National Maternity and Neonatal Investigation

Workforce Survey

Supplementary Evidence

Workforce Survey

Background

Baroness Valerie Amos was appointed to chair the National Maternity and Neonatal Investigation (`the Investigation') on 14 August 2025. This rapid, independent investigation was commissioned by the then Secretary of State for Health and Social Care, Wes Streeting MP.

The Investigation aimed to develop a single set of national recommendations to improve quality and safety, reduce inequalities and help bereaved and harmed families to receive justice and accountability in the future. In January 2026, Baroness Amos asked women, birthing people and families across England to share their experiences of maternity and neonatal care through a public Call for Evidence.

The Investigation team appointed Picker, a health and social care research charity, to administer a survey to NHS maternity and neonatal staff across England. The workforce survey focused on the experiences of staff delivering care across the maternity and neonatal pathway and how best to support teams to provide high-quality, safe and compassionate care.

Methodology

Questionnaire development

The questionnaire was designed by the Investigation team, Expert Advisors and Picker. The questionnaire aimed to gather insight into the experience of working within the maternity and neonatal pathway and contained two sections. The first section, titled 'Your job', included a screening question to filter out those not working in the maternity and neonatal care pathway, along with five demographic questions. The second section, titled 'Your experience', included 17 statement-agreement questions and three open-ended free-text questions. A copy of the questionnaire can be found in Appendix 1.

To improve the respondent experience, survey routing was implemented. This meant that survey respondents were only shown questions relevant to their job. For example, only respondents who indicated they had management responsibilities were shown the question *'Does your management role involve any of the following?'*.

Sampling process

The sample for this Investigation comprised of NHS staff working within the maternity and neonatal care pathway across England. Picker identified 122 NHS trusts providing relevant services. Of these, 119 trusts were recognised providers of maternity and neonatal care and three children's hospital trusts with neonatal units were included to maximise representation across the pathway.

NHS trusts were encouraged to share with all staff working in or supporting maternity and neonatal services, spanning both clinical and non-clinical roles and including substantive and bank staff. The accompanying FAQ document clarified that this included a broad range of professions and support functions, such as midwifery, obstetrics, neonatology, anaesthetics, paediatrics, theatres, radiology, pharmacy, sonography, community teams, governance, quality, estates, IT and administrative staff.

Survey fieldwork

The survey was conducted online using trust-specific open links, allowing the number of responses received from each trust to be monitored. These links were distributed to designated contacts within each trust, who were responsible for cascading them through their usual communication channels to ensure wide dissemination among maternity and neonatal staff. The survey was open from 26 January 2026 to 9 March 2026.

A generic link was also shared amongst staff whose role was not directly associated with a specific trust; for example, those working for NHS England.

In late January 2026, Picker issued an initial notification mailing to 357 individuals across the 122 trusts. This included survey leads and secondary leads for the 2026 Neonatal Care Experience Survey, survey leads for the 2025 CQC Maternity Survey and 49 NHS Staff Survey leads whose contact details Picker held. Recipients were invited to inform Picker of any additional contacts who should receive future mailings and new contacts were added to the mailing list as they were provided.

Following the initial notification and the distribution of survey links, all contacts on the mailing list received three reminder emails.

During fieldwork, the Investigation obtained a list of Directors of Midwifery for the 119 trusts providing maternity services. These contacts were sent the first reminder in February 2026 and were included in all subsequent reminders.

In late February 2026, the Investigation obtained a list of Obstetric and Neonatal Leads for the same trusts. These contacts were not added to the main mailing list but received a separate initial communication followed by a final reminder.

Separately to the fieldwork reminders supplied by Picker, the Investigation team provided communication text information about the survey to NHS England, Royal College of Obstetricians & Gynaecologists, the Royal College of Midwives and the British Association of Perinatal Medicine asking them to promote the survey within their own networks.

Data cleaning and validation

To ensure participants were eligible, a screener question was added at the start of the survey. A total of 772 individuals who did not work in the maternity and neonatal care pathway were screened out.

When the survey closed, the raw data was analysed and responses that did not meet the inclusion criteria were removed. Criteria for inclusion were submitting a response and answering at least one question from Q7 to Q13.

When the survey closed, there were 13,636 responses. Of these, 4,363 responses did not meet the inclusion criteria and were removed from the dataset.

The number of final responses was 9,273.

Respondent profile

Respondents were most likely to work in pregnancy care, labour and birth (63%); following this was postnatal care (46%) and neonatal care (39%). A third (33%) reported working in care and support and just over a fifth (22%) in pre-pregnancy advice and care.

Nearly all respondents (97%) had contact with patients as part of their role; only 3% did not.

Respondents were most likely to work on a ward/inpatient unit (62%). Around one in eight (13%) reported working in the community and just over a tenth (11%) in clinics/outpatient services. Similarly, just over a tenth (11%) reported working in an office setting.

With over half of respondents, general and specialist midwives made up the largest staff group (55%). Around one in eight (13%) worked as neonatal nurses, midwives or assistants. Medical consultants comprised an eighth (12%) of the respondents. The following report identifies for each of the quantitative questions where workforce groups differ by 3 percentage points or more. A full list of groupings and the assigned questionnaire label can be found in Appendix 2.

Respondents were spread across all regions, with the largest proportion of respondents from London (17%), North East and Yorkshire (17%) and the South East (17%) commissioning regions. The Midlands (15%), North West (13%) and South West (12%) commissioning regions followed. The East of England had the lowest proportion (10%) of respondents.

Quantitative reporting

As set out in the questionnaire section of the background and methodology, the Investigation asked 17 statement-agreement questions.

Participation in the staff survey was voluntary, the responses come from only a sample of those who work in the maternity and neonatal care. We have reported the responses to all questions from everyone who responded and we have highlighted where workforce groups differ by at least 3 percentage points. This provides indicative analysis rather than statistical evidence of a significant or genuine differences.

Expectations, resources and influence

Overall, the majority of respondents agreed they knew exactly what was expected of them (83%); less than one in ten disagreed (8%). The following workforce groups were more likely to agree by at least 3 percentage points that they knew exactly what was expected of them:

- Medical/Dental - In Training (91%)
- Neonatal nurses, midwife or assistant (87%)
- Medical/Dental – Consultant (86%)

Less than half (48%) agreed they were able to influence the way things are done within their team; three in ten (29%) disagreed. The following workforce groups were more likely to agree by at least 3 percentage points they were able to influence the way things are done within their team:

- Medical/Dental – Consultant (60%)
- Neonatal nurses, midwife or assistant (57%)
- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (56%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (54%)
- Other Medical/Dental (54%)

The following workforce groups were less likely to agree by at least 3 percentage points they were able to influence the way things are done within their team:

- General and specialist midwives (44%)
- Medical/Dental - In Training (41%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (37%)

Less than half (46%) agreed they have adequate resources to do a good job, four in ten (41%) disagreed. The following workforce groups were more likely to agree by at least 3 percentage points they have adequate resources to do a good job:

- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (65%)
- Other Medical/Dental (64%)
- Neonatal nurses, midwife or assistant (64%)
- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (55%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (55%)
- Medical/Dental - In Training (54%)

The following workforce groups were less likely to agree by at least 3 percentage points they have adequate resources to do a good job:

- General and specialist midwives (39%)

Just over a third (35%) agreed unacceptable behaviour is consistently tackled, four in ten (41%) disagreed. The following workforce groups were more likely to agree by at least 3 percentage points that unacceptable behaviour is consistently tackled:

- Medical/Dental – Consultant (49%)
- Medical/Dental - In Training (44%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (43%)
- Neonatal nurses, midwife or assistant (41%)
- Other Medical/Dental (41%)

The following workforce groups were less likely to agree by at least 3 percentage points that unacceptable behaviour is consistently tackled:

- General and specialist midwives (30%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (30%)

Around three in ten (31%) agreed they have sufficient time to do their job well; over half (54%) disagreed. The following workforce groups were more likely to agree by at least 3 percentage points they have sufficient time to do their job well:

- Other Medical/Dental (47%)
- Neonatal nurses, midwife or assistant (47%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (42%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (42%)
- Medical/Dental – Consultant (40%)

- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (37%)

The following workforce groups were less likely to agree by at least 3 percentage points they have sufficient time to do their job well:

