National Maternity and Neonatal Investigation

Bradford Teaching Hospitals NHS Foundation 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 Bradford 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 Bradford Teaching Hospitals NHS Foundation Trust

The National Maternity and Neonatal Investigation Team visited Bradford Teaching Hospitals NHS Foundation Trust (from here on referred to as Bradford or the Trust) on the 1 and 2 December 2025. The Trust has one site that delivers hospital-based maternity and neonatal services: Bradford Royal Infirmary.

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

Bradford's maternity services were rated 'Good' by the CQC in November 2025, following an inspection in September 2025. This was an improvement from a previous rating of 'Requires Improvement' in November 2024.

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

Activity and modes of delivery

Activity:

National published statistics

- In 2024/25, Bradford supported 5,025 births.

Statistics provided by the Trust

- In 2024/25, Bradford supported 5,283 births.

Modes of delivery:

National published statistics

- In February 2026, 37.7% of deliveries were by caesarean section, compared with 29.2% three years earlier in February 2023.
- In February 2026, labour was induced for 31.9% of deliveries, compared with 36.1% three years earlier in February 2023.

Statistics provided by the Trust

- In 2025, 38.4% of deliveries were by caesarean section, compared with 31.5% three years earlier in 2023.
- In 2025, labour was induced for 32.7% of deliveries, compared with 31.71% three years earlier in 2023.

Workforce

National published statistics

As of January 2026, the Trust employed:

- 248.7 full-time equivalent midwives.
- 53.26 full time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 23.7 close to the national average of 23.1. Bradford is in quintile 3 i.e. the middle 20% of NHS trusts.

Statistics provided by the Trust

- 258.32 full-time equivalent midwives.
- 60.90 full time equivalent doctors working in obstetrics and gynaecology.

Estates

The Trust has invested in new and improved maternity facilities, including a new maternity assessment centre, a new antenatal clinic, refurbishment of the Snowdrop Suite (this is a private, soundproofed maternity bereavement suite which provides a quiet, self-contained space away from the main labour ward for families experiencing the loss of a baby), a new antenatal day unit and an additional two-bed bay on the maternity assessment centre.

Neonatal services

The Trust's neonatal services were rated 'Outstanding' by the Care Quality Commission in November 2024 following an inspection in May 2024.

Unit and care pathway

Bradford has a Level 3 Neonatal Intensive Care Unit, providing care for babies who need the highest level of medical support. It includes advanced breathing support, life and organ support as well as other specialist services. There are 43 Level 3 Neonatal Intensive Care Units across the country.

In 2024, babies were cared for in neonatal units for a total of 9,278 days of care, placing Bradford in the top 20% providers of neonatal care nationally.

Workforce

As of January 2026, the neonatal service employed 70.5 full-time equivalent neonatal nurses. In the 12 months ending December 2025, 78.5% 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 Annex 2: Glossary.

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences of feeding their baby were rated better than average. Experience in other areas of maternity care, including pregnancy, labour and postnatal wards were rated around 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 1.8 per 1,000 live births, lower than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.6 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 Bradford, the first thing the team did was to hold family evidence panels in locations separate from the Trust sites. We invited women, birthing people, fathers and partners[1] to share their experiences of maternity and neonatal care 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.

Many women and birthing people told us they were not believed, listened to or taken seriously when they raised concerns about their own health or their baby's wellbeing. Some said they felt patronised or treated as if they did not understand their own bodies. Women and birthing people described their symptoms, including pain and reduced movements, being dismissed, minimised, or explained away as anxiety. Some families recounted being spoken to in a way that lacked compassion and an understanding of trauma.

> *"... none of the valid things I was experiencing were treated as valid. They were almost treated as, "Oh, she's a first time mum"*

Women and birthing people spoke about not being involved in decisions about their care and not being given clear information or asked for consent before procedures or interventions. For some, this created fear and lasting distress.

[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 at Annex: Glossary

They described being instructed to follow care pathways without real choice. For example, being told they could not go home or make feeding decisions unless they complied with staff expectations, which made them feel coerced rather than supported. Fathers and partners often felt pushed into making decisions, undervalued and were not included in communication about what was going on or in decision making about their partner's care.

