National Maternity and Neonatal Investigation

Gloucestershire 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 Gloucestershire 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 Gloucestershire Hospitals NHS Foundation Trust

We visited Gloucestershire Hospitals NHS Foundation Trust (from here on referred to as Gloucestershire or the Trust) on 4 and 5 of December 2025. Gloucestershire has three sites that offer maternity and neonatal services: Gloucestershire Royal Hospital, Stroud Maternity Unit and Cheltenham General Hospital.

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

The CQC inspected Gloucestershire in March and May 2024 and published its report in January 2025 rating the maternity services as 'Inadequate' at Gloucestershire Royal Hospital with no update to the previous 'Inadequate' rating from November 2023.

The CQC rated the maternity services at Stroud Maternity Hospital as 'Requires Improvement' in March 2024.

An explanation of what the Care Quality Commission is and what their ratings mean can be found in Annex 2: Glossary.

Activity and modes of delivery

- In 2024/25, Gloucestershire supported 5,865 births.

Modes of delivery:

- In February 2026, 45.1% of deliveries were by caesarean section, compared with 36.0% three years earlier in February 2023.
- In February 2026, labour was induced for 28.0% of deliveries, compared with 30.7% three years earlier in February 2023.

Workforce

As of January 2026, the Trust employed:

- 262.1 full-time equivalent midwives.
- 62.6 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 22.1 which is lower than the national figure of 23.1.

Estate

At the time of our visit, labour and delivery services at the midwife-led unit at Cheltenham General Hospital (Aveta Birth Centre), had been suspended since Autumn 2022 due to staffing issues.

Neonatal services

The CQC inspected Gloucestershire in 2015 and found that, while the services for children and young people had an overall rating of ‘Good’, they had concerns about the medical cover for middle grade doctors on both the neonatal and children’s units.

Unit and care pathway

Gloucestershire has a Level 2 Neonatal High Dependency Unit (NICU) providing care 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 its neonatal unit for a total of 5,574 days of care, placing Gloucestershire in the middle 20% of providers of neonatal care nationally.

Workforce

In the 12 months ending December 2025, 83.3% 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 their labour and birth and staff caring for them was better than average. Experience in other areas of maternity care, including antenatal check-ups, pregnancy, 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 0.9 per 1,000 live births, lower than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.0 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 Gloucestershire, the first thing the Investigation team did was to 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.

We were repeatedly told by women and families that they were not listened to when they raised concerns, even when those concerns related to changes in their body, their baby's movements, or symptoms that felt urgent or frightening. Many women said they felt a strong sense that *"something wasn't right"* but were dismissed or their concerns were minimised, leaving families feeling powerless, anxious and unsafe, particularly at moments when they were most vulnerable.

> *"I knew my body wasn't able to… I knew something wasn't right, my gut knew something wasn't right and I was ignored."*

Women told us that concerns about their own or their baby's health were sometimes dismissed, and that this was made worse by poor communication and a lack of involvement in decisions about care. They described not always being listened to when symptoms were persistent or worsening, not being given clear or timely information when they needed reassurance and feeling that important decisions were made for them rather

[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

than with them. During labour and birth, several women said pain, fear, exhaustion and the perceived power imbalance of the clinical setting made it even harder to question what was happening or express what they wanted, including when interventions were not part of their birth plan.

Women also described how language and tone used by staff contributed to this feeling of powerlessness. We heard how rather than being asked for consent, they were often told what was going to happen. Women who felt confident and well-prepared going into hospital told us how they became unable to speak up once labour was underway. Some women felt they had agreed to procedures without fully understanding what was happening. It was only afterwards that they realised they had not really been given a clear choice. Others said they felt unable to speak up because they were worried staff might see them as difficult, or that questioning decisions could affect the care they received.

"Instead of saying, 'Do you want to have this?' they'll say, 'We're just going to', or 'I'm just going to do this'... that phrasing makes it feel like you don't have a choice."

Women and families described long waits, uncertainty about when care would happen, and delays in being seen, transferred or discharged, sometimes while in established labour or experiencing complications.

Some women also felt that decisions about their care were being shaped by a lack of space rather than by clinical need or personal choice, including being moved between areas, asked to leave rooms soon after birth, or being unable to continue with planned care. One woman said she was told *"we need the room,"* which left her feeling that capacity pressures were being placed above her wellbeing.