- General and specialist midwives (22%)

Line management and coworkers

Overall, the majority of respondents agreed they feel respected by their co-workers (79%); less than one in ten disagreed (9%). The following workforce groups were more likely to agree by at least 3 percentage points they feel respected by their co-workers:

- Medical/Dental – Consultant (84%)
- Other Medical/Dental (83%)

The following workforce groups were less likely to agree by at least 3 percentage points they feel respected by their co-workers:

- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (75%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (71%)

The majority of respondents agreed they are able to ask for help when they need it (78%); just over one in ten disagreed (11%). The following workforce groups were more likely to agree by at least 3 percentage points that they are able to ask for help when they need it:

- Other Medical/Dental (89%)
- Medical/Dental - In Training (89%)
- Medical/Dental – Consultant (88%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (83%)

The following workforce groups were less likely to agree by at least 3 percentage points that they are able to ask for help when they need it:

- General and specialist midwives (75%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (71%)

Two thirds (66%) of respondents agreed they feel well supported by their line manager; around a fifth disagreed (19%). The following workforce groups were more likely to agree by at least 3 percentage points they feel well supported by their line manager:

- Medical/Dental - In Training (72%)
- Other Medical/Dental (71%)

- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (71%)
- Medical/Dental – Consultant (71%)

The majority (62%) of respondents agreed their concerns are taken seriously by their line manager; around a fifth disagreed (19%). The following workforce groups were more likely to agree by at least 3 percentage points their concerns are taken seriously by their line manager:

- Other Medical/Dental (70%)
- Medical/Dental – Consultant (68%)
- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (67%)
- Medical/Dental - In Training (66%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (66%)

Just under six in ten (59%) of respondents agreed they are kept well informed about what is going on within their team; just under a quarter (23%) disagreed. The following workforce groups were more likely to agree by at least 3 percentage points they are kept well informed about what is going on within their team:

- Neonatal nurses, midwife or assistant (66%)
- Medical/Dental – Consultant (64%)
- Medical/Dental - In Training (63%)

The following workforce groups were less likely to agree by at least 3 percentage points they are kept well informed about what is going on within their team

- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (54%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (53%)

Trust management and training

The majority (70%) of respondents agreed they get the training and development they need; less than a fifth disagreed (17%). The following workforce groups were more likely to agree by at least 3 percentage points they get the training and development they need:

- Medical/Dental – Consultant (77%)
- Neonatal nurses, midwife or assistant (74%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (73%)

The following workforce groups were less likely to agree by at least 3 percentage points they are kept well informed about what is going on within their team:

- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (66%)
- Other Medical/Dental (58%)
- Medical/Dental - In Training (58%)

Under half (47%) of respondents agreed they would recommend their trust as a good place to work; less than a quarter disagreed (23%). The following workforce groups were more likely to agree by at least 3 percentage points they would recommend their trust as a good place to work:

- Medical/Dental – Consultant (58%)
- Medical/Dental - In Training (54%)
- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (53%)
- Neonatal nurses, midwife or assistant (50%)

The following workforce groups were less likely to agree by at least 3 percentage points they would recommend their trust as a good place to work:

- General and specialist midwives (45%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (38%)

Under half (45%) of respondents agreed their trust values the service they provide; less than a quarter disagreed (33%). The following workforce groups were more likely to agree by at least 3 percentage points their trust values the service they provide:

- Neonatal nurses, midwife or assistant (53%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (53%)

The following workforce groups were less likely to agree by at least 3 percentage points their trust values the service they provide:

- Other Medical/Dental (42%)
- Medical/Dental - In Training (42%)

Around a quarter (26%) of respondents agreed their trust listens to staff views; just under half disagreed (45%). The following workforce groups were more likely to agree by at least 3 percentage points their trust listens to staff views:

- Medical/Dental – Consultant (35%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (31%)
- Neonatal nurses, midwife or assistant (30%)

The following workforce groups were less likely to agree by at least 3 percentage points their trust listens to staff views:

- Nursing auxiliary/Nursing assistant/Healthcare assistant (20%)

Around a quarter (27%) of respondents agree trust managers know how things really are; just under half disagreed (54%). The following workforce groups were more likely to agree by at least 3 percentage points that trust managers know how things really are:

- Medical/Dental – Consultant (32%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (32%)
- Neonatal nurses, midwife or assistant (30%)

The following workforce groups were less likely to agree by at least 3 percentage points trust managers know how things really are:

- Other Medical/Dental (22%)
- Medical/Dental - In Training (16%)

Raising concerns

The majority (71%) of respondents agreed they would feel secure raising concerns about unsafe clinical practice; less than a fifth disagreed (17%). The following workforce groups were more likely to agree by at least 3 percentage points they would feel secure raising concerns about unsafe clinical practice:

- Medical/Dental – Consultant (79%)
- Neonatal nurses, midwife or assistant (77%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (76%).

The following workforce groups were less likely to agree by at least 3 percentage points they would feel secure raising concerns about unsafe clinical practice:

- Allied Health Professionals/Healthcare Scientists/Scientific and Technical (68%)
- Other Medical/Dental (65%)
- Nursing auxiliary/Nursing assistant/Healthcare assistant (62%)

Less than half (44%) of respondents agreed they would feel confident that their organisation would address concerns about unsafe clinical practice; around three in ten disagreed (29%). The following workforce groups were more likely to agree by at least 3 percentage points they would feel secure raising concerns about unsafe clinical practice:

- Neonatal nurses, midwife or assistant (53%)

- Medical/Dental – Consultant (52%)
- Medical/Dental - In Training (50%)
- Other Registered Nurses and Midwives and Nursing or Healthcare assistants (49%)

The following workforce groups were less likely to agree by at least 3 percentage points they would feel confident that their organisation would address concerns about unsafe clinical practice:

- Nursing auxiliary/Nursing assistant/Healthcare assistant (41%)
- General and specialist midwives (41%)
- Other Medical/Dental (38%)

Qualitative reporting

As set out in the questionnaire section of the background and methodology, the Investigation asked three open-ended questions. The following section reports the overall summary of the responses to each question; it also includes analysis by 11 themes pre-defined by the Investigation. A breakdown of the three open-ended questions by workforce group can be found in Appendix 3.

Supporting high-quality, safe and compassionate care

Summary

Participants consistently identified adequate staffing levels, appropriate skill mixes and sufficient time for patient interaction as foundational enablers for delivering high-quality, safe and compassionate care. Responses suggest that robust multidisciplinary teamwork, characterised by mutual respect, open communication and psychological safety, serves as a critical support system, allowing staff to collaborate effectively and escalate concerns without fear. Strong, visible leadership that actively listens to frontline concerns and fosters a non-punitive culture was frequently cited as essential for maintaining morale and empowering staff to speak up.

Feedback indicates that access to functional equipment, reliable IT systems and continuous professional development opportunities are vital for operational efficiency and clinical competence. Specific models such as continuity of care and flexible working arrangements were highlighted as positive factors that enhance staff wellbeing and patient trust. However, significant barriers were also reported, including chronic understaffing, excessive workloads, resource constraints and outdated infrastructure, which participants described as compromising safety standards and contributing to burnout.

While personal dedication, professional pride and intrinsic motivation were noted as powerful drivers sustaining service delivery, respondents emphasised that reliance on individual goodwill is unsustainable without structural support. Some participants described a disconnect between management perspectives and frontline realities, citing inconsistent leadership engagement and administrative burdens as impediments to care. Overall, the tone leans towards a desire for systemic investment in workforce stability and resources to ensure the long-term sustainability of compassionate care standards.

Barriers to high-quality, safe and compassionate care

Summary

Chronic understaffing and unsafe patient-to-staff ratios emerged as the predominant barrier to delivering high-quality, safe and compassionate care. Participants described excessive workloads, high patient acuity and insufficient skill mix as forcing staff to prioritise task completion over holistic support. This workforce instability often leads to

reliance on agency staff, redeployment to unfamiliar areas and the cancellation of breaks, leading to widespread burnout, fatigue and compromised patient safety. Responses suggest that these staffing deficits are exacerbated by high sickness rates, unfilled vacancies and recruitment challenges, creating an environment where continuity of care is disrupted and clinical risks are elevated.

