National Maternity and Neonatal Investigation

Blackpool Teaching Hospitals Trust

Trust Report

Note of acknowledgement

We would like to thank the women, birthing people and families who came forward to share their experiences of maternity and neonatal services at Blackpool Teaching Hospitals with us. By sharing their experiences, families relived deeply painful and traumatic events in their lives, and we are grateful for them for their preparedness to do so. From the outset we have put the voices of women and families at the heart of this Investigation, and that is why our visits to trusts carried out family evidence panels separate from trust premises.

We would like to thank staff at the Trust 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.

Introduction to Blackpool Teaching Hospitals Trust

The National Maternity and Neonatal Investigation team visited Blackpool Teaching Hospitals (from here on referred to as Blackpool or the Trust) on 9 and 10 December 2025. A second visit took place on 26 January 2026. Blackpool has one site (Blackpool Victoria Hospital) that offers maternity and neonatal services.

The aim of our visit to the Trust was to speak to families about their experiences and understand the experience of staff working there. It was also important for us to view the estate itself, as staff and families reported the impact this could have on services. The trust visit contributed to our understanding of what is happening in maternity and neonatal services in England.

Each individual trust report provides a snapshot in time, based on the evidence gathered during our site visit and review. These reports were not intended to replicate the role of the Care Quality Commission (CQC), and they should not be read as equivalent to a formal inspection or rating.

We have used nationally published and validated statistics to help us understand the performance and the context in which services are delivered as part of our site visits to NHS Trusts.

Some trusts have told us that there are differences between these national data sets and the information they hold locally, or in how they define certain measures.

We recognise that these differences exist. Where a Trust has raised this with us, we have noted this and, for completeness, included both the nationally published data and the Trust's own data or explanation.

Maternity services

Blackpool's maternity services were rated 'Requires Improvement' by the CQC in August 2025.

An explanation of what the CQC is and what their ratings mean can be found at the appendices in Annex 2: Glossary.

Activity and modes of delivery

Activity:

National published statistics

- In 2024/25, Blackpool supported 2,850 births.

Statistics provided by the Trust

- Between the 1 April 2024 and 31 March 2025, Blackpool supported 2,365 births.

Modes of delivery:

National published statistics

- In February 2026, 42.5% of deliveries were by caesarean section, compared with 39.5% three years earlier in February 2023.
- In February 2026, labour was induced for 30.2% of deliveries, compared with 36.8% three years earlier in February 2023.

Statistics provided by the Trust:

- In February 2026, 40.6% of deliveries were by caesarean section.
- In February 2026, labour was induced for 46.4% of deliveries.

Workforce

National published statistics

As of January 2026, the Trust employed:

- 99.3 full-time equivalent midwives.
- 22.6 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 23.2 which is close to the national average of 23.1. Blackpool is in quintile 3 i.e. the middle 20% of NHS trusts.

Statistics provided by the Trust

- 103.96 full-time equivalent midwives.
- 36 full-time equivalent doctors working in obstetrics and gynaecology

The number of deliveries per midwife in 2024/25 was 22.7 which is lower than the national figure of 23.1. Blackpool is in quintile 3 i.e. the middle 20% of NHS trusts.

Neonatal services

The CQC rated Blackpool’s neonatal services as ‘Good’ in 2019.

Unit and care pathway

Blackpool has a Level 2 Neonatal Unit for babies who need a higher level of medical care and for babies born after 27 weeks' gestation. This might include short-term intensive care, ventilation for breathing support, or tube feeding. There are 74 Level 2 Units across the country.

In 2024, babies were cared for in neonatal units for a total of 2,507 days of care, placing Blackpool in the lowest 20% of providers of neonatal care nationally.

Workforce

National published statistics

As of January 2026, the neonatal service employed 39.4 full-time equivalent neonatal nurses. In the 12 months ending December 2025, 66.7% of neonatal nursing shifts were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

Statistics provided by the Trust

As of January 2026, the neonatal service employed 37.33 full-time equivalent neonatal nurses. In the 12 months ending December 2025, 67.44% of neonatal nursing shifts were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

This means that the neonatal staff-to-patient ratio was followed as suggested by BAPM. A full explanation of neonatal staffing guidelines and service specifications can be found in the Annex 2: Glossary.

