National Maternity and Neonatal Investigation

Trust Report Annexes

June 2026

Intent

In August 2025 I was asked to chair a rapid, independent National Investigation into maternity and neonatal care in England. The purpose of the Investigation was to develop a set of national recommendations to drive system improvements in maternity and neonatal care across England and support families to find accountability. To inform the system level review, 12 trusts were chosen from across the country for local review.

Note of acknowledgement

I would like to thank the women and families who came forward to share their experiences of maternity and neonatal services with us. By sharing their experiences, families relived deeply painful and traumatic events in their lives, and I am grateful to them for their preparedness to do so. From the outset, I have put the voices of women and families at the heart of this investigation, and that is why in our visits to Trusts we carried out family evidence panels in places which were separate from Trust premises.

I would like to thank staff at the various Trusts we visited for their time and contributions to the National Maternity and Neonatal Investigation (NMNI) including organising our visits, sharing data and evidence, and for their honesty and openness in interviews and panels.

The reports

The Terms of Reference for the NMNI stated that the Investigation Team would conduct and publish 12 local investigations of maternity and neonatal services in NHS Trusts and use these, alongside other sources of data and evidence gathered by the investigation, to inform the development of the national recommendations.

I selected the 12 Trusts with a view ensuring a diverse mix of Trusts, including variation in case mix, Trust type, and geographic and demographic coverage. By taking this approach, the investigation has been able to capture experiences from different parts of the country to facilitate our understandings of the challenges facing maternity and neonatal care. The criteria, which supported the selection of the 12 Trusts, included data on Trusts with poor outcomes or experience, MBRRACE-UK perinatal mortality rates (2021-23), and CQC maternity patient survey data (2024). I also considered Trusts proposed by bereaved and harmed families who had experienced failures in maternity care.

In addition to the above criteria, East Kent and Morecambe Bay were chosen as they had previously been investigated and I wanted to test the sustainability of reforms that had been made.

The individual reports are a snapshot in time. They contain our key findings following our visits to each Trust. They are not the result of in-depth investigation, and we stated at the outset that we would not be making recommendations. It is oversight and regulatory bodies such as the Care Quality Commission (CQC), NHSE Oversight Framework and the Maternity Neonatal Intensive Support Team that undertake detailed reviews of Trusts to identify areas of strengths and areas requiring improvement at a local level and then make recommendations.

These individual Trust reports form a vital part of our investigation. They bring together the experiences of women, birthing people, families and staff, what the investigation team saw during our visits and our view of what this means for the Trust. Taking both a local and a national approach enabled us to identify systemic issues and areas that need urgent national action.
I took a Families First approach to evidence gathering which meant that women, birthing people and families were the first people I spoke to during our visits.

Methodology

The investigation drew on written evidence, interviews and panel sessions with families, staff and stakeholders in maternity and neonatal services at each Trust.

Investigation team members visited every maternity and/or neonatal site in each of the 12 Trusts (except certain sites that were temporarily closed).

The aim of the visits was to observe the Trust's maternity and neonatal services first hand and to conduct both one-to-one, group interviews and panels with families and staff about their experiences of receiving and providing care.

I visited each site and was joined by:

- Expert Advisors
- Members of the investigation support team
- Transcription officials
- Representatives from PAM Wellness (the Investigation's psychological support service).

Engaging with women, birthing people and families:

Family evidence panels were held at the start of Trust visits, with at least 2 panels held for each NHS Trust, including with harmed and bereaved families. To maximise participation from affected families and to ensure as broad a representation of experiences as possible, the Investigation held additional evidence panels with families from specific Trusts after the conclusion of the wider programme of site visits.

When seeking participants for family evidence panels, contact was made through a range of organisations and individuals, including:

- Maternity and Neonatal Voice Partnerships
- Maternity and Neonatal Independent Senior Advocates (where the Trust's Integrated Care Board (ICB) had been part of the ISA pilot)
- Bereaved or harmed families or family groups who were in contact with the Investigation
- Voluntary and community groups
- Local MPs

Overall, the investigation held 40 family panels and spoke to 323 families at the 12 Trusts.