"Yeah, it just felt like you were sort of brushed to one side and you were along for the ride, rather than, as a dad, actually being there and involved."

Families felt vulnerable and unsupported during moments of distress. One woman was left alone after a miscarriage because staff had to attend to other patients, even though she still needed care. While families recognised that they were not the only patient on the ward requiring care, this shows the need for more flexible staffing models, to allow patients to be taken care of in their time of need.

Communication from clinicians was often confusing or inconsistent, with different advice from staff members, families not being told why certain decisions were made and important conversations not consistently recorded. This left families unsure about what was happening and why, and risked inconsistency in ongoing treatments as notes were not accurate.

Families who experienced serious incidents, frightening experiences, harm or loss felt they were met with silence and a lack of explanation. The complaints process was hard to understand and slow. They faced long delays while waiting for information. In some cases, families said they only learned important details about what had happened through solicitors or by requesting records.

"I wasn't involved in that process… we never actually saw the report through the hospital…. I received a finalised report two years after it was finalised"

One family had a positive experience after contacting the Patient Advice and Liaison Service (PALS) while still in hospital. Their questions were answered quickly and clearly and they felt supported. The family explained that they understood the system and knew about PALS in advance. As with other trust visits we saw the impact that poor communication or a lack of communication with woman and families had. This underlines the importance of women, birthing people and families being given clear information to help them understand who to turn to for the answers to their questions.

Families experienced a service they described as feeling under pressure and this affected the care they experienced. One woman described being sent home because there were not enough staff available. Postnatal wards were described as busy, loud and disruptive.

Many found it difficult to rest and recover in these conditions but were reluctant to complain because they could see how busy and overstretched staff were.

> *"...the staff and you can see that they're overworked... I think the rudeness comes out because of that overworkedness, if you like."*

How families are treated based on their backgrounds, ethnicities and languages matters deeply and we have seen across the country how this affects their care and experiences. In Bradford we heard about differences in care linked to language, confidence and background as well as unfair treatment and stereotyping. This included being told of a woman whose first language was not English being left in visible pain and in labour while waiting in triage. We were told that midwives walked past her until a fellow patient stepped in to help. When staff reassessed the woman, she was found to be 7cm dilated and needed urgent admission. Many families did not feel listened to in the moment when they needed it or reassured after raising concerns.

> *"There was a Bengali lady with a husband. Both of them, English wasn't their first language. She was in labour, but she was sat on this bench trying to breathe through this pain. There was [a midwives] walking past... I had to speak to her in Bengali and ask her, "Are you okay and do you need some help?""*

> *"It's just that they brush every Asian or brown person, black person with the same brush... The concerns are not taken seriously."*

Similar to other Trusts we visited during the Investigation, families told us the physical estate and facilities at Bradford impacted their experience of labour and recovery, how safe they felt and whether they were treated with dignity and compassion. They described the contrast they experienced in different wards across the Trust. For example, having to queue to use facilities or walk long distances to use toilets and showers on busy wards.

> *"Like I said, even the C-section was perfect, the staff were brilliant. It was as soon as they sent me to the ward, that was it. The ward was just like ...it was like third-world care, almost. It was just dark, dingy. I was, like I said, the furthest room you can get in the back of that ward, and nobody would come."*

At many trusts we were told about the time midwives spend using computers and how this made women and birthing people feel that they were a second priority to the computer. This was the case at Bradford. We additionally heard how digital systems and

processes made it difficult for families to see information about their care and seek follow ups.

When care went well

Families also shared examples of good care where individual midwives and teams explained things clearly, offered reassurance, listened to what women and birthing people wanted and where possible tried to make it happen. Families linked positive experiences to staff who showed kindness and advocated for them, even under pressure.

"The midwife was so lovely. She said to me, you have done amazing. I am so proud of you. Go rest up… You've done really well. I'm really proud of you. I felt so good about myself."