Resource constraints and infrastructure deficits were consistently cited as significant impediments to operational efficiency. Feedback indicates that shortages of essential equipment, outdated or malfunctioning IT systems and deteriorating physical facilities divert critical time from direct patient interaction. Participants noted that fragmented digital documentation and excessive administrative burdens further reduce opportunities for compassionate patient engagement. Additionally, financial limitations restrict access to necessary supplies, training and professional development, leaving staff to manage complex cases with diminishing support and increasing the potential for errors.

A toxic organisational culture characterised by a lack of psychological safety and leadership disconnect was a recurring theme. Staff reported feeling undervalued and unsupported, with concerns often dismissed or met with defensiveness. Responses highlight a perceived prioritisation of financial targets and administrative metrics over clinical needs and staff wellbeing. This environment fosters a blame culture, incivility and hierarchical barriers that discourage open communication and collaboration. The cumulative effect of these systemic failures creates a high-pressure atmosphere where staff morale is eroded and the capacity to provide individualised, person-centered care is critically diminished.

Improving outcomes and preventing trauma and harm

Summary

Participants consistently identified safe staffing levels as the primary determinant for improving outcomes and preventing workplace trauma. Responses suggest that chronic understaffing, particularly in midwifery and neonatal care, leads to excessive workloads, burnout and compromised patient safety. Feedback indicates a critical need for increased recruitment, appropriate skill mixes and staffing models that account for patient acuity rather than simply birth rates. Adequate resourcing, including functional equipment, modern IT systems and fit-for-purpose facilities, was frequently cited as essential to reduce administrative burdens and allow staff to focus on direct clinical care.

A recurring theme was the necessity for a cultural shift towards psychological safety and compassionate leadership. Participants described a need for management to be clinically visible, actively listening to frontline concerns and fostering a non-punitive environment where staff can raise issues without fear of retribution. Responses highlighted the importance of robust support systems, including regular debriefing sessions, psychological supervision and protected time for breaks and training. Enhancing multidisciplinary collaboration, streamlining communication pathways and addressing

toxic behaviours or bullying were also emphasised as vital for staff wellbeing and retention.

Overall, the feedback leans towards a sense of urgency regarding systemic under-resourcing and the need for structural reform. While some respondents noted specific operational improvements like reducing unnecessary interventions and improving antenatal education, the dominant sentiment reflects a call for fundamental changes in workforce planning and organisational culture. Participants suggest that aligning financial investment with clinical needs, ensuring fair pay, and prioritising staff wellbeing are fundamental to creating a sustainable, safe working environment that benefits both staff and patients.

Thematic analysis: Staffing, recruitment and retention (19,152 comments)

Feedback indicates a pervasive and critical concern regarding staffing levels, recruitment and retention across maternity and neonatal services. Participants consistently describe chronic understaffing, unsafe patient-to-staff ratios and excessive workloads that compromise patient safety and staff wellbeing. A recurring theme is the 'vicious cycle' where shortages lead to burnout and sickness, further exacerbating vacancies and retention issues. Many respondents link these pressures directly to compromised patient safety, discontinuity of care and the inability to provide a compassionate service. While a smaller group of comments highlights isolated instances of adequate staffing or suggests that improved workforce planning and increased numbers would resolve these issues, the overwhelming sentiment reflects a systemic crisis where staff feel stretched beyond safe limits.

Specific concerns include the inability to take breaks, reliance on agency staff and the redeployment of senior staff leaving junior teams unsupported. Feedback indicates that current staffing templates often fail to reflect patient acuity, leading to rushed care and safety risks. The sentiment suggests that without significant investment in staffing numbers and skill mix, the quality of care and staff wellbeing will continue to deteriorate.

A smaller group of comments expresses neutral or positive sentiments, often framing adequate staffing as a necessary goal or describing isolated instances of improvement. Some respondents note that when units are fully staffed, care quality and job satisfaction improve. A few comments highlight specific successes, such as the recruitment of Advanced Neonatal Nurse Practitioners or improved weekend rostering, though these are exceptions to the prevailing narrative of under-resourcing. There are no significant assertions that current staffing levels are generally adequate.

Thematic analysis: Professional relationships, organisational culture and leadership styles (15,180 comments)

Feedback indicates a deeply polarised landscape regarding professional relationships, organisational culture and leadership styles. A dominant pattern describes a stark contrast between strong, supportive peer-level teamwork and significant tensions with middle and senior management. Many participants describe close-knit, compassionate relationships with immediate colleagues and multidisciplinary teams as a key strength and a buffer against high-pressure environments. Conversely, a recurring theme involves leadership being perceived as disconnected from frontline realities, authoritarian and lacking clinical understanding. This disconnect is frequently linked to a pervasive blame culture, where staff feel undervalued, unheard and fearful of speaking up. While some respondents report positive experiences with specific line managers or coordinators who are approachable and supportive, the broader sentiment suggests that organisational culture is heavily dependent on individual leaders rather than systemic support. This leads to variability in psychological safety and morale across different units.

The dominant pattern reveals a split between peer support and leadership failure. Most negative feedback focuses on senior and middle management being described as unapproachable, dictatorial or forming exclusive cliques, which fosters a toxic environment characterised by bullying, incivility and a lack of psychological safety. Staff frequently report that concerns are ignored, swept under the rug or met with punitive measures rather than support. There is a strong sentiment that management lacks clinical credibility and imposes changes without consultation, leading to feelings of disempowerment and defensive medicine. This is often contrasted with the 'shop floor' reality where colleagues rely on each other for survival and quality care, highlighting a gap between organisational rhetoric (e.g. 'no blame') and the lived experience of staff.

A smaller group of respondents describe positive experiences with leadership and culture, citing approachable managers, open-door policies and strong multidisciplinary collaboration. These accounts often highlight specific units or individuals where leadership is clinically engaged, visible and empathetic, fostering an environment where staff feel safe to escalate concerns and receive support. Some participants note that while senior leadership may be disconnected, their immediate line managers or coordinators provide a protective buffer, enabling them to maintain morale and deliver compassionate care. There are also instances where staff report effective teamwork between midwives and obstetricians, challenging the broader narrative of hierarchical barriers.

Thematic analysis: Estates (5,255 comments)

Feedback indicates a pervasive and critical dissatisfaction with the physical estate and infrastructure across maternity and neonatal services. Participants describe environments that are frequently 'not fit for purpose,' characterised by ageing buildings, severe space constraints and a chronic lack of essential, functional equipment. These

physical deficits are consistently linked to operational barriers, safety risks and compromised patient dignity. While a minority of comments highlight isolated instances of adequate resources or recent improvements in specific units, the dominant narrative reflects urgent needs for modernisation, investment and better maintenance to support safe care delivery.

The dominant pattern is a systemic failure of the physical environment to support modern clinical practice. Most respondents report that infrastructure is outdated, often citing buildings from the 1970s or earlier that are in disrepair, with issues such as leaks, mould and infestations. A recurring mechanism of harm is the shortage of working equipment (e.g. CTGs, monitors, thermometers), which forces staff to spend significant time searching for resources, delaying care and increasing clinical risk. Spatial constraints are equally prevalent, with cramped wards, lack of privacy for labouring women and insufficient storage leading to cluttered corridors that pose fire and safety hazards. These estate challenges are described as directly impeding the ability to provide safe, compassionate and family-centred care.

A smaller group of comments expresses neutral or positive sentiments, often framing the need for better facilities as a requirement for safety rather than a current reality. Some respondents note isolated instances where equipment is readily available, functional or recently upgraded, particularly in specific new units or areas where investment has occurred. A few comments highlight the benefits of modern infrastructure, such as spacious maternity units or mobile telemetry devices that enhance patient mobility. However, these positive views are significantly outnumbered by reports of inadequacy and are often framed as exceptions or aspirations rather than the norm.

Thematic analysis: System design (4,712 comments)

Participants described a dominant pattern of systemic design flaws in maternity and neonatal services, characterised by fragmented pathways, rigid operational models and unclear role boundaries. Responses suggest that current structures often prioritise throughput, administrative compliance and institutional efficiency over individualised care, creating a 'conveyor belt' environment that compromises safety and staff experience. Key issues included disjointed interfaces between community and acute services, geographic dispersal causing logistical burdens and guidelines perceived as outdated or impractical. While a smaller group highlighted well-functioning elements such as specific continuity models, robust MDT working and effective specialist pathways, these were often contrasted with broader systemic failures or described as isolated successes.