Engaging with staff

We used a range of methods to collect data from staff about their experiences of working at each Trust, including:

- An introductory meeting with myself, members of the NMNI team, members of the Trust's senior leadership team and Neonatal Voice Partnerships
- Site walk-arounds to all areas where maternity and/or neonatal services were delivered
- Interviews with labour ward coordinators and neonatal ward coordinators
- Interviews with senior leaders from each Trust, including representatives from Trust boards and senior staff across maternity and neonatal services.
- Staff panels split into the below groups following our first two Trust visits:
  - Band 7s and below and resident doctors
  - Band 8s and above
  - Consultants

Staff panels were split into groups to give staff a safe space where they could speak openly alongside their peers. Where a Trust had more than one site delivering maternity and neonatal services, we carried out at least one walkaround and staff panel at each site. Where there were gaps in our evidence collection, or staff groups were not fully representative, the Investigation team revisited Trusts or held staff panels and interviews virtually at a later date.

Overall, the investigation held 53 staff evidence panels and interviewed 119 senior leaders.

Escalation protocols:

A clear escalation protocol was in place to address any serious concerns and risks to patients and staff we encountered during our visits. These concerns were discussed between the visits team and with our clinical Expert Advisers to determine whether a formal escalation should be made.

Where escalation was required, the investigation team notified the Chief Executive of the Trust and/or Medical/Nursing Director and NHS England. During the period of our work, a number of escalations were made using this protocol.

A full methodology for the Investigation can be found in the National Report at Annex 2.

Summary of findings across the Trust reports

The investigation spoke to women and families from across the country, each with their own personal and unique lived experiences. To enable us to work in a trauma informed way, separate sessions were held for families who had suffered harm and/or bereavement.

The reports are a reminder of the unacceptable care that some women, and families have experienced and continue to experience in some Trusts and may be deeply upsetting to families who are reminded of harm and loss.

We met staff working in different services and at different levels of seniority. In each Trust, we were told about staff burnout, stress and the immense pressures that staff were working under. Staff acknowledged that in these situations empathy and compassion could often be 'the first thing to go.'

Across the 12 Trusts visited, there were consistent themes that emerged when reviewing the evidence. These are:

1) Women not being listened to:

Across all Trusts we heard from women and families who were not listened to, dismissed and excluded from decision making.

2) Staffing:

Staffing levels that do not match demand, leading to heavy workloads, and reduced continuity of care.

3) Demand and capacity:

High demand on services, alongside the increasingly complex care needs of women which puts pressure on available capacity. This leads to delays, overcrowding and, at times, care decisions being shaped by available space and patient flow rather than clinical need.

4) Leadership and governance:

Leadership and executive teams were aware of the challenges facing maternity and neonatal services but were not always equipped with the skills, knowledge and capabilities to make the changes required.

5) Response when things go wrong

Women and families across the country told us about traumatic experiences after things went wrong with slow or defensive responses from Trusts, apologies not/or grudgingly made which were felt to be meaningless.

6) Inequalities:

Inequalities across maternity and neonatal services were consistently raised during panel sessions with differences in experience linked to ethnicity, socioeconomic status, language, disability and gender.

7) Estates

Across the Trusts we saw examples of estates that were not fit for purpose. Women and families lacked privacy for sensitive conversations and staff were delivering care in cramped conditions

8) IT systems

Trusts are working with multiple IT systems that do not 'talk to each other' or are unable to share information. This can create potential patient safety risks if information is not consistently shared across platforms and creates additional burdens for staff.

What this means for Trusts

Structural and systemic issues mean that delivering kind and compassionate care is not always possible. We heard about teams operating with high levels of vacancies or working well beyond their hours because of the high demands on services. Staff told us about the scrutiny they were under, the fear of making mistakes given the media attention directed towards maternity services and the challenge of working in 'blame culture'.

We also heard positive experiences of teams working well together, supportive colleagues and initiatives that are leading to positive changes and outcomes for women, families and babies.