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences of feeding their baby were rated average and their experiences of labour and postnatal wards were rated average. However, care at the start and during pregnancy and care at home after birth were rated worse than average.

In the 12 months ending October 2024:

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) of 1.2 per 1,000 live births, within 5% of comparable trusts.
- A stabilised and adjusted stillbirth rate of 2.9 per 1,000 births, comparable with similar trusts.

A full list of evidence sources that were used to inform this report alongside details on what analytical methods we used can be found in the 'How we gathered and analysed our evidence' section at the end of this report.

What families told us

The Investigation's engagement strategy has been underpinned by a Families First approach. 'Families First' originated as a key principle of the Hillsborough Independent Panel and has been adopted in several subsequent investigations, including maternity investigations.

When visiting Blackpool, the first thing the team did was hold family panels in locations separate from the Trust's sites. We invited women and birthing people, fathers and partners[1] who received care from the Trust to share their experiences at the panels.

Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences speak to the lasting impact of harm and bereavement on their lives and the lives of their loved ones. Families told us that they came forward as they did not want other families to go through the experiences that they did and they wanted to see long term change.

We did not place any restrictions on the time period in which experiences of maternity and neonatal care occurred, allowing women, birthing people and families to share their experiences from different time periods. As a result, some of the issues raised, such as the condition of the estate or ways of working may have changed, got worse or improved since those experiences. However, there is consistency in the issues raised and the themes which have emerged remain important in understanding how families felt and what mattered most to them at the time.

Women, birthing people and families told us that not being listened to was a recurring and deeply distressing part of their care. Many described raising concerns about symptoms, changes in their bodies or their baby's wellbeing and feeling dismissed. Women and families told us that they received mixed messages between teams and shifts, which increased their stress. Families said this left them feeling unsafe and powerless when they most needed to be heard. Some also described how assumptions were made about them and how this affected whether they thought their concerns were taken seriously. For example, being seen as anxious or being judged based on whether they had previously had children.

"I rang them up anyway, because I was obviously on edge thinking about infection…and instantly got very dismissed. I was made to feel a bit silly really."

[1] 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. Further information on our approach to inclusive language and terminology is provided in the Annex: Glossary.

Families also described warning signs not being acted on, with symptoms such as pain, reduced movements and raised temperatures sometimes explained away as normal, rather than investigated. Across the panels and interviews, families described not only a failure to listen, but a failure to recognise that they needed clear explanations of what was happening. Families described feeling embarrassed for speaking up, doubting their own judgement and becoming less likely to seek help again. For those who experienced harm, this feeling was made worse when there was no clear acknowledgement or apology after things had gone wrong.

"I feel like, in those 12 hours, if I'd have been checked on, things might have been different, and I know I would have felt a lot better. So, by the time I went to delivery I was in an absolute state, so, I think that, for me, would be the main thing really."

Women and birthing people also described having *"no choice"* or repeated pressure put on them to agree to interventions.

"Every time I'd said no, I'd been flat out ignored and they'd just done what they wanted anyway."

Women, birthing people and families repeatedly said services felt overstretched, with demand exceeding capacity. Staffing shortages and system pressures directly impacted the quality of their care. We also heard of staffing pressures with *"only two midwives for 22 beds"*. This was experienced most acutely on hospital wards, in triage and during nights and weekends. Families told us that being kept informed and involved, even when services were under pressure would have helped them deal with their worries and made them feel more informed about what was happening.

"Everything grinds to a halt at a weekend. If you go into the triage at the weekend, there's one midwife and one healthcare assistant on duty. It's wait until Monday".

Several women and birthing people described long waits for assessment, treatment or support, particularly during labour or after birth. Some said they were left without help for a long time, even when in pain or distressed. A family described waiting all day and evening without monitoring because there were not enough staff available.