"I waited till midnight for the night shift midwife to say to me, 'Look, I don't think we're going to induce you tonight because there's not enough monitors around and there's other women that are being induced'.

Women and families consistently described how staffing pressures shaped their experiences of maternity care. Many said staff were working hard in difficult circumstances, but that shortages, high workload and lack of time affected safety, compassion and communication. Several families said staff appeared "*spread thin*", which left them feeling less supported and less visible during labour, birth and postnatal care.

"It definitely felt like there weren't enough staff to care appropriately for the amount of women that were on the ward."

Several families said overcrowded wards and pressure on space meant staff were often rushed and unable to respond promptly. Women described pressing call bells and waiting a long time for help, sometimes at moments when they were in pain, frightened or recovering after birth. A recurring theme was that women felt unseen or forgotten, particularly on postnatal wards, with some saying that closed curtains and busy staff added to their sense of isolation and distress. They also described seeing others in visible distress who did not receive timely support, which could make the space feel even more upsetting and unsafe.

Continuity and handover were also raised as concerns, with families explaining seeing many different staff, sometimes without clear communication between them. One family reflected "*that nobody looked at the bigger picture*" and that repeated staff changes meant important information was missed. Another woman described having to repeatedly explain her clinical history to every staff member, which she said was exhausting and distressing.

"It seemed like a lot of people didn't take the time to read notes because every time you saw somebody that wasn't part of the fetal medicine team or our gynaecology consultant who's known us for the past 10 years, no one seemed to know that we were a high-risk pregnancy and we had to explain, every new person we met we had to re-explain the previous 10 years"

Despite these challenges, women acknowledged positive experiences with individual staff. Many spoke warmly about specific midwives who were kind, attentive, and made them feel safe, even within a pressured system.

"I felt really, really safe with those women and actually it is important to point this out, as well because there are some people who are doing their job really, really well. I really felt safe."

We heard about inconsistencies in care and treatment; one family told us they noticed a clear difference in how they were treated once staff became aware that they worked in healthcare and therefore understood systems and policies. Some women linked unequal care to race, class and level of education, and described being acutely aware that these factors shaped how safe they felt in maternity services.

> *"I'll be okay because I'm white and middle class and I work for the hospital. That's the reality of it.... If my care can still be pretty poor at times, it makes you wonder how everyone else is being treated."*

Other women described feeling that those who were younger, quieter, or less confident were spoken to more condescendingly or were less likely to be listened to. Families also told us that inequalities were reinforced by who felt able to advocate strongly, complain, or *"make a fuss"*.

A Black family described bring racially stereotyped and how this affected the way they were spoken to.

> *"I just thought, 'Is she trying to give me a negative connotation that I'm an angry black lady?' No, I just want to know what's happening."*

We also heard how this worsened their anxiety as they were aware of evidence about worse outcomes for Black women and were seeing this happen in how they were spoken to.

> "I couldn't relax… knowing the statistics, that Black women['s] mortality rates are so much higher."

We were also told that the maternity estate affected family's sense of safety, dignity and wellbeing. Some described buildings and clinical spaces as tired, crowded, poorly maintained or unsuitable, especially after birth or when receiving devastating news. Families said these spaces did not always support privacy, emotional safety or recovery.

Women told us that postnatal wards and recovery areas often felt overcrowded, chaotic and impersonal, and that this could make physical recovery and emotional wellbeing harder after birth. Some said these spaces did not reflect the seriousness of what they had experienced, and raised concerns about cleanliness, privacy and dignity at a time when they felt physically unwell and emotionally vulnerable.

When care went well

We were told that when care went well, it was usually because staff took time to listen, explained what was happening, and treated them with dignity and respect. For some families these experiences stood out clearly because they often felt very different from the care received at other times.

"I was so lucky to have a good team. I would like to go personally and thank those midwives if I could."

One woman told us how she felt involved in decision making and the positive effect this had on her experience.

"That was the very first time, three pregnancies in, that I actually felt I was being treated as an adult, as somebody who should have a say in the process."

Families also remembered being treated kindly and with compassion after telling staff about anxieties they had about their baby. They were listened to, given clear explanations and reassurances that were based on facts and then talked through what could happen next.