Whilst meeting executive teams and senior leaders we saw different levels of understanding and engagement with what was happening in maternity and neonatal services in their Trust. We also saw, in the evidence that Trusts shared with us, differences in the governance systems for maternity and neonatal services. Some Trusts did not have a direct 'ward to board' governance mechanism with a resultant lack of executive oversight of what was happening on the ground.

At each Trust we also saw local improvements that were delivering results. However, there was limited evidence that these improvements or learnings were being shared across Trusts or that there was a mechanism that easily allowed Trusts to do so. This differs to other services such as Stroke or Cancer services where mechanisms or networks are in place that allow learning so that successful initiatives can easily be shared between Trusts.

Finally, it is important to consider when reading the Trust reports that often experience lags behind improvement. What this means is that Trusts may be on a learning journey and are putting in place improvement plans these improvements may not yet be consistently felt by women and families using the services.

Annex 1: Inclusive language and terminology

Purpose of this annex

Language matters in maternity and neonatal care. It can shape whether people feel recognised, respected and safe, and whether they feel able to ask questions, raise concerns and seek help. It also matters because this report speaks to several audiences at once: women and birthing people, families, bereaved families, staff, policy makers, researchers, regulators and the wider public.

This annex explains the approach to terminology used in the Trust reports. It is intended to support clarity, transparency and inclusion, while recognising that language in maternity and neonatal care is complex, evolving and sometimes contested.

Our approach

The Trust reports recognise that entirely gender-neutral language that removes the term "women or men" can create communication issues. Therefore, this report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services, identifies as a woman or mother. The report therefore does not use a single term in all contexts. It uses language according to meaning, evidence source and audience. Terms used across the report include “women”, “mothers”, “women and birthing people”, “parents”, “partners”, “fathers”, “babies” and “families”.

Where the report discusses national data, maternal mortality, clinical evidence or inequalities based on sex, it often uses “women”. This reflects the way much of the evidence base, policy literature and routinely collected data are currently framed, and it allows the report to describe clearly the inequalities and harms experienced by women in maternity care.

Where the report describes lived experience, family involvement, discrimination, access to care or individualised support, it may also use broader terms such as “birthing people”, “parents”, “partners” and “families”. This reflects the diversity of people and families who use maternity and neonatal services, including trans men, non-binary people, LGBTQ+ families, adoptive parents, non-birthing partners and wider family or support networks.

The purpose of this approach is not to replace the language of women and motherhood. It is to add language where needed so that people who may otherwise be overlooked are also recognised.

How this approach was developed

The Investigation considered a broad range of views on terminology discussed by the expert advisors. In developing the report, we considered current NHS and Department of Health and Social Care language, maternity and neonatal policy, equality and inclusion guidance, clinical terminology, academic evidence and the language used by families and staff who contributed to the Investigation.

The review also heard that people can experience exclusion, discrimination or poorer care in many different ways. This includes discrimination or disadvantage linked to race, ethnicity, faith, language, disability, age, mental health, social circumstances, migration status, sex, gender identity, sexuality or family structure. Inclusive language is therefore not only about gender identity. It is part of a wider commitment to respectful, accessible and equitable care.

Principles used in the report

The approach to terminology has been guided by the following principles:

- to use clear and accessible language for a national audience
- to recognise the central importance of women's experiences and sex-based inequalities in maternity care
- to acknowledge that some people who use maternity and perinatal services do not identify as women or mothers
- to avoid language that unnecessarily excludes people or families
- to use broader terms where these are more accurate or inclusive in context
- to reflect the language used in the evidence base without allowing that to limit recognition of people whose experiences may be less visible in existing data
- to ensure that language supports, rather than distracts from, the report's central purpose: improving safety, equity, dignity and outcomes in maternity and neonatal care

Population language and individualised care

There is an important distinction between language used in a national report and language used in direct care.

At population level, terms such as "women" and "mothers" are often necessary to describe evidence, data, inequalities and policy responsibilities clearly. These terms are also meaningful to many people who use maternity services and should not be treated as interchangeable or incidental.