The prevailing feedback indicates that system design is frequently misaligned with clinical reality, forcing reactive care and penalising individualised approaches. Participants described pathways that are fragmented between hospital and community settings, leading to continuity breaks and safety risks. Role clarity was often compromised by scope creep, with specialist roles repurposed to plug staffing gaps or

community midwives managing complex cases without adequate support. Operational rigidity, including insufficient appointment times and inflexible staffing templates, was cited as a major barrier to effective care. Geographic dispersal and poor interfaces between services further exacerbated inefficiencies, with staff reporting excessive travel and communication breakdowns. Administrative burdens, including excessive documentation requirements and multiple IT systems, were reported to detract from direct clinical time and contribute to cognitive overload.

A smaller group of respondents identified specific areas where system design functions effectively. These included well-coordinated continuity of care models, robust multidisciplinary team working and specialist pathways for complex needs. Some participants noted positive experiences with protected handover times, effective escalation pathways and dedicated support roles such as family care coordinators. However, these positive examples were often described as isolated successes within a generally flawed system or were qualified by concerns about resource constraints and implementation gaps.

Thematic analysis: Training and education (3,960 comments)

Feedback indicates a polarised landscape regarding training and education, characterised by a tension between the recognised value of professional development for safety and competence, and significant systemic barriers to accessing it. Many respondents affirm that specific high-quality programmes, such as multidisciplinary simulations and mandatory updates, build confidence. However, a dominant narrative highlights structural constraints including lack of protected time, funding limitations and operational pressures that force learning into personal time. Participants describe critical gaps in induction, preceptorship and specialist clinical skills, with concerns that mandatory training is often perceived as irrelevant or insufficiently retained. Conversely, a smaller group reports positive experiences with supportive supervision, dedicated education teams and funded study leave, though these are often qualified by the fragility of such opportunities amidst service demands.

The dominant pattern reveals a significant disconnect between the aspiration for high-quality, comprehensive learning and the reality of resource constraints. Many participants describe training as compromised by staffing pressures, with learning frequently cancelled, rushed or conducted outside working hours. There is a recurring critique of mandatory training being generic or irrelevant to specific roles, alongside concerns about the lack of practical application for new skills. Specific gaps are frequently noted in areas such as trauma-informed care, leadership, neonatal procedures and support for newly qualified staff. The expectation to self-fund specialist training is viewed as demoralising and inequitable, particularly for non-registered staff. Furthermore, the absence of protected time for online learning and reflection is cited as a barrier to embedding good practice, leading to feelings of being underprepared and creating safety risks.

A smaller group of respondents reported positive experiences where training is prioritised, well-structured, and effectively builds confidence and competence. These views highlight successful implementation of mandatory training, simulation, and multidisciplinary learning that supports professional growth and safe practice. Some staff describe robust education packages, supportive supervision, and access to external courses that enhance their ability to provide compassionate care. However, even these positive accounts are often qualified by the caveat that such opportunities are fragile, frequently compromised by service needs, or limited to specific units rather than being consistent across the service.

Thematic analysis: Governance, funding and accountability (3,242 comments)

Feedback indicates an inescapable disconnect between governance expectations and the financial resources provided to meet them, with most responses describing chronic underfunding and cost-cutting measures as prioritised over patient safety and clinical quality. A recurring theme was the perception that governance structures have become bureaucratic and performative, characterised by excessive reporting burdens and 'tick-box' exercises that divert time from direct care without delivering tangible improvements. Accountability mechanisms were frequently criticised as ineffective, with respondents reporting that escalation routes are ignored, concerns are not acted upon and senior leadership remains disconnected from frontline realities. While a smaller group of respondents noted confidence in specific governance frameworks or clear escalation pathways, these views were significantly outnumbered by accounts of systemic resource scarcity and oversight failures.

The dominant pattern across the feedback is a systemic failure of governance and funding to support safe service delivery. Respondents consistently linked financial constraints to unsafe working conditions, equipment shortages and an inability to implement national directives. There is a strong sentiment that financial targets and cost-saving imperatives override clinical needs, leading to a culture where safety is compromised. Governance processes are often described as 'invisible' or 'marking their own homework', with assurance activities viewed as burdensome rather than supportive. Accountability is perceived as lacking, particularly regarding senior management's response to escalated concerns and the management of underperforming clinicians.

A smaller group of respondents expressed confidence in existing governance structures, citing robust safety processes, clear escalation pathways and effective sharing of learning within their specific contexts. Some noted that national initiatives, such as the Maternity Incentive Scheme, have helped keep safety high on agendas by linking accountability to funding. A few comments highlighted strong leadership and the ability to raise concerns with confidence that they would be acted upon, though these positive experiences were often framed as exceptions to the broader trend of resource scarcity and bureaucratic failure.

Thematic analysis: Staff listening to women, birthing people and families (2,424 comments)

Feedback indicates an intrinsic tension between staff aspirations for person-centred, compassionate listening and systemic barriers that prevent meaningful engagement with women, birthing people and families. A dominant pattern across responses describes how time pressures, staffing shortages, administrative burdens and task-oriented workflows force care to become transactional, rushed and focused on clinical tasks rather than emotional support or informed decision-making. Many staff report that these constraints lead to women and birthing people feeling unheard, dismissed or 'done to', with concerns often being shut down or gaslit. Participants describe a 'conveyor belt' culture where women and birthing people are treated as numbers, and digital systems or excessive documentation displace time for genuine connection. While some respondents note that adequate time, continuity of care and specific supportive initiatives enable trust-building and validation of lived experience, these are frequently framed as exceptions or dependent on specific conditions rather than the norm. The evidence suggests that the ability to listen is strongly linked to workforce investment and resource allocation, with staff expressing frustration and demoralisation at their inability to provide the care they intend.

The dominant pattern is that systemic barriers—primarily insufficient time, high workloads, staffing constraints and administrative burdens—prevent staff from listening effectively to women, birthing people and families. Responses suggest that care becomes task-focused, rushed and depersonalised, leading to women and birthing people feeling unheard, unprepared or coerced into decisions. Staff frequently report that short appointment slots (e.g. 20-30 minutes) and the need to complete digital paperwork or 'tick boxes' leave no room for emotional support, rapport-building or validating concerns. This results in a breakdown of trust, with women and birthing people feeling 'processed' rather than cared for and staff feeling exhausted and unable to deliver compassionate care. There is a recurring sentiment that women and birthing people's voices are not being heard, particularly regarding informed consent and intervention choices, and that concerns raised are often dismissed or met with a lack of action.

A smaller group of comments describes positive experiences where staff have sufficient time and resources to listen, build trust and support women and birthing people's choices. These instances are often linked to specific models of care (e.g. Family Integrated Care, continuity of care), supportive leadership or individual staff efforts to prioritise time despite constraints. Some respondents note that when time is available, staff can provide compassionate, person-centred care where women and birthing people feel heard, valued and involved in decisions. However, even these positive accounts often acknowledge that such experiences are exceptions rather than the norm or are contingent on specific conditions like adequate staffing or reduced workload.

Thematic analysis: Digital systems and electronic patient records (1,888 comments)

Feedback indicates that digital systems and Electronic Patient Records (EPRs) are a significant source of frustration, administrative burden and safety risk for staff. The dominant narrative describes systems as 'not fit for purpose', characterised by poor interoperability, frequent technical failures and outdated hardware. Staff report spending excessive time navigating multiple disconnected platforms, duplicating documentation and dealing with system crashes, which detracts from direct patient care. Specific complaints highlight the lack of maternity-specific workflows, with many systems described as 'American' or 'nursing-focused' and ill-suited for midwifery practice. While a minority of comments express aspirations for integrated, streamlined systems which could enhance safety and efficiency, these are largely framed as future goals rather than reflections of current reality.

The dominant pattern is strong dissatisfaction with digital infrastructure, driven by fragmentation, duplication and unreliability. Participants describe a landscape where multiple non-integrated systems require manual data transfer, leading to significant time loss and safety risks. Hardware issues, such as slow computers, battery failures and poor connectivity in community settings are frequently cited as barriers to contemporaneous care. The shift to digital is often perceived as increasing administrative burden rather than reducing it, with staff noting that documentation takes longer than paper-based methods and forces them to prioritise screens over patients.