"She put the doppler on and she was like, 'listen to this sound, you know he's okay, you can hear him'... they taught me how to look out for [my baby]."

What we saw and heard at Gloucestershire

During our investigation, we spent two days at Gloucestershire, including a full walkaround of all areas where maternity and neonatal care are delivered as well as visiting Stroud Maternity Unit. The Investigation team in attendance included two neonatologists and a midwife.

The community served by Gloucestershire has a higher proportion of White women, women aged 35 and over, and those taking folic acid in early pregnancy. This suggests that services are likely to have to support people with specific needs linked to older maternal age, including managing more complex pregnancies and associated risks. Care planning therefore has to focus on personalised support, while building on strong engagement with early antenatal care and preventative behaviours such as folic acid uptake.

During our visit

At the Gloucester site, the layout of services allows for easy mobility between different areas, including the postnatal ward and neonatal services. However, staff consistently reported that high levels of acuity were placing significant pressure on the service. This was described as contributing to delays in triage and induction, and difficulties in meeting demand. Staff also highlighted limited theatre capacity, which was not keeping pace with the rising number of caesarean sections, leading to procedures being cancelled or rearranged. Concerns were also raised about bereavement facilities, where limited soundproofing in delivery rooms increased distress for families experiencing loss.

We also visited Stroud Maternity Hospital, a midwife-led unit and community maternity hub, which has strong local community support. The unit has relatively low birth numbers, holds midwifery and obstetric antenatal clinics and acts as a hub for community midwifery services. Staff described the service as well supported and resourced.

The executive team described the improvements that the Trust was making after receiving back-to-back CQC ratings of ‘Inadequate’ for its maternity services. We heard of ongoing work in midwifery recruitment, retention and management to ease pressure on staff, and that the Trust had employed an interim Director of Midwifery, who has since left, to oversee governance and improvement. The Trust informed us that they have commissioned two external reviews into maternal mortality and neonatal mortality. In addition, the perinatal leadership team had sought external support through the Perinatal Leadership and Culture Programme to address leadership and cultural issues between professions.

However, the executive team also fed back to us that the Trust faced significant financial pressures that affected what they were able to commission, along with communications challenges caused by different IT systems being used in different places.

What staff told us

Staff consistently described services being under sustained pressure, with demand and complexity increasing faster than staffing, capacity and resources. While some changes had been made to rotas and new roles introduced, staff said the overall volume and intensity of work had not reduced.

Frontline staff told us that women were increasingly presenting with multiple needs within the same appointment. This created pressure to balance safe care with limited time, while also causing long waits for other women. Staff said these pressures affected their ability to spend time with women and birthing people in the way they wanted, and described an ongoing tension between providing compassionate, personalised care and responding to high levels of demand.

> *"A real tension… between the constant pressures of the volume of work and the desire to do your job to the absolute best of your ability and in a way that every woman deserves"*

Several staff described the emotional impact of working in these conditions, including what they referred to as "moral injury", when they were unable to provide the level of care, they felt women needed because of workload and capacity constraints.

They told us induction rates have increased significantly without a matching increase in capacity, leading to delays and distress for women and families. Staff described having to tell women that an induction was needed but that they could not yet be admitted because no bed was available and said this was distressing for women and difficult for staff to communicate.

> *"We induce so many women, but we haven't really got capacity to induce them… we're just going to scare you. Send you home for 48 hours and when we've got space you can come onto the ward. Which also is awful"*

Neonatal staff described periods of extreme pressure when units were operating beyond what felt like safe staffing levels. Some told us there were weeks when services were at *"black status"*, meaning no further admissions could be safely accepted.

> *"We were going beyond [safe staffing guidance] quite regularly because we weren't safely staffed and we couldn't find enough staff for the amount of babies."*

Managers described how restrictions on booking bank staff, introduced as a cost saving measure, reduced their decision-making abilities and made it harder to respond to predictable surges in demand, even when staff were available and willing to work extra shifts.

"When this decision was made, it was made like a blanket Trust wide [decision]… but we have a smaller pool of nurses to take it from. It doesn't feel like when this decision was made that we were thought about."