"We got there at 9.00 in the morning... they just left us all day... they kept saying they didn't have the staff for it right now."

Many women, birthing people and families showed empathy for staff and recognised the strain they were working under, telling us staff were visibly rushed, covering multiple roles, or working alone. Families were clear that individual acts of kindness made a significant difference during these periods of pressure. Some staff were said to be compassionate and reassuring, even in pressured situations.

"You can have the best midwife, but if she's overrun and too busy, she's much more likely to not give you the care that you should be getting."

In addition to staffing pressures, we heard that women and birthing people rarely saw the same midwife or clinician more than once. This lack of continuity meant they repeatedly had to retell their clinical history and felt staff did not know them or understand their needs. For some, this increased anxiety and left them feeling unsupported, particularly when they were already vulnerable.

"I saw a different midwife every single appointment I had through my whole pregnancy. I never had the same person twice. So that was a bit unsettling."

We heard from one woman how information was not logged correctly on the system after she lost her baby. She was then contacted by a different member of staff reminding her about a scan, adding to her distress and trauma.

"Because they hadn't cancelled my scan and they rang me up to tell me I've missed my scan. That was just like such a punch in the stomach, like how it affected me. I was like, I can't believe you've just done this. Like you've just took -- like, they obviously forgot to cancel it, but the impact that that has on you when someone then says, you know, basically tells me off, I like felt awful."

We heard about clear differences in being able to use services depending on where families lived. Several families spoke about how support varied between neighbouring areas, particularly in relation to antenatal education, health visiting and postnatal follow up. Women and birthing people felt that these gaps placed additional emotional and practical burdens on families, particularly those already dealing with anxiety or trauma. Several women described how their follow up care varied significantly once their babies were discharged from neonatal care.

"Get antenatal classes, they get far better feeding support, all sorts. We get very, very limited. Purely because of the postcode, even though we all access the same hospital."

Women and families found that the physical estate often intensified distress rather than providing them with reassurance or dignity. Shared bays, lack of privacy, noise and being surrounded by reminders of healthy babies were described as particularly difficult, especially for women who had experienced a loss or were separated from their baby.

Some women and birthing people described feeling claustrophobic and trapped, with little control over their surroundings. We heard about how a woman was placed on a maternity ward following miscarriage which was inappropriate and distressing.

"I ended up in the maternity ward in a bay with pictures of mothers with babies in their arms… I remember thinking, this is very strange to be in this environment, in this scenario".

When care went well

We also heard about instances when care went well, with women and families describing feeling listened to, believed and reassured. They said staff encouraged them to seek help and made it clear they were never a burden for raising concerns.

"Every time we've gone in to get checked, it's always been reiterated that we would much rather get you checked and you be happy rather than not call you."

Positive experiences were also described consistently in neonatal care, where families spoke about professionalism, kindness and emotional support during times of significant uncertainty and distress.

"Honestly, that neonatal experience for me was just brilliant. I just see them as angels."

What we saw and heard in Blackpool

During our Investigation we spent three days at Blackpool including a full walkaround of all areas where maternity and neonatal care are delivered. On our initial visit we visited the services with two neonatologists from the Investigation team. We visited the Trust a second time with an obstetrician and a midwife.

The community served by the Trust are more likely to be white and live in the areas more deprived than the national average. The trust also sees more women who smoked in early pregnancy or who are aged under 20, and more women with at least two previous live births or a previous caesarean section. This means that the service has to provide public health interventions such as smoking cessation services and consider how their home lives might impact what care they need during their pregnancy, birth and recovery.

During the visit, the executive team described a local community experiencing high levels of deprivation, poor health outcomes and significant social pressures, including poverty, insecure housing and complex trauma. The executive team also described the emotional burden that this places on the staff and were clear that these realities shape demand on services and must be recognised if care is to be planned and delivered well. The executive team also recognised that the staff delivering the service are also members of the community experiencing disadvantages and may face the same complexity.