A smaller group of comments expresses neutral or positive sentiments, often in the form of aspirations for better technology or specific praise for isolated tools. Some respondents note that specific systems can improve safety and oversight. Others suggest that a unified, end-to-end digital system or AI solutions could theoretically free up clinical time and improve data accuracy. However, these positive views are frequently qualified by broader systemic issues or represent isolated successes rather than the norm.

Thematic analysis: Inequalities (550 comments)

Feedback indicates an entrenched pattern of systemic inequality in maternity services, driven primarily by language barriers, racism and geographic or socioeconomic disparities. Participants described significant challenges for non-English speaking families, including inadequate interpreting services that compromise communication and safety. Racism and discrimination were frequently cited as critical issues affecting both patients and staff, with reports of biased leadership, exclusion from senior roles and differential treatment. Geographic inequity, often described as a 'postcode lottery', was highlighted as a barrier to accessing specialist care, forcing some women to choose less optimal pathways due to logistical constraints. While some positive initiatives were noted, such as culturally sensitive care models and targeted support teams, these were often framed as exceptions or aspirational goals rather than widespread realities.

The dominant pattern across responses is one of structural failure and exclusion, where protected characteristics such as race, language and socioeconomic status create barriers to equitable care. Many respondents reported that language barriers are exacerbated by poor translation infrastructure, leading to delays and reliance on unqualified interpreters. Racism was described as both overt and subtle, influencing clinical decision-making, staff progression and patient outcomes. Geographic disparities were linked to unequal access to fetal medicine and specialist support, disproportionately affecting women in deprived or rural areas. The feedback suggests a 'two-tier' system where vulnerable groups receive less favourable care and staff from global majority backgrounds face disproportionate scrutiny and lack of psychological safety.

A smaller group of comments highlighted positive initiatives or neutral perspectives, such as the value of culturally sensitive care, co-production with communities and the potential of utilising staff language skills. Some respondents noted the existence of specialist ethnic minority teams, improved access to interpreters via iPads and the introduction of inclusivity rounds. However, these positive examples were often qualified by concerns about limited leadership action, insufficient resources or the sentiment that implementation is slow and underfunded. A few comments expressed confidence in applying for opportunities without racial bias or described successful local initiatives to drive equity, though these were outweighed by the prevalence of negative experiences.

Thematic analysis: Response to incidents (519 comments)

Feedback indicates a predominantly negative experience regarding the response to incidents, characterised by delays, lack of follow-through and perceived inequity in how concerns are handled. Many participants described escalation processes as complex, ineffective or ignored, leading to a sense of abandonment and futility. A recurring theme was the perception that incidents are met with blame or 'cloak and dagger' attitudes rather than support, particularly affecting midwives and when concerns involve medical staff. While some respondents noted clear pathways, rapid reviews and dedicated emergency teams, these positive accounts were often qualified by a lack of transparency in outcomes or overshadowed by the volume of negative experiences regarding timeliness and support.

The dominant pattern is a critical view of incident response, characterised by perceptions of inconsistent, slow or ineffective escalation processes and a lack of supportive follow-up. Participants frequently described escalation as a 'box ticking exercise' or 'shouting into the void', where concerns are raised but rarely result in tangible action or support. There is a strong sentiment that the response to incidents often feels punitive rather than supportive, with staff feeling unsafe or unsupported when raising concerns. Barriers include complicated reporting systems, unclear escalation pathways, dismissive attitudes from senior colleagues and a lack of staff availability.

A smaller group of respondents reported positive experiences with incident response, citing clear escalation pathways, rapid review meetings and dedicated emergency teams.

Some noted that when concerns were raised, they were responded to positively with senior involvement, and specific roles (e.g. Flow matron, Chair, Medical Director) could lead to quicker acknowledgement. There were also mentions of robust reporting systems, quick team responses to emergencies and respectful escalation processes where the team comes together compassionately.

Thematic analysis: Previous recommendations from public inquiries and national investigations (203 comments)

Feedback indicates a prevalent sense of frustration and fatigue regarding the cycle of national maternity inquiries and recommendations. Participants describe a recurring pattern where high-profile reviews, including the Ockenden and Kirkup inquiries, identify systemic issues such as underfunding, staffing shortages and inadequate resources, yet fail to result in meaningful or sustained change. Many respondents perceive recommendations as ignored, under-resourced or implemented superficially as 'tick-box' exercises without addressing root causes. There is a strong sentiment that repeated investigations retraumatise families, erode staff morale and create defensive practice without delivering system-wide improvements. While a small minority acknowledge specific positive actions or the importance of recommendations, these views are often qualified by concerns over resource constraints and the reactionary nature of current initiatives.

The dominant pattern is a deep-seated cynicism regarding the effectiveness of national inquiries, characterised by 'investigation fatigue' and the perception that recommendations are repeatedly ignored or inadequately resourced. Respondents highlight that despite decades of reports identifying the same core issues—particularly staffing, funding and monitoring technology—little has changed. There is a recurring complaint that inquiries focus on blaming staff rather than addressing systemic failures, leading to a 'postcode lottery' of care and a culture of compliance rather than genuine improvement.

A small minority of comments express a neutral or slightly positive view, acknowledging that recommendations are important for good care or that specific actions (like implementing Ockenden recommendations) are necessary. Some respondents noted specific positive actions taken in response to recommendations, such as the implementation of Allied Health Professional teams following Ockenden in one trust or past improvements following the Stafford Hospital scandal (Mid Staffs scandal). However, these views are often framed within the context of the broader failure to act or are qualified by concerns over resources.

Appendix 1: Questionnaire

National Maternity and Neonatal Investigation Staff Experience Survey

On 23 June 2025 the Secretary of State for Health and Social Care announced a rapid, national, independent investigation into NHS maternity and neonatal services in England.

Baroness Amos was appointed as Chair of the Independent Maternity and Neonatal Investigation on 14 August 2025.

The Investigation is looking at individual services across the country alongside reviewing the maternity and neonatal system as well as reviewing the findings of past reviews. Baroness Amos has been asked to produce one set of national actions to ensure every woman and baby receives safe, high-quality and compassionate care.

Following the conclusion of the Investigation Baroness Amos will deliver one set of national recommendations. A reflections report setting out issues raised by women, families and staff was published in December 2025.

Understanding the experiences of staff and healthcare professionals

The Investigation wants to understand the experiences of staff and healthcare professionals delivering care at all stages of the maternity and neonatal care pathway and how they can best be supported in providing high-quality, safe and compassionate care.

This includes:

- Understanding the experiences of staff and healthcare professionals, at local, regional and national levels, working in the maternity and neonatal care pathway.
- Understanding how organisational culture and leadership styles influence how staff and healthcare professionals deliver care across maternity and neonatal pathways.
- Identifying the extent to which recruitment, retention, education and training support staff as they deliver care across the maternity and neonatal pathway.

This Investigation considers the maternity and neonatal care pathway to include pre-pregnancy advice and care, pregnancy care, labour, birth, neonatal care, postnatal care including psychological support and care and support including bereavement care for adverse outcomes such as miscarriage, stillbirth, perinatal, and maternal morbidity and mortality.

Data protection and privacy

Picker is facilitating this survey on behalf of the Investigation, which is the data controller. All personal data will be handled lawfully and securely in line with data protection legislation. **All responses will be identifiable by Trust but not by individual. For reporting, responses will be aggregated; no individual data will be shared with the Investigation.**

If you need support completing the survey, please contact programmes@pickereurope.ac.uk. If you have any queries, please contact matneoinvestigation@dhsc.gov.uk.

YOUR JOB

Q1. [MULTICODE for 1-7, single code 8-10] Do you work in the maternity and neonatal care pathway?

1. Yes - pre-pregnancy advice and care
2. Yes - pregnancy care, labour, birth
3. Yes - neonatal care
4. Yes - postnatal care including psychological support
5. Yes - care and support including bereavement care for adverse outcomes such as miscarriage, stillbirth, perinatal, and maternal morbidity and mortality
6. Yes – in a management role within an individual maternity or neonatal unit
7. Yes – in a management role outside of a particular maternity or neonatal unit
8. No [END SURVEY]
9. Don’t know [END SURVEY]
10. Prefer not to say [END SURVEY]

Q2. Do you have face-to-face, video or telephone contact with patients / service users as part of your job?