"On that day, the [midwife] just came out and completely wiped the floor with them, basically. Because, like, the care and compassion that they showed, again, greatly outweighed the lack of it that I'd seen in a couple of hours previous."

Families also consistently described care on the neonatal unit as kind and attentive. They felt staff were present and compassionate.

What we saw and heard in Bradford

During our visit, we spent two days at Bradford Royal Infirmary, including a full walkaround of all areas where maternity and neonatal care are delivered. The Investigation team in attendance included a neonatologist and an obstetrician.

The community that the Trust serves is very diverse. Compared to national averages, there are more Asian families and young families using the services alongside people from a range of other backgrounds, cultures and ethnicities. Many people in the Bradford community live with higher-than-average levels of complex economic, social and health needs with some families served by the Trust living in some of the most deprived areas in England.

This means that the services have to plan and deliver care that is suitable for families who may need more medical or social care during pregnancy, birth and after birth, such as gestational diabetes support, newborn parenting education or practical support for attending appointments.

Across maternity and neonatal services in Bradford, we saw staff who were committed and motivated to provide good care in a challenging setting. We also saw a clear gap between how services are intended to operate and how care is experienced by families in practice.

In maternity services, we saw a modern, clean and clutter-free unit, with maternity and neonatal services located close together. The midwife-led unit felt welcoming, and the delivery suite includes two large modern theatres updated in 2023, although the capacity of the theatres was described by staff as limited. Posters across the unit shared family feedback, information on local services as well as staffing information, including who was on shift.

However, staff told us that space is tight in some working areas, particularly in the maternity assessment centre office. In some rooms it is difficult to fit a computer by the bedside, which can affect how care is documented. These practical constraints sit alongside wider pressure from rising demand, increasing inductions and women and birthing people who need more complex care.

In neonatal services, we saw a unit that was clean, well-kept and thoughtfully decorated. There was a spacious waiting area for visitors and visible effort to make it welcoming for families. Boards across the unit showed photos and names of staff, stories of neonatal graduates and gave information about fundraising plans for additional family facilities.

We also saw staff exhibit pride in and care for the estate, making efforts to improve spaces where possible. One example was the plan to develop *“home from home”* accommodation within the neonatal unit, designed to support parents whose babies spend long periods in care.

In neonatal services space was limited in some areas, and when babies need to be isolated due to infection, they are moved to side rooms that can hold up to four babies. This reduces the capacity of the unit and can add pressure at busy times.

Alongside estates, we heard about pressure across maternity services, including busy wards, stretched staffing, heavy administrative workload and digital systems that are difficult to navigate. Staff spend significant time looking for information or completing tasks that take them away from families. Families noticed this too, describing staff being drawn to computers when what they needed was reassurance and encouragement.

In neonatal care, we heard more consistently positive accounts. Families described care as attentive. Good staffing levels, visible leadership and a culture where it felt safe to ask for help were described by staff as positive enablers of the care experience. In neonatal services there can be surges in demand, with clusters of very unwell babies leading to intense pressure that is hard to plan for.

Across the Trust, we saw and heard about strong leadership commitment, improvement plans based on patient feedback and any findings from Maternity and Newborn Safety Investigations. Robust governance structures were said to be in place. These were well evidenced in documents, meeting minutes and reporting processes. However, many families do not feel that these governance systems are working for them or delivering what they want when they are worried, harmed or seeking answers. This shows that however robust the executive team consider their governance processes and procedures to be, they need to positively impact people’s care and experiences.

What staff told us

We heard from the executive team about the context that the Trust is operating in, current challenges and Trust improvement plans. These are aimed at streamlining systems and improving women and birthing people's journeys through maternity and neonatal services. The Trust was also implementing initiatives aimed at investing in the workforce. We met and spoke with frontline staff who talked about women, birthing people and families as *"our women"* and *"our patients"* and showed strong commitment and care. There was a sense of belonging in how staff described families. Staff spoke about a supportive team culture that despite the pressures and demands meant that they enjoyed working at the Trust. The phrase *"#teambradford"* was used often, with staff describing pride in their teams and workplace.