Despite the challenging context, we met staff who were committed to providing the best care they could to women, birthing people and families. Staff acknowledged that the service was not where it needs to be yet and that problems persist such as staffing gaps. However, we heard about improvement plans introducing more board oversight and incident reporting, and that the Trust had worked through over 300 actions from all their reviews to produce one plan.

Vacancies could be seen across staff groups and services and created a reliance on bank staff or locums (temporary staff). This in turn put pressure on permanent staff members. In the Trust documents that were shared with us there was conflicting evidence about whether 1:1 care for women during active labour was consistently achieved and staffing concerns were raised at every quality committee meeting in 2025.

Across the Trust, we saw maternity and neonatal services that were welcoming despite being busy. Whilst some of the estate was old and in places, cramped (especially areas for partners to stay) there were efforts to make the space personal with family feedback boards, posters for local support groups and toys for children to use.

We heard about inconsistencies in the acuity and levels of pressure felt across maternity services. For example, when we visited the Trust, we were unable to see any delivery suites or antenatal/postnatal ward rooms as they were all in use. However, when visiting the midwife-led unit, we saw large spacious rooms that were not in use at the time of our visit.

Bereavement facilities at the Trust were a clear strength. The Swan bereavement suite was a modern, thoughtfully designed space with a separate entrance and exit, private

parking and soundproofing to protect privacy and dignity. Families were able to leave without passing through busy maternity areas. Staff told us that they were "*proud of their bereavement services*" which had been designed with direct involvement from local bereaved families and the Stillbirth and Neonatal Death Charity (SANDS).

What staff told us

As part of our Investigation, we spoke with staff and members of the executive team in Blackpool to improve our understanding of the context in which they work. Discussions centred around the challenges of providing maternity and neonatal care in the area, and any future plans to improve the delivery of services and workforce operations. We held three panels including groups of frontline employees and several interviews with senior board members and senior clinical leaders.

Staff felt that solely relying on the number of births did not accurately reflect their staffing requirements, as the complexity of cases demanded higher staffing levels than the number of births suggests. They described the difficulties in caring for women and birthing people with high levels of maternal and fetal risk, including growth restriction, smoking in pregnancy, the need for pre-term surveillance and complex social circumstances. The time and effort required to provide care to those with additional risks led to understaffing.

> *"Models of staffing... everything is governed by birth rate and very, very little is governed... by demographics or acuity."*

Staff also described being moved between areas to manage immediate safety risks and the knock-on impact this could have on other parts of the service. Staff particularly felt these risks when wards were already carrying a mixed group of antenatal and postnatal women. We also heard cases where staff were asked to cover other areas in which they were less comfortable working. Whilst the Trust considers escalation needs and staff skills before making these decisions, we heard that some staff are anxious about working in unfamiliar areas.

> *"If they're busy in the unit, you are asked to go and cover... we've had very good members of staff actually leave the trust because they have so much anxiety about going and working in an area... [they] don't feel safe in."*

Discharge of patients could be impacted and slowed by staff shortages, particularly when services such as prescribing and pharmacy were not available at the point a patient is ready to be discharged. We heard how problems with bed availability and patient flow had meant that maternity services had, at times, needed to divert patients to other trusts in the area.

The executive team noted a number of strategies for supporting staff, including wellbeing sessions and clear channels to raise concerns. We heard that staff could use a clinical

psychologist to provide guidance after difficult events. We also heard of a strong culture of recognition of positive work to improve morale and staff engagement.

During our discussions, staff linked capacity pressures to the complexity of the community served by the Trust. They described how high levels of deprivation and social complexity in the area shaped the care that they provided and described caring for many women and birthing people living on low incomes. Staff also described wider social concerns and challenges that communities faced such as safeguarding concerns relating to domestic abuse, substance misuse and late presentation to services.

“It has become trickier. There's a lot of complex babies out there, a lot of complex families, a lot of social deprivation. So that's challenging.”

“One of the highest nationally for safeguarding -- with significant social concerns who may well go into care.”