1. Yes, frequently
2. Yes, occasionally
3. No

Q3. Which setting do you spend most time in?

1. Community
2. Ward/inpatient units
3. Office

4. Clinics/outpatient services
5. Residential
6. Other (please specify)

Q4. What is your occupational group? Please select one only.

Allied Health Professionals/Healthcare Scientists/Scientific and Technical

1. Occupational Therapy
2. Physiotherapy
3. Radiography
4. Pharmacy
5. Clinical Psychology
6. Psychotherapy
7. Operating Department Practitioner
8. Speech and Language Therapy
9. Other qualified Allied Health Professionals (e.g. dietetics, podiatry, osteopathy) and support (e.g. support worker, therapy helper, therapy assistant)
10. Other qualified Scientific and Technical or Healthcare Scientists (e.g. haematology, clinical biochemistry, microbiology) and support (e.g. technicians, assistants or students)

Medical and Dental

11. Medical/Dental - Consultant
12. Medical/Dental - In Training (e.g. Foundation Y1, Foundation Y2, Core trainees, Specialty trainees (including GPs))
13. Medical/Dental - SAS doctor (Specialty Doctor, Specialist, Staff Grade or Associate Specialist)
14. Medical/Dental - Other (e.g. Locally Employed Doctor, Trust Grade Doctor, Clinical Fellow, etc.)
15. Salaried Primary Care Dentists

Public Health

16. Public Health/Health Improvement

Registered Nurses and Midwives and Nursing or Healthcare assistants

17. Adult/General

18. Mental health
19. Learning disabilities
20. Children
21. Neonatal
22. General midwife
23. Specialist midwife
24. Health Visitors
25. District/Community
26. Other Registered Nurses
27. Nursing auxiliary/Nursing assistant/Healthcare assistant (including Health/Clinical/Nursing Support Worker)

Other

28. Ambulance (operational) (e.g. emergency care practitioner, paramedic, emergency care assistant, ambulance technician, ambulance control staff or patient transport service)
29. Social Care (e.g. social workers, care manager or support staff)
30. Wider Healthcare Team (e.g. Maternity and Neonatal Voices Partnership leads, admin and clerical staff such as a medical secretary, central functions/corporate services such as HR, finance, IT and maintenance/ancillary such as housekeeping, domestic staff, maintenance, facilities or estates)
31. Commissioning managers/support staff
32. General Management (N.B. If you are a manager and can choose a group from elsewhere in the list, please select that other occupational group)
33. Other occupational group (please specify)

[IF YES TO Q4. CODE 11-14] Q5. Are you …

1. Qualified or training in obstetrics
2. Qualified or training in neonatology
3. Qualified or training in anaesthetics
4. Other (please specify)
5. Prefer not to say

[IF YES TO Q1. CODE 6 or 7] [MULTICODE 1-5 SINGLE CODE 6] Q6. Does your management role involve any of the following? Please select all that apply.

1. Line management
2. Clinical supervision
3. Ward leadership
4. Departmental leadership
5. Service leadership
6. None of the above

YOUR EXPERIENCE

The independent Investigation into NHS maternity and neonatal services is focused on how best these services can be supported to provide high-quality, safe and compassionate care.

The Investigation is interested in understanding how organisational culture and leadership styles influence how staff and healthcare professionals deliver care across maternity and neonatal pathways and identifying the extent to which recruitment, retention, education and training support staff as they deliver care across the maternity and neonatal pathway.

Q7. To what extent do you agree or disagree with the following statements?

a. Strongly disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly agree
f. Don't know

1. I have the resources I need to do a good job
2. I have sufficient time to do my job well
3. I know exactly what is expected of me in my job
4. I am able to influence the way things are done in my team
5. Unacceptable behaviour is consistently tackled

Q8. To what extent do you agree or disagree with the following statements?

6. I feel well supported by my line manager
7. My concerns are taken seriously by my line manager

8. I feel respected by my co-workers
9. I feel able to ask for help when I need it
10. I am kept well informed about what is going on in our team

Q9. To what extent do you agree or disagree with the following statements?

11. I get the training and development I need
12. The Trust values the service we provide
13. Trust managers know how things really are
14. The Trust listens to staff views
15. I would recommend this Trust as a good place to work

Q10. To what extent do you agree with the following statements about unsafe clinical practice?

a. Strongly disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly agree
f. Don't know

1. I would feel secure raising concerns about unsafe clinical practice
2. I am confident that my organisation would address my concern

Please do not include any personal information on this page if you want to remain anonymous. Please be aware that if the information provided on this page suggests that you or someone else is at serious risk of harm, your details would be provided to the appropriate authority to investigate, as part of our safeguarding duty.

Q11. What supports you to provide high-quality, safe and compassionate care at work? Please share up to three things.

Please describe how they support you to provide high-quality, safe and compassionate care. This could include what gives you most satisfaction in your role, areas you think that could make a difference to local and national care if introduced more widely or factors that improve staff and family experience.

[FREE TEXT]

Q12. What prevents you from providing high-quality, safe and compassionate care at work? Please share up to three things.

Please describe how they prevent you from providing high-quality, safe and compassionate care. This could include the pressures you experience in your role, what causes you dissatisfaction, safety and quality issues or factors that disrupt staff or family experience.

[FREE TEXT]

Q13. What actions would help improve outcomes and prevent trauma and harm at work? Please share up to three actions.

Please describe how these actions would support you to delivering high-quality, safe and compassionate care.

[FREE TEXT]

Appendix 2: Workforce grouping for analysis

Questionnaire label	Workforce grouping for analysis
Allied Health Professionals/Health Care Scientists and Technical	
Occupational Therapy	Allied Health Professionals/Healthcare Scientists/Scientific and Technical
Physiotherapy	
Radiotherapy	
Pharmacy	
Clinical Psychology	
Psychotherapy	
Operating Department Practitioner	
Speech and Language Therapy	
Other qualified Allied Health Professionals (e.g. dietetics, podiatry, osteopathy) and support (e.g. support worker, therapy helper, therapy assistant)	
Other qualified Scientific and Technical or Healthcare Scientists (e.g. haematology, clinical biochemistry, microbiology) and support (e.g. technicians, assistants or students)	
Medical/Dental	
Medical/Dental - Consultant	Medical/Dental – consultant
Medical/Dental - In Training (e.g. Foundation Y1, Foundation Y2, Core trainees, Specialty trainees (including GPs))	Medical/Dental - In Training

Questionnaire label	Workforce grouping for analysis
Medical/Dental - SAS doctor (Specialty Doctor, Specialist, Staff Grade or Associate Specialist)	Other Medical/Dental
Medical/Dental - Other (e.g. Locally Employed Doctor, Trust Grade Doctor, Clinical Fellow, etc.)	
Salaried Primary Care Dentists	
Public Health	
Public Health / Health Improvement	Other
Registered Nurses and Midwives and Nursing or Healthcare assistants	
Adult/General	Other Registered Nurses and Midwives and Nursing or Healthcare assistants
Mental health	
Learning disabilities	
Children	
Health Visitors	
District/Community	
Other Registered Nurses	
Neonatal nurses, midwife or assistant	Neonatal nurses, midwife or assistant
General midwife	General and specialist midwives
Specialist midwife	
Nursing auxiliary/Nursing assistant/Healthcare assistant (including Health/Clinical/Nursing Support Worker)	Nursing auxiliary/Nursing assistant/Healthcare assistant (including

Questionnaire label	Workforce grouping for analysis
	Health/Clinical/Nursing Support Worker)
Other	
Ambulance (operational) (e.g. emergency care practitioner, paramedic, emergency care assistant, ambulance technician, ambulance control staff or patient transport service)	Other
Social Care (e.g. social workers, care manager or support staff)	
Wider Healthcare Team (e.g. Maternity and Neonatal Voices Partnership leads, admin and clerical staff such as a medical secretary, central functions/corporate services such as HR, finance, IT and maintenance/ancillary such as housekeeping, domestic staff, maintenance, facilities or estates)	
Commissioning managers/support staff	
General Management (N.B. If you are a manager and can choose a group from elsewhere in the list, please select that other occupational group)	
Other occupational group (please specify)	

Appendix 3: Workforce grouping qualitative analysis

Allied Health Professionals/Healthcare Scientists/Scientific and Technical

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants described robust multidisciplinary teamwork as the primary enabler of high-quality, safe and compassionate care, emphasising collaborative decision-making, mutual respect and effective communication across professional boundaries. Responses suggest that supportive leadership, particularly from line managers who actively listen and foster psychological safety, is critical for maintaining staff morale and confidence. A recurring theme was the fundamental necessity of adequate staffing levels, which allow staff to transition from task-focused to patient-led care and manage workloads without compromising safety.