In direct care, however, language should be personalised. Staff should use the name, pronouns and terms that an individual uses for themselves. Services should recognise different family structures and should not require people to repeatedly explain, justify or

correct assumptions about who they are, who their partner is, or who is important to their care.

This is not simply a matter of courtesy. Being misrecognised, dismissed or treated as unusual or “too complex” can affect trust, communication, seeking help and safety. Inclusive language should therefore be understood as part of safe, compassionate and personalised care.

Limitations

We acknowledge the limitations of any approach to terminology. Language evolves over time, and different people and communities may reasonably prefer different terms. Some readers may feel that the report should have used more gender specific language throughout. Others may feel that it should have used more consistently gender inclusive language.

The Investigation has not sought to resolve all wider debates about language. Instead, it has sought to use terminology that is clear, proportionate to the purpose of the report, grounded in the evidence reviewed and respectful of the diversity of people and families who use maternity and neonatal services.

We also recognise that inclusive language alone is not sufficient. Respectful terminology must be matched by accessible services, good interpretation, cultural safety, disability inclusion, trauma informed care, LGBTQ+ inclusion, meaningful family involvement and systems that respond to people’s needs in practice.

Annex 2: Glossary

Term	Description
Acuity	A measure a patient's condition and the intensity or complexity of clinical care they require, often used to determine staffing levels.
Adverse outcomes	Adverse outcomes in maternity and neonatal care refers to unintended harm to mother or baby occurring during pregnancy, labour, birth or the immediate postnatal period. This includes maternal death or severe morbidity (such as haemorrhage, sepsis, or organ failure), stillbirth, early neonatal death, and significant neonatal morbidity including hypoxic brain injury, seizures, or conditions requiring admission to neonatal intensive care. The term encompasses both clinical events that were potentially avoidable and those that occur despite optimal care.
Alongside midwifery led unit (AMU)	An alongside midwifery led unit is located in the same building as an obstetric unit so it has access obstetric, neonatal and anaesthetic care if required.
Anaesthetist	An anaesthetist is a specialist doctor who gives patients medication to prevent them feeling pain during operations and other medical procedures and monitors their safety throughout.
Antenatal	The period between conception and birth.
Bereavement	Having a close relation or loved one who has recently died.
Birthrate Plus®	A workforce planning tool used in the UK to calculate midwifery staffing levels.
Body Mass Index (BMI)	Body Mass Index (BMI) a measurement to work out the range of healthy weights for a person. It is calculated by dividing your weight (in kilograms) by your height (in metres squared – that is, your height in metres multiplied by itself). The healthy range is between 19 and 25.

British Sign Language (BSL)	BLS is the most common form of sign language used in the UK.
Caesarean Birth	An operation in which a baby is born through a cut made in the wall of the abdomen and the uterus. It may be done as a planned (elective) or an emergency procedure.
Childbearing Women	Females within their reproductive years, commonly cited as ages 15-45, who are physiologically capable of conceiving and giving birth. This term is used in medical and demographic contexts to identify individuals with the potential for pregnancy.
Care Quality Commission (CQC)	CQC is the independent regulator of health and social care services in England, established to ensure that care is consistently safe, effective, and compassionate and provide a layer of oversight. During an inspection, the CQC evaluates evidence to assess if a service is ‘Safe, Effective, Caring, Responsive, and Well-led'. Each of these is then awarded one of the below ratings. Outstanding: The service is performing exceptionally well. Good: The service is meeting legal requirements and doing what is expected. Requires Improvement: The service is not performing well enough and has been ordered to improve. Inadequate: The service is performing poorly and putting people at risk. The CQC uses the ratings to decide the overall rating for a service. This is based on the overall pattern of strengths and weaknesses, rather than a simple average.
Community Maternity Unit	A maternity unit, midwife managed, occasionally with GP involvement, which may be a stand-alone unit or adjacent to a non-Obstetric hospital or adjacent to a maternity unit.
Consultant	A consultant is a senior doctor that has completed full medical training in a specialised area of medicine and are listed on the GMC’s specialist register.