The executive team described the additional levels of funding and support that were required for groups who may face barriers to equitable care, including asylum seekers, refugees and people who do not speak English as a first language. Planning for groups such as asylum seekers can be challenging, as they may not have links to the local area, understand how to use services and may only remain in the area for a short period of time and so can experience care that is inconsistent.

“It’s challenging because… you haven’t got the commissioning for… asylum seekers who have been placed in one of the large hotels… I’m not aware that there’s been any commissioning around that.”

We heard about work underway to address these needs, including a team focused on those who do not speak English or do not speak it as a first language and specialised staff caring for asylum seekers and other vulnerable groups. The executive team also spoke explicitly about inequalities by race and ethnicity and recognised that a *“one size fits all”* approach is not sufficient.

We noted, through concerns raised with us, that there are tensions between medical staff. Recognising how important positive professional relationships are to patient safety we raised these issues with the Trust executive team. The executive team were fully aware of these tensions and were taking action to resolve them.

"*There is rivalry within the medical leadership. It's not working the way it should*"

Staff described challenges to maintaining morale caused by *"relentless"* shifts, where they would often work long hours without breaks. This not only led to staff feeling exhausted and burnt out, but we heard that these pressures were affecting new starters experiences and, in some cases, affected staff retention.

"We would go 12, 13, 14 hours without a break… difficult sometimes even to go to the toilet."

"We recruit new midwives, but, unfortunately, we're struggling to retain them… they're shell shocked at how bad it can be, and we've lost so many newly qualified midwives recently."

We also heard how clinical leadership gaps and delays in backfilling roles added pressure, with responsibilities being spread across teams when managerial posts were left unfilled. Alongside midwifery staffing pressures, staff described medical staffing gaps, particularly at consultant level, and a reliance on locums.

"The gaps have appeared, which has resulted in lots of locums - - you've got 11 or 10 on the rota but you've only got 7 [permanent staff]."

Despite these challenges, in our discussions with Blackpool maternity and neonatal staff, we were struck by a positive culture of encouraging trust, accountability, and shared learning and reflection. Several staff described strong peer-support networks, wellbeing resources and opportunities to decompress after high-stress events. Maternity staff spoke positively about managers, who they found to be approachable. We heard that staff and managers had worked together to make improvements to the estate, such as refurbishing facilities for families, demonstrating a sense of ownership and pride in their work.

What this means for families and services in Blackpool

The local deprivation and challenges that affect people living and working in Blackpool create significant challenges for the delivery of maternity and neonatal services.

We collected different sources of evidence that show significant staffing issues at the Trust. Staff raised whistleblowing concerns about the lack of maternity staff on shifts during the period of our Investigation. We were unclear whether senior clinical leaders had fully taken into consideration the wellbeing implications when staff were transferred across different parts of the service to meet fluctuating acuity demands. There was clearly a difference of opinion between senior clinical leaders and front-line staff regarding whether staffing levels were safe. Reliance on agency staff put pressure on permanent staff to ensure they understood local processes and limited the continuity of care that patients could receive. Whilst the Trust is running multiple recruitment campaigns, staff told us about the struggles to fill vacancies and that these pressures would therefore continue.

The varying levels of acuity across maternity services at the Trust, from the delivery suite to the midwife led unit, raised questions about whether the Trust needed to reassess how space is being used across the site to help create more capacity on the delivery suite or post- and antenatal wards.

Staff and Trust leaders appeared committed to providing the best care possible for the women and families who use their services. However, there are challenges facing the Trust, in particular midwifery staffing levels and tensions between medical staff. These challenges impact on the Trust’s ability to delivery consistently safe services to local people in areas of high deprivation which require a multi-agency approach linked to public health providers.