Feedback indicates that access to regular training, clinical supervision and reflective practice opportunities facilitates continuous professional development and emotional management. Specific structural supports, such as dedicated bereavement teams and family-integrated care models, were noted to enhance service quality. However, significant barriers persist, including severe underfunding, resource constraints and incompatible electronic systems, which threaten the sustainability of care. Some respondents noted that staff dedication often compensates for systemic gaps, yet the need for increased financial investment and protected time for professional development remains urgent.

The overall tone leans towards a pragmatic acknowledgment of systemic challenges alongside a strong commitment to excellence. While participants highlighted a positive organisational culture that values evidence-based practice and encourages peer support, the feedback underscores the tension between current resource limitations and the requirements for consistent, equitable care provision. The findings suggest that while personal motivation drives current performance, structural improvements are essential to ensure long-term sustainability.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Chronic understaffing and insufficient funding emerged as the primary barriers preventing staff from delivering high-quality, safe and compassionate care. Participants described workforce deficits that frequently fall below national standards, forcing prioritisation of essential tasks over patient interaction and limiting time for family support. This resource strain necessitates reliance on agency staff and disrupts continuity, while inadequate investment restricts recruitment, professional development and access to essential equipment or private spaces.

Operational inefficiencies and systemic cultural issues further impede care delivery. Responses suggest that excessive bureaucracy, rigid appointment schedules and fragmented multidisciplinary working hinder collaborative care. A recurring theme was a toxic workplace culture characterised by hierarchical structures, poor interdepartmental communication and management disconnect from frontline realities. Some respondents noted resistance to evidence-based practice changes and inconsistent IT systems, which erode morale and compromise safety.

The cumulative effect of these constraints creates an environment where staff feel unsupported and at risk of burnout. Feedback indicates that high patient acuity, unpredictable demand and the absence of protected administrative time contribute to moral injury and mental health deterioration. Ultimately, these systemic failures prevent the provision of holistic, family-integrated care and optimal clinical outcomes, with the overall tone leaning towards frustration and concern regarding patient safety.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

A recurring theme across responses was the critical need for adequate staffing levels across all disciplines to meet national standards and reduce reliance on agency or redeployed staff. Participants described how consistent staffing is essential to prevent burnout, ensure safe patient-to-staff ratios and allow for protected breaks. Feedback indicates that funding must support hiring additional midwives, nurses, sonographers, pharmacists and Allied Health Professionals to enable individualised care and reduce service strain.

Responses suggest that enhanced training and robust psychological support systems are vital for upskilling staff and mitigating moral distress. Participants highlighted the importance of mandatory trauma-informed care, clinical supervision and embedded psychology posts to support staff to process traumatic experiences. A supportive culture characterised by compassionate leadership, clear communication channels and addressing incivility was noted as key to fostering trust and collaboration among multidisciplinary teams.

Operational improvements and investment in physical resources were also emphasised to support both staff and patient wellbeing. Feedback indicates that fit-for-purpose units, functional equipment and efficient risk reporting systems can streamline processes and reduce errors. Ultimately, participants described a need for systemic investment in staffing, resources and psychological safety to sustain a resilient workforce capable of delivering high-quality, compassionate care.

Medical/Dental - Consultant

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants consistently identified cohesive multidisciplinary teamwork as the primary enabler of high-quality, safe, and compassionate care. Responses suggest that mutual

respect, open communication and flattened hierarchies across medical, nursing, midwifery and allied health professions foster psychological safety and collaborative decision-making. Strong, approachable leadership that actively listens and prioritises patient safety over productivity was frequently cited as critical for maintaining a non-judgmental culture where staff feel empowered to raise concerns. A recurring theme was the importance of robust governance structures, including non-punitive incident reporting and continuous learning opportunities, which facilitate service improvement and clinical competence.

Feedback indicates that adequate staffing levels, sufficient time for patient interaction and access to functional resources are fundamental prerequisites for delivering effective care. Participants described how modern equipment, reliable IT systems and well-designed estates underpin clinical safety and operational efficiency. Professional development through regular training and simulation was noted as essential for sustaining confidence and adherence to evidence-based guidelines. However, significant barriers were highlighted, including chronic understaffing, resource constraints and administrative burdens that force reliance on personal goodwill and unpaid overtime to maintain standards.

The overall tone leans towards resilience and professional dedication, with many respondents citing intrinsic motivation and a shared commitment to patient-centred values as powerful drivers despite systemic challenges. Some participants noted a disconnect between senior management and clinical realities, citing cost-cutting measures and perceived indifference to workforce concerns as detrimental to team cohesion and wellbeing. While a culture of kindness and shared purpose remains a foundational support, the tension between organisational investment and clinical needs continues to threaten care delivery and staff satisfaction.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Participants described chronic understaffing across midwifery, medical and allied health roles as the primary barrier to delivering high-quality, safe and compassionate care. Responses suggest that severe workforce deficits, exacerbated by rota gaps, high sickness rates and recruitment challenges, force staff to manage excessive patient acuity without adequate time for personalised interaction. This strain is compounded by insufficient financial resources and restrictive budgetary constraints, which limit the ability to fill vacancies, invest in necessary equipment or upgrade dilapidated physical infrastructure. Feedback indicates that outdated estates, inadequate theatre capacity and poor environmental conditions directly impede clinical workflows and compromise patient safety.

A recurring theme in the feedback was the impact of excessive administrative burdens and unreliable IT systems, which divert clinical focus from direct patient care. Participants noted that fragmented digital records and documentation prioritising data capture over clinical interaction significantly reduce time available for supervision and

compassionate engagement. Leadership challenges were also pervasive, with respondents describing a culture of blame, fear, and top-down management that discourages speaking up and erodes psychological safety. Some respondents highlighted a disconnect between leadership and frontline realities, characterised by a perceived prioritisation of financial targets over clinical needs and staff well-being.

The overall tone of the feedback leans heavily towards frustration and moral injury, reflecting an environment where staff feel overworked, undervalued and unable to meet rising demand. External pressures, including negative media narratives, unrealistic patient expectations and a litigious environment were cited as factors fostering defensive medicine and staff burnout. The cumulative effect of these systemic failures—ranging from operational inefficiencies to cultural deficits—creates a hostile working environment that consistently undermines the capacity to provide safe and effective care. These insights suggest that without addressing resource scarcity and cultural barriers, the delivery of compassionate care will remain compromised.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

Participants described a critical need for substantial investment in staffing levels, infrastructure and cultural transformation to improve outcomes and prevent workplace trauma. Responses consistently emphasised that adequate resourcing across midwifery, medical and neonatal roles is essential to mitigate burnout and ensure safe patient care. Feedback indicates that current staffing deficits and reliance on bank shifts contribute to cognitive overload and rota gaps, necessitating realistic job planning and protected funding aligned with national standards.

A recurring theme was the necessity of shifting from a punitive, blame-based culture to a compassionate, learning-oriented environment. Participants noted that reducing administrative burdens, simplifying reporting processes and removing middle management layers would grant clinicians greater autonomy. Furthermore, responses suggest that implementing robust psychological support, debriefing and supervision following traumatic incidents is vital for staff wellbeing. Enhancing multidisciplinary collaboration and breaking down silos between nursing, medical and midwifery staff were also highlighted as key strategies for improving safety.

Infrastructure and digital solutions emerged as foundational requirements for sustainable service delivery. Feedback indicates that upgrading outdated estates, expanding theatre capacity and embedding interoperable IT systems are critical to reducing operational strain and documentation time. Some respondents noted that addressing health inequalities through tailored care and diverse leadership, alongside managing public expectations through better communication, supports workforce retention. Overall, the tone leans towards urgent concern regarding systemic underfunding, with a strong emphasis on the need for clinically-led governance and long-term workforce planning to restore morale and safety.