Continuity of Care	Describes a situation where all the professionals involved in delivery of care share common ways of working and a common philosophy. The aim being to reduce conflicting advice experienced by women, and the same philosophy of care is experienced by the woman throughout the period of her care.
Delivery suite	The delivery suite specialises in high-risk maternity care, where obstetricians and midwives manage labour, birth, and immediate postnatal care.
Department of Health and Social Care (DHSC)	DHSC is the UK government department responsible for health and adult social care policy.
Deprivation	Deprivation refers to the lack of necessary resources, socioeconomic stability, and access to opportunities such as income, education, employment, and adequate housing that directly impacts the health of a pregnant person and their baby.
Director of Midwifery (DoM)	A Director of Midwifery is a senior, highly experienced midwife manager and leader within the maternity service.
Doula	A non-medical professional, not employed by or affiliated with the NHS, who provides support to individuals and families before, during, and after childbirth.
Duty of Candour	A legal requirement introduced in April 2023 for all NHS organisations to be open and honest with patients, service users, or their families when they experience unexpected or unintended moderate/severe harm, or death, while receiving care.
Early Pregnancy Unit (EPU)	An EPU is a specialist unit that provides care and support for women and birthing people with problems in early pregnancy.
Electronic Patient Record (EPR)	An EPR is a secure digital version of a patient's hospital medical record.
Family Integrated Care (FiCare)	Family Integrated Care is a model of neonatal care that promotes a culture of partnership between parents, carers

	and health care professionals working together to care for babies on the neonatal unit.
Freedom to Speak Up	A national policy within the NHS that aims to make raising concerns "business as usual" so that patient safety is never compromised.
Freestanding Midwifery Unit (FMU)	A facility where midwives have primary responsibility for care of women at low risk of complications during labour and birth which is not located on the same site as an obstetric unit.
Early Pregnancy Unit (EPU)	An EPU is a specialist unit that provides care and support for women and birthing people with problems in early pregnancy.
Gestation	The process/period of a foetus developing inside the uterus between conception and birth.
General Medical Council (GMC)	GMC is the independent regulator of doctors, physician associates and anaesthesia associates in the UK.
Governance	The processes, structures, and accountabilities ensuring organisations deliver high-quality, safe, effective care, manage risks, and use resources efficiently.
Gynaecologist	A gynaecologist is a specialist doctor who focuses on the health of the female reproductive system, including the uterus, ovaries, and related organs, and treats conditions ranging from routine menstrual and hormonal problems to complex surgical and fertility issues.
Gynaecology	The branch of physiology and medicine which deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.
Gestation	The process/period of a foetus developing inside the uterus between conception and birth.
Head of Midwifery (HoM)	A Head of Midwifery is a highly experienced senior midwife, manager and professional leader with an

	operational overview and responsibility for maternity services from acute to community provision.
Health Visitor	A qualified nurse or midwife with specialised training in community public health, focusing on the development and wellbeing of children aged 0–5.
Incontinence	Lack of voluntary control over urination or defecation.
Induction of labour	Starting labour artificially.
Initial Assessment	The maternity pathway initial assessment, sometimes referred to as the booking appointment, is the first comprehensive, contact with a midwife to assess the health and social needs of a pregnant person and their baby.
Integrated Care Boards (ICBs)	ICBs are NHS organisations responsible for planning health services for their local population.
Intrapartum Care	The term used to describe care given to women during labour and birth.
Key performance indicator (KPI)	Metrics which are used to measure and monitor performance.
Labour	The stages of childbirth. Labour is divided into three stages; first, second and third.
Labour ward	A specialised hospital department designed for childbirth, specifically for women and babies requiring higher risk obstetric care or continuous monitoring.
Late fetal loss (MBRRACE UK definition)	A baby born at 22 and 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
Late preterm infant	Babies born between 34-36+6 completed weeks of gestation.