Staff across maternity and neonatal services consistently described staffing as one of the most significant pressures affecting their ability to provide safe, compassionate care. They said that when demand increased, staffing arrangements did not always adapt quickly enough, leaving them stretched, worried about safety and emotionally exhausted.

Community midwives and staff working across hospital and community settings highlighted challenges with on call and home birth work. They described long days followed by being called out at night, sometimes feeling that this was unsafe for them and for the women they were caring for.

"You've had a full day that you do not stop, and you go home, and then half an hour later you're called… and I didn't feel safe myself to do it."

Staff described inequalities affecting women and families as longstanding and structural issues. They told us that teams in more deprived areas were often supporting women with greater complexity, needing more time, follow-up and support, without the staffing or local resources to match. Some staff also raised concerns about possible differences in outcomes linked to ethnicity, particularly in neonatal and bereavement care, and said more work was needed to understand and address these issues.

"We have a very low rate of black and brown women but… there are women that end up in HDU and our bereavement suite. It's a higher proportion than it should be considering we don't have many."

Staff told us that the estate affected the safety, dignity and wellbeing of women, and their experiences of care. Although some areas were described as clean and functional, staff raised concerns about limited space, unsuitable rooms and the way areas were being used under pressure.

Staff described pressure on theatres and triage, with limited space contributing to delays, cancellations, long waits and additional distress for women and families. Staff also said the estate was not designed for the level and complexity of care now being provided, which made it harder to offer privacy and reassurance during periods of high demand.

Staff also raised concerns about the loss of supportive spaces for families such as feeding rooms, quiet areas and private assessment rooms. Bereavement spaces were described as available but not always separate from busy clinical areas, which could undermine the privacy of families and make their experience even harder.

Digital systems and IT are also creating challenges for staff. Community midwives told us that electronic records often created issues in home-birth settings where laptops did not always hold their charge and not all families had Wi-Fi. This added stress for staff when they needed to use the internet when managing a patient in labour at a home birth.

"You're going into these vulnerable houses, and you go to the patient, 'What's your Wi-Fi password?'... and we were told from IT you're not allowed to use your hotspot."

Staff also said that how the need to log every note in detail reduced the time they had to provide reassurance and emotional support, and not all staff felt confident using IT systems due to a lack of training.

What this means for families and services in Gloucestershire

Families across the Trust are still experiencing care that they find worrying and dismissive of their concerns. Families are finding it harder to receive the support they need than it should be. Whilst individual staff members were recognised for being kind and compassionate, this was not consistent.

Staff are struggling to cope with levels of acuity at the Trust, and this is causing them emotional distress and anxiety not only because they are working under immense pressure but because they feel a sense of guilt for not being able to give women and families the care and time they want to.

Staffing levels are causing risks to neonatal services where at times new admissions must be paused. A lack of staffing is made worse by financial pressures across the Trust, with managers interpreting cost-saving restrictions to not allowing the booking of bank staff and reported that this limited their ability to respond to predictable surges in demand, even where staff were available and willing to take on additional shifts. Without additional staffing and sustainable staffing solutions women are going to continue to face delays.

The services in the two sites across the Trust are very different. The Gloucestershire Royal Hospital is running with high demand and a service that is stretched thin. Stroud has low birth numbers but offers personalised care in a quiet setting. Home births are paused, and the freestanding maternity unit in Cheltenham is closed for births due to staffing and safety concerns. This seriously restricts choice of planned place of birth for women and further increases pressure on services at Gloucestershire Royal Hospital.

The executive team are aware of the challenges regarding the inconsistency of care, the pressure staff are working under, and the staffing and financial pressures. Whilst mitigations and action plans, such as cultural improvement plans and recruitment measures are in place, there needs to be a large-scale shift in efforts to address these challenges, together with investment in community and hospital-based services. Women need to be listened to, involved in decisions about their care and treated with compassion.

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
- 2 family evidence panels with women and families
- 6 listening events across different staff groups and grades
- Interviews with 15 members of staff
- 6 additional pieces of information were sent to the Investigation email box which were submitted as evidence for Gloucestershire Hospitals NHS Foundation Trust.

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) Communications and Engagement Officer, MNVP Strategic Lead, and Maternity and Neonatal Independent Senior Advocate. To ensure widespread involvement, an additional event was held community representatives.

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