How we gathered and analysed our evidence

How we gathered evidence

How we gathered evidence

The evidence in this report was gathered through multiple sources. These included:

- Trust documents and data reviewed:
  - Quality Committee (or equivalent) minutes
  - Finance Committee minutes
  - All maternity and neonatal performance and service data that goes to the Trust Board
  - Any CQC warning notices or other formal or informal actions related to maternity and neonatal services
  - Complaint documentation relating to maternity and neonatal services
  - Any Freedom of Information requests received by Trusts in relation to maternity and neonatal services
  - Patient Safety Incident Investigations Reports (PSII) related to maternity and neonatal services
  - Patient Safety Incident Response Plan
  - Maternity and Newborn Safety Investigation (MNSI) data
  - Maternity Safety Support Programme (MSSP) documentation reports
  - ICB performance reports
  - NHS Resolution reports and activity
  - Improvement strategies for Maternity and Neonatal Services
  - Maternity and Neonatal risk register
  - Staff disciplinary data
  - Freedom to speak up occurrences
  - Prevention of Future Death Reports
- 3 family evidence panels with women, birthing people and families
- 1 interview with a family
- 3 listening events across different staff groups and grades

- Interviews with 16 members of staff

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the Maternity and Neonatal Voices Partnership (MNVP) Leads for Blackpool. In addition to these activities, further virtual family evidence panels were convened to broaden participation. To ensure widespread involvement, local third sector organisations and local MPs were approached to help promote the events and support recruitment, with particular focus on reaching those who may otherwise be underrepresented.

Through these listening events, we engaged directly with women and birthing people, fathers and partners, and families from a wide variety of backgrounds, including those from marginalised communities and deprived groups. Our approach was intentionally inclusive, aiming to capture the perspectives of seldom heard voices and ensure their experiences were reflected within our findings. During the panel events, participants shared personal stories and expressed their views about the care they received at the Trust.

These candid discussions provided valuable insights into both positive experiences and areas where improvements are needed, highlighting the diversity of needs and expectations amongst the community.

The listening events with staff were structured so that staff prioritised the issues for discussion based on those they experienced as most important to giving high-quality, safe and compassionate care.

Interviews with senior leaders in maternity and in the Trust were structured around a set of questions developed to gather information about key issues and requirements if care is to be high-quality care. For example:

- How do maternity and neonatal services level governance meetings report to the board to highlight any concerns, issues or good practice?
- What would you say now are the main barriers to giving safe and compassionate care? On the flip side of that, what would you say if you were to speak to another trust who were in the 'struggling' or 'requires improvement' CQC report landscape now, what would you say to them?
- During the site visit, we heard about the amount of work carried out to meet the needs of the local population, which is often quite complex. Can you tell us about how that impacts your service?
- How are the needs of different groups of women considered? Do you provide any support or training to deliver culturally sensitive care?
- We want to understand how the board supports the Trust to listen to women, families and staff. What processes are in place to hold the Trust to account on this?

- What is your view of where the organisation is at, in terms of maturity, in terms of PSIRF and its aim of involving patients and families and listening to them more as part of investigations?
- How would you describe incident investigations on the maternity and neonatal unit? Are wider system issues considered or is the focus on individuals and blame? How are staff supported during incident investigations?

The interviews were recorded and transcribed. The interview transcripts were sent to interviewees to check for factual accuracy and add any additional elements they may have omitted on the day.

How we analysed the evidence gathered

Trust documents and data received from the Trust were reviewed by the Investigation team to triangulate evidence and review governance structures.

The listening events with women, birthing people and families, and those held with staff, were recorded in order to ensure evidence was accurately captured word by word and not misrepresented. Individual interview and panel interview transcripts were analysed through a mixture of AI use and human analysts. Analysts developed a specific AI programme for the analytical work that focused on qualitative data analysis. The analytical steps taken were:

- Analysts gave the AI tool information about the aims of the Investigation and the analytical approach. Analysts reviewed the tool's contextual understanding of this.
- The AI tool identified clear topics across the evidence and signposted where this was found across the evidence including suggested quotes. This was checked for accuracy by analysts.
- The AI tool coded the full dataset and organised these codes into suggested themes. Analysts reviewed and refined the themes to ensure they were accurate, clear and firmly grounded in the accounts of women and birthing people, families and staff.
- The final analysis was handed over to the Investigation team to feed into this local trust report and inform the themes and recommendations in the national report.

National
Maternity and
Neonatal
Investigation