Local Maternity and Neonatal System (LMNS)	An LMNS is an NHS structure in England responsible for delivering safe, personalized, and equitable maternity and neonatal care. They bring together midwives, doctors, and user voices (via Maternity Voices Partnerships) to improve services locally.
Local Neonatal Unit (LNU)	A neonatal unit that provides high dependency or short-term intensive care for babies born from 27 weeks completed gestation.
Maternity Assessment Unit (MAU) / Maternity Day Assessment Unit (MDAU)	A Maternity Assessment Unit or Maternity Day Assessment Unit is an outpatient, midwife-led service providing urgent, non-emergency, or planned monitoring for pregnant people, usually from 18-20 weeks pregnancy up to 6 weeks postnatal.
Maternal Mortality	Maternal mortality is the death of a woman during pregnancy, childbirth, or within 42 days of the end of the pregnancy, caused by complications related to the pregnancy or its management.
Maternity and Neonatal System	We define the maternity and neonatal system as all stages that women, babies and families have lived experiences of. This includes pre-pregnancy advice and care, pregnancy care, labour, birth, neonatal care, postnatal care including psychological support and care and support including bereavement care.
Maternity & Newborn Safety Investigations (MNSI)	The Maternity and Newborn Safety Investigations programme is part of a national strategy to improve maternity safety across the NHS in England.
Midwife	Midwives provide care and support to women and their families while pregnant, throughout labour and during the period after a baby's birth.
Midwifery Led Care	Care for pregnant women where the midwife is the lead professional. Midwifery-led care is suitable for healthy women who have a low risk, uncomplicated pregnancy.
Miscarriage	Spontaneous ending of a pregnancy before 24 weeks' gestation.

Mobility	The ability to move or be moved freely and easily.
Mode of Birth	How a baby is birthed, categorised as vaginal (spontaneous or assisted) or via caesarean section.
Multidisciplinary team (MDT)	Health and care professionals from different disciplines working together as a team to support patients.
Neonatal	The neonatal period is the time from a live birth up to 28 days following birth. This includes babies born preterm and term.
Neonatal Death (MBRRACE UK definition)	A live born baby (born from 20 completed weeks' gestation) who died before 28 days after birth.
Neonatal Unit	A hospital ward for the provision of specialist care to neonates. Neonatal care is organised according to both a description of the type of unit providing the care and the level of care provided.
Neonatal Intensive Care Unit (NICU)	A neonatal unit that cares for babies who are born extremely premature or sick, who require intensive care as well as those who may need high dependency or special care.
Neonate	A newborn infant.
Neonatologist	A neonatologist is a specialist doctor who cares for newborn babies, particularly those who are premature, seriously ill, or born with medical conditions requiring intensive or specialist support.
NHS England	The executive non-departmental public body responsible for the overall management, planning, and delivery of healthcare services within the NHS in England.
NHS trust	A legal entity within the NHS in England responsible for providing healthcare services. There are several types of NHS Trusts that provide specific services for example, acute, community, mental health, specialist and ambulance Trusts.

NICU (Neonatal Intensive Care Unit)	A neonatal unit that cares for babies born who are born extremely premature or sick, who require intensive care as well as those who may need high dependency or special care.
Nursing Midwifery Council (NMC)	The NMC is the nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland.
Obstetrician	An obstetrician is a specialist doctor who cares for women during preconception, pregnancy, childbirth and postpartum.
Obstetrics	The branch of medicine and surgery concerned with childbirth and midwifery.
Out of Guidance	Choosing maternity care that differs from standard guidelines.
Outlier	Performing statistically above or below expected.
Patient Reported Experience Measures (PREMs)	Validated surveys that capture a patient's personal perspective on the care they received.
Parity	The number of times a woman has given birth, including live births at any gestation and all births from 24 weeks or more.
Patient flow	The movement of patients through a healthcare system from initial contact, through to assessment, treatment, discharge and follow-up care.
Patient Safety Integrated Response Framework (PSIRF)	The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Perinatal	A number of definitions are used for the 'perinatal period'. The term perinatal encompasses the pathway of maternity and neonatal care.

