopens, increasing access and choice
Nov 2024	Llais completes primary engagement phase
24 Jan 2025	Maternity and Neonatal Review update report presented at January Board meeting
Feb 2025	HIW inspection of maternity services at Neath Port Talbot Hospital
27 Mar 2025	Gold Command Maternity Report presented at Board meeting
3 April 2025	Draft Llais insight report shared with SBUHB
2 May 2025	SBUHB share notes on progress with Llais
9 May 2025	HIW report on maternity services Neath Porth Talbot Hospital published
12 May 2025	Llais SBUHB Maternity Services insight report released

Appendix 2: Survey questions

- When did you receive maternity care from Swansea Bay University Health Board?
- How do you feel about the care you received throughout your pregnancy?
- What do you think was good about the care and support you received?
- Was there anything about your care and support that did not go well?
- What do you think could have been better?
- Did you always feel involved in decisions about your care? Please tell us more about that...
- Did you always feel that you had enough time with your midwife or doctor to talk through your care at any time? Please tell us more about that...
- Did you feel after talking through any concerns they were listened to and acted on? Please describe your experience...
- What did you think about the information you were given during pregnancy? (i.e. did it give you the information you needed in a way you could understand)
- What went well during birth?
- What could have been better?
- What went well with the maternity care you received after birth?
- What could have been better?
- Were you given information about how to raise a concern?
- If you raised concerns, what was the experience like? (you might like to think about: how long it took, the way the concerns were looked at, the explanation and response)
- Is there anything that could have been done differently to improve the response?
- Is there anything else you'd like to tell us?

Appendix 3: Demographic information for survey respondents

QUESTION – What is your preferred language?		
English (437)	Welsh (3)	English/Swedish (1)
Polish (1)	English/Welsh (4)	British (1)

QUESTION – Which gender do you identify with?		
Woman/girl (441)	Non-binary (1)	Man/Boy (2)
Prefer not to say (1)	Other - not specified (2)	

QUESTION - Do you consider yourself to be a trans person?	
Yes (1)	No (444)
Prefer not to say (2)	

QUESTION – What is your sexual orientation?		
Heterosexual (395)	Bisexual (21)	Asexual (17)
Pansexual (3)	Lesbian (4)	Prefer not to say (6)
Other (1)		

QUESTION – What is your ethnicity?		
White Welsh/English (413)	White other (16)	Prefer not to say (9)
White Irish (2)	Asian or Asian British Pakistani (2)	Mixed Asian/White (1)
Mixed other (1)	Asian or Asian British other (1)	Black or Black British African (1)
Other (1)		

QUESTION – When were you born?
[Year of birth of mother only, with numbers in each year. Note: no data provided for 1973, or 2005]

1968	1969	1971	1972	1974	1975	1976
1	1	1	2	2	1	6
1977	**1978**	**1979**	**1980**	**1981**	**1982**	**1983**
1	3	5	8	7	9	15
1984	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**
13	7	21	23	17	25	33
1991	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**
29	28	29	36	23	22	15
1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
10	8	10	8	6	12	3
2006						
2						

QUESTION – Do you have a religion?		
No religion (291)	Christianity (117)	Prefer not to say (21)
Other (7)	Atheism (6)	Islam (3)
Buddhism (1)	Judaism (1)	

QUESTION – Do you consider yourself to have a disability?		
Yes (30)	No (398)	Prefer not to say (19)

QUESTION – Do you look after, or give any help or support to a family member, friend or neighbour because of a long-term physical disability, learning difficulty, mental ill-health, or age related problems?		
Yes (83)	No (345)	Prefer not to say (9)

QUESTION – Are you currently pregnant or have you been pregnant in the last year?		
Yes (224)	No (223)	

QUESTION – Which of the following best describes your financial status?	
I have more than enough for necessities, and a large amount of disposable income, that I can save or spend on extras or leisure	47
I have more than enough for basic necessities, and a small amount of disposable income, that I can save or spend on extras or leisure	224
I have just enough for basic necessities and little else	112
I don't have enough for basic necessities and sometimes run out of money	64