There was clear awareness of the challenges some families face, especially those new to the country or unfamiliar with how to obtain the right care. The executive team staff recognised that more needed to be done to help patients feel understood and safe. We heard about work to reduce health inequalities, including food bags from local food banks, a coat and school uniform rail in outpatient settings for families facing financial hardship, and data and devices for families who face barriers to getting online because of poor equipment, limited digital skills or high costs.

In neonatal services, the use of digital tools, virtual ward rounds and family focused care to support communication and involvement, including for families struggling to be present in person was highlighted.

We heard that the estate is often at or near full capacity. Pressure builds up quickly and slows how patients can move between services, for example from triage to delivery suite. This was consistent with many other places we visited. The rising numbers of inductions was described as a recurring pressure. Delays were described as increasingly common because national guidance has changed, while staffing levels and buildings have not kept pace. Inductions can also be delayed when neonatal cots are not available, i.e. when a baby is identified in advance as needing neonatal care. If the neonatal unit is full, induction must wait until care can be provided safely.

Staff identified the postnatal ward as another pressure point. This was in part due to more women and birthing people having caesarean births and needing more complex care, but staffing patterns had not been updated to reflect this.

> *"I don't think we are particularly under established with midwives when you look at numbers. I think the problem has come with the workload, and the complexities of the women changing over time, and the numbers that we need on paper to staff those women hasn't changed."*

A labour ward coordinator described holding *"significant risk"* when beds were blocked and discharges were delayed.

"It's like walking through treacle sometimes… I need to ward these ladies and it's just like a pressure cooker."

Challenges managing open visiting hours on busy postnatal wards were also a recurring theme. While family visits are valued, overcrowding can make care harder to deliver safely, and staff felt the pressure of this.

"… it's a really big problem on the ward for us to manage everything when it's very busy with managing how many people are in there because there's too many or there's children running around."

In community services, heavy workloads and large caseloads were described as a daily reality. This makes continuity of care difficult, even though it is especially important for the people who the Trust serves due to social challenges including some of the most deprived areas in England.

"There's zero continuity as a standard community midwife. It's a fire fight on a daily basis. We are managing massive caseloads. We're providing on call support for home births. We are now coming into the unit and doing birth centre shifts."

Concerns were also raised about more women and birthing people choosing home birth outside guidance, with little national direction on how to support safe care in these circumstances.

"I think we have so many women now that are choose a home birth that they're out of guideline… we're a little bit working in the dark to support the woman, to support the midwives. We do need some national guidance around that."

In neonatal services, the picture was more consistently positive. Good staffing levels across nursing, medical and wider support roles were described, along with the benefits this brings to workload, learning and family involvement.

"Staffing has never been as good as it is now."

"They're increasing our knowledge and skills and they're getting the parents involved as well"

The nature of neonatal services meant that consultants felt that staffing tools (models that help determine safe staffing levels based on the number of births) were not always flexible enough to reflect sudden changes in neonatal demand, such as clusters of very premature births.

The culture of the Trust was spoken about in relation to teamwork, communication and support. A flat hierarchy, supportive senior staff and a strong sense of teamwork made it easier to ask for help and respond to pressure. There was also a strong reporting and learning culture, with daily risk huddles focused on learning rather than blame, clear ownership of actions, feedback shared openly and regular incident reporting.

"It wasn't difficult, I don't think, for the night team, clearly the on-call person, to call for additional help to come and that help came even though those people weren't on call."

The Investigation team requested a set of documents from each trust we visited, including Freedom to Speak Up reports. For this Trust, between September 2023 and November 2025, there were 19 instances in which maternity staff raised concerns with the Freedom to Speak Up Guardian. During the same period, no concerns were raised by neonatal staff.

Similar to what we saw across the country, the wider estate and capacity that wards and services can support were significant factors affecting services. These included limited theatre space and the difficulty of adapting buildings to cope with rising numbers of caesarean births and inductions.

"We've got an increase in caesarean section rate, an increase in induction of labour rate. What we need is the infrastructure and the estate and the facilities to be able to cope with that growing demand, and that, we'd struggle to do that in two years let alone two months. So I think that there needs to be some investment."