Perinatal Mortality Review Tool (PMRT)	A web-based, standardised tool for NHS maternity and neonatal units in the UK, which enables multidisciplinary reviews of care after a baby's death (late miscarriage to 28 days post-birth).
Perineal Trauma	Damage to the perineum, the area between the vagina and anus, during childbirth.
Physiological birth	A spontaneous vaginal birth that occurs with minimal or no intervention, relying on the natural, hormonal, and physical processes of the body.
Postnatal/postpartum	The period from birth until 6 weeks following birth.
Postnatal care	Care provided to woman and baby, from birth for approx. 6 weeks.
Postpartum Haemorrhage (PPH)	Severe bleeding after childbirth.
Preterm Birth	A birth before 37 completed weeks of pregnancy, rather than the full 40 weeks.
Protected Characteristics	The Equality Act 2010 defines nine protected characteristics which serve to protect individuals from discrimination, harassment, or victimisation in the workplace, provision of services and wider society: age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/ belief, sex, and sexual orientation.
Psychological Safety	'A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes, and that the team is safe for interpersonal risk taking' - Amy Edmundson.
Socioeconomic	Socioeconomic describes the combination or interaction of social (people, culture, and status) and economic (money, jobs, and financial security) factors. It is used to measure a person's or group's standing in society based on a mix of their income, education, and occupation.

Special Care Baby Unit (SCBU or SCU)	A neonatal unit that cares for babies born after 32 weeks of gestation and who don't need intensive care.
Stillbirth (MBRRACE-UK definition)	A baby born from 24 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
Term	Babies born on or after the 37th completed week of pregnancy.
Transitional Care (TC)	Transitional care supports resident mothers/parents as primary care providers for their babies with care requirements more than normal newborn care but not needing admission to the neonatal unit.
Trauma Informed Approach	Where a person, organisation, programme or system realises the impact of trauma and understands potential paths for healing and overcoming adversity and trauma.
Trimester	One third of a pregnancy.
Ventilation	Ventilation refers to the medical process of helping a person breathe when they cannot do so adequately on their own. It ensures the person's body gets enough oxygen and removes carbon dioxide, usually administered via a machine.

Annex 3: Analytical annex – data sources and definitions

This table summarises the data sources, definitions, and key caveats for each measure based on published data that is presented in the report, and outlines the approach used to benchmark results against national distributions.

Measure	Data Source	Notes / caveats	Benchmarking
Number of births	NHS England, NHS Maternity Statistics, Maternity Services Data Set (MSDS)	The total number of distinct babies (live or stillbirth) born in the financial year recorded by each Trust. Rounded to the nearest 5.	N/A
Induction rate	NHS England, Maternity Services Monthly Statistics, MSDS measures	Percentage of women giving birth to a singleton term liveborn infant, whose delivery commenced with an induction of labour.	N/A
Caesarean rate	NHS England, Maternity Services Monthly Statistics, MSDS measures	Percentage of women giving birth to a singleton term liveborn infant, who gave birth by caesarean.	N/A
Deliveries per midwife	NHS England, NHS Maternity Statistics, Hospital Episode Statistics (HES) NHS England, NHS workforce statistics	For consistency with the methodology used in the technical annex of Lord Darzi's independent investigation of the NHS in England (slide 105), deliveries per midwife is calculated with the number of delivery episodes recorded at the Trust in a financial year divided by the total midwife FTE	The distribution across English NHS trusts was split into quintiles (5 equal groups), ranking trusts from lowest to highest deliveries per midwife. The quintile a Trust is in

Measure	Data Source	Notes / caveats	Benchmarking
		employed by that Trust in September of that year. The ratio of deliveries per midwife required to deliver safe and appropriate care will vary between Trust depending on service specification and the specific needs of the population being served. This measure should be treated as purely informative rather than as a performance metric.	provides a relative benchmark, with the national figure used as a reference point for interpretation.
Neonatal care days	National Neonatal Audit Programme (NNAP), Extended analysis report	Total of intensive care days (recorded as HRG XA01Z), high dependency days (HRG XA02Z), and special care days (HRG XA03Z) recorded by the Trust in the calendar year. Excludes days of special care in a transitional care area with the primary carer resident with the baby (HRG XA04Z) and days of neonatology supported care (HRG XA05Z) where the baby is receiving care in a neonatal unit but does not meet the criteria for HRC XA01Z-XA03Z, or the baby is receiving phototherapy.	The distribution across English NHS Trusts was split into quintiles (5 equal groups), ranking Trusts from lowest to highest number of neonatal care days. The quintile a Trust is in provides a relative benchmark.
Deliveries per midwife	NHS England, NHS Maternity Statistics,	For consistency with the methodology used in the technical annex of Lord Darzi's independent investigation of the NHS in	The distribution across English NHS Trusts was split