Moving around the estate poses significant challenges for maternity and neonatal patients and staff. There is no direct internal route between maternity and neonatal services and the main hospital site. As a result, if a patient needs care such as an X-ray or CT scan, the ambulance service is needed to transfer that patient.

"This happened to us yesterday with an incredibly unstable ventilated baby that needed to go for an MRI which I think is a relatively, you know, half an hour in a scanner. But the process and the logistics of getting that baby, not only, it wasn't even the clinical logistics of getting the baby settled in the transport incubator, it was getting the ambulance to us that must have taken about five and a half hours."

Digital systems also create challenges for staff to manage. They add extra steps at times when staff need information quickly, they do not provide a clear overview of risk and they are clunky to use. These are not just irritating factors for staff to deal with but can cause patient safety risks if information is missed.

"The thing that I find with it, it's so multi-layered and so clunky that you can't automatically look at... and get a reading of this woman's risk assessment that you used to be able to [from] previous systems and paper notes. So you have to go looking. So every time you take over care of the patient, in reality if you were going to do this safely, you've probably got an hour's worth of work to go back to look at all of her antenatal care, to look at scan reports, to look at blood results. Because you don't have an automatic feed through to a summary page and that hour realistically you don't have."

The executive team spoke about the challenges and positives that existed and recognised the need for improvement by putting plans, resources and executive support in place to deliver change.

The Trust received additional external funding which allowed additional posts to be recruited, however the majority of maternity and neonatal services, were prioritised from within existing trust budgets. This included Board approved recruitment and staffing uplift in maternity services and the over recruitment of midwives to cover maternity leave. The Board also approved investment in neonatal services, including Qualified in Specialty training and additional educator roles to support workforce development.

"We've invested £5 million of recurrent revenue because we acknowledged that we needed to do that. We listened to the midwives, we listened to the obstetricians, and we listened to the women, and that's how we targeted all of that investment, and we prioritised maternity."

What this means for families and services in Bradford

The estate, staffing levels, digital systems and leadership all shape how care is experienced by families in Bradford.

In maternity services, modern facilities sit alongside older parts of the estate that struggle to support the rising numbers of caesarean births and inductions. The original maternity block dates back to the 1960s, with parts of the hospital site dating to 1937. The age and layout of the site, particularly the lack of a direct internal route between the Women's and Newborn Unit and the main hospital, adds delay, stress and pressure. This affects families directly and increases demand on ambulatory services, with knock-on effects across the wider system and into the community.

Changes in maternity care, including higher induction rates and rising caesarean births, also place strain on space, staffing and medical infrastructure. While refurbishments such as the maternity assessment centre, antenatal clinic and new induction suite show the Trust is responding, not all parts of the estate are keeping pace with modern care needs.

Well-maintained and family-focused neonatal services support better experiences. However, space constraints and infection control needs can quickly reduce capacity. Continued investment in family accommodation, such as *"home from home"* facilities, is an important step in supporting parents during long neonatal stays.

More broadly, there is still a gap between leadership intent and family experience. While leaders describe strategies to reduce health inequalities and improve maternity services including working with local community groups to provide wraparound care, families often experience delays, confusion or not being listened to when it matters most. Estates, staffing pressure and IT systems all play a role in this gap.

Good care in Bradford depends not only on commitment and plans, but on whether buildings and systems support families at moments of need. Where the estate enables compassion and clear communication, care feels safer and more personal. Where they do not, the impact is felt by families and staff.

How we gathered and analysed our 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
- Three family evidence panels with women, birthing people and families
- Interviews with three women and families
- Three listening events across different staff groups and grades
- Interviews with 11 members of staff

- 15 additional pieces of information were sent to the Investigation email address which were submitted as evidence for Bradford Teaching Hospital NHS Foundation Trust.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by both the Maternity and Neonatal Voices Partnership (MNVP) Leads for Bradford District and Craven and the Maternity and Neonatal Independent Senior Advocate (MNISA) for West Yorkshire. In addition to these activities, further virtual engagement 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