Measure	Data Source	Notes / caveats	Benchmarking
	Hospital Episode Statistics (HES) NHS England, NHS workforce statistics	England (slide 105), deliveries per midwife is calculated with the number of delivery episodes recorded at the trust in a financial year divided by the total midwife FTE employed by that Trust in September of that year. The ratio of deliveries per midwife required to deliver safe and appropriate care will vary between Trust depending on service specification and the specific needs of the population being served. This measure should be treated as purely informative rather than as a performance metric.	into quintiles (5 equal groups), ranking Trusts from lowest to highest deliveries per midwife. The quintile a Trust is in provides a relative benchmark, with the national figure used as a reference point for interpretation.
Neonatal care days	National Neonatal Audit Programme (NNAP), Extended analysis report	Total of intensive care days (recorded as HRG XA01Z), high dependency days (HRG XA02Z), and special care days (HRG XA03Z) recorded by the Trust in the calendar year. Excludes days of special care in a transitional care area with the primary carer resident with the baby (HRG XA04Z) and days of neonatology supported care (HRG XA05Z) where the baby is receiving care in a neonatal unit but does not meet the criteria for HRC XA01Z-XA03Z, or the baby is receiving phototherapy.	The distribution across English NHS Trusts was split into quintiles (5 equal groups), ranking Trusts from lowest to highest number of neonatal care days. The quintile a Trust is in provides a relative benchmark.

Measure	Data Source	Notes / caveats	Benchmarking
Neonatal nurse shift staffing	NNAP, Public Access Dashboard	The number of shifts where nurse staffing met or exceeded service specification rules (1:1 intensive care; 1:2 high dependency care; 1:4 special care; additional shift coordinator) (see Neonatal Critical Care service specification) divided by the number of shifts with complete cot occupancy and qualified nurse data. Data collection instrument and measure based on a two-shift model of each calendar day.	N/A
Service user experience	Care Quality Commission (CQC), Maternity survey	Mean section scores are derived from survey responses and standardised for age and parity for each Trust to improve comparability. Estimates are subject to sampling variation, and scores are not reported where the number of responses was too low.	Standardised mean section scores are compared with the national distribution of Trusts and grouped into performance bands ('Much better' to 'Much worse'). The band a Trust is in provides a relative benchmark against national performance.
Stabilised & adjusted stillbirth rate	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	A stillbirth is a baby who at no point breathes or shows signs of life and a neonatal death is a baby born alive who dies in their first 28 days of life. All rates reported here are for babies	To allow for robust comparison, Trust and health boards are classified into **five comparator groups** based on level of service provision (e.g.

Measure	Data Source	Notes / caveats	Benchmarking
	(MBRRACE-UK), Perinatal mortality data viewer	born after at least 24 completed weeks of pregnancy. MBRRACE-UK figures are based on notifications followed by case ascertainment, and exclude the small number of late terminations of pregnancy that are reported as stillbirths in sources based on statutory registration. Reported rates are **stabilised** across time (to reduce the impact of random yearly variation) and **adjusted** for mother and baby characteristics known to increase the risk of perinatal mortality (to reduce the impact of different patient populations on comparisons between Trusts and health boards). For more information see the technical manual.	Level 3 Neonatal Intensive Care Unit) and are compared within these groups instead of across the UK as a whole. If the mortality rate at a Trust is over 15% lower than the average mortality rate for the relevant comparator group it is described as ‘much lower’, if it is 5-15% lower it is described as ‘lower’, if it is within 5% it is described as ‘similar to/around average’, and if it is over 5% higher it is described as ‘higher’.
Population data	NHS England, Maternity Services Monthly Statistics - NHS England Digital	N/A	N/A

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