Medical/Dental - In Training (e.g. Foundation Y1, Foundation Y2, Core trainees, Specialty trainees (including GPs))

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants described robust multidisciplinary teamwork as the primary enabler of high-quality, safe and compassionate care. Responses suggest that non-hierarchical collaboration, mutual respect and effective communication across medical, midwifery and nursing disciplines are critical. A recurring theme was the importance of senior clinical presence, with approachable consultants and senior nurses and midwives providing essential supervision and role modelling that fosters clinical autonomy. Feedback indicates that adequate staffing levels are foundational, preventing burnout and ensuring sufficient time for patient interaction and safe handovers.

Structured educational opportunities and functional resources were identified as vital supports. Participants noted that simulation training, regular teaching sessions and protected time for professional development maintain clinical standards. Access to modern IT systems, well-stocked facilities and dedicated rest areas supports operational efficiency. Conversely, some respondents highlighted systemic barriers such as understaffing, inefficient IT and lack of senior support during out-of-hours as factors that compromise care quality and staff morale. The availability of specialised support services, including language interpreters and psychological support, was also cited as significant.

The overall tone leans towards a recognition of the interdependence between resource adequacy, supportive interpersonal dynamics and systemic enablers. Effective leadership and a supportive organisational culture that prioritises staff wellbeing were described as underpinning care delivery. Responses suggest that psychological safety, open communication and a no-blame culture foster positive energy. While challenges like low morale exist, personal dedication and proactive celebration of good care help sustain standards. Ultimately, the convergence of sufficient resources, strong team dynamics and supportive senior leadership creates the necessary conditions for delivering optimal patient outcomes.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Chronic understaffing and excessive workloads emerged as the most significant barriers to delivering safe, high-quality care, with participants describing a workforce deficit across medical, midwifery and nursing tiers. Responses suggest that insufficient staffing forces staff to manage excessive patient volumes, cover multiple wards and work beyond shift hours without adequate breaks, leading to burnout and fatigue. This workforce strain is compounded by inadequate skill mix, high turnover and reliance on junior or agency staff, which participants noted results in role displacement and delayed clinical escalations.

Operational inefficiencies and a toxic workplace culture were recurring themes in the feedback. Participants described outdated, fragmented IT systems and insufficient clinical equipment as hindering documentation and patient safety, while deteriorating physical infrastructure further exacerbates delays. A blame-focused environment characterised by incivility and bullying was reported to discourage open communication and impede teamwork, preventing staff from raising safety concerns without fear of backlash. Management decisions prioritising cost-cutting over clinical safety were also highlighted as fostering defensive medicine practices.

The overall tone of the feedback leans heavily towards frustration and concern regarding systemic failures. Participants indicated that training opportunities are frequently cancelled due to service pressures, resulting in insufficient skill development. High patient complexity, media expectations and litigation fears contribute to pressure, while management inaction on capacity requests perpetuates resource constraints. These factors collectively overwhelm staff, delay treatments and compromise the clinical environment, preventing the delivery of compassionate, family-centred care.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

A recurring theme across responses was the critical need for adequate staffing levels to prevent trauma and improve outcomes. Participants described how increasing the number of experienced midwives, obstetricians and doctors, particularly during peak periods and out-of-hours, would reduce rushing, minimise clinical errors and allow time for compassionate care. Feedback indicates that reducing reliance on locums and implementing flexible rosters are essential to mitigate burnout and support clinical decision-making. Some respondents noted that ensuring 24-hour consultant presence on-site and expanding hospital capacity through financial investment are vital for immediate safety and long-term sustainability.

Responses suggest that infrastructure upgrades and enhanced training are foundational to a safer work environment. Participants highlighted demands for modern IT systems to reduce administrative burdens, reliable communication tools and well-maintained facilities including dedicated rest areas. Training initiatives, such as protected time for simulation exercises, consistent protocols for monitoring and expanded access to ultrasound and surgical experience, were described as necessary to build staff competence and confidence. Additionally, feedback indicates that consolidating contradictory recommendations and implementing a national maternity notes system designed by staff would facilitate evidence-based care.

A shift in workplace culture emerged as a significant factor in preventing harm, with participants emphasising the need for psychological safety and mutual respect. Feedback indicates that moving away from hierarchical or blame-oriented environments through blame-free debriefing sessions and accessible psychological support is crucial. Some respondents noted that leadership must actively listen to concerns and foster collaboration between multidisciplinary teams. The overall tone leans towards a strong

desire for systemic support, including addressing funding constraints and recruitment challenges, to create a compassionate, well-communicated organisational culture that prioritises staff well-being alongside patient safety.

Other Medical/Dental

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

A recurring theme across responses is the critical role of supportive multidisciplinary teamwork and accessible senior supervision in enabling high-quality, safe and compassionate care. Participants frequently described colleagues, consultants and senior nurses and midwives as primary sources of guidance, emphasising the value of approachable leadership, collaborative decision-making and a culture that prioritises teaching and continuous learning. Many respondents highlighted the importance of effective communication across professional boundaries, noting that strong relationships between midwives, doctors, and allied health professionals facilitate coordinated care and build clinical confidence.

However, feedback also indicates significant operational barriers that challenge care delivery. Several participants identified insufficient staffing levels, equipment shortages, and restrictive policies as impediments to working to the full extent of their capabilities. Concerns were raised regarding inadequate training opportunities for junior staff, malfunctioning equipment during emergencies and excessive workloads that limit time for patient interaction. Some respondents noted that while leadership is often viewed positively, systemic issues such as rota gaps and lack of protected administrative time create stress and hinder safe documentation and knowledge updates.

Overall, the tone of the feedback leans towards a recognition of strong interpersonal support and professional dedication, balanced by frustration with resource constraints and structural inefficiencies. Participants expressed appreciation for a no-blame culture, regular debriefs and investment in electronic records, yet called for improved staffing ratios, better IT systems and more flexible policies to support staff wellbeing and patient safety. These insights suggest that while the human element of care is robust, addressing logistical and systemic challenges is essential to sustaining high standards.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

A recurring theme across responses was the impact of chronic understaffing and excessive workloads on the ability to deliver high-quality, safe and compassionate care. Participants described how insufficient staffing levels, rota gaps and high patient volumes create time pressures that limit thorough assessment, documentation, and meaningful communication. This environment often forces staff into task-focused care, leading to delays, prolonged waiting times and moral distress. Some respondents noted that these pressures are compounded by the diversion of key roles, such as ward managers and educators, to cover clinical shifts, which prevents the fulfilment of leadership duties and service progression.

Feedback indicates significant barriers related to physical resources, infrastructure and management support. Participants identified outdated equipment, inadequate IT system, and poor estate conditions as impediments to efficient care delivery. Specific concerns included insufficient bed capacity, lack of dedicated recovery spaces and inefficient electronic documentation systems. Additionally, a disconnect between frontline staff and senior management was highlighted, with some respondents noting a lack of understanding regarding real workplace problems and ineffective leadership in addressing behavioural and professional standard challenges.

The overall tone of the feedback leans towards frustration and concern regarding systemic issues. Some participants described a culture resistant to change, characterised by a lack of psychological safety when raising concerns, perceived favouritism and a blame culture. Responses suggest that these cultural and educational challenges, combined with resource shortages and rigid protocols, hinder collaboration and compromise the ability to provide person-centred care. While a few respondents indicated they were currently providing high-quality care without barriers, the predominant sentiment reflects significant operational and cultural obstacles.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

A recurring theme across responses was the critical need for increased staffing levels across all clinical and non-clinical roles to manage patient volume, reduce workload pressure and prevent burnout. Participants described inadequate staffing as a primary driver of compromised care quality and workplace trauma, with specific calls for safe numbers of doctors, midwives and support staff during out-of-hours and peak periods. Feedback indicates that management decisions regarding staffing often lack clinical insight, leading to unsafe conditions that participants fear will result in inevitable patient harm and increased litigation costs.

Responses suggest that enhanced training, education and psychological support are essential for improving outcomes and fostering a safer working environment. Participants recommended implementing regular hot and cold debriefs, multi-disciplinary simulation training and protected time for learning and reflection. There was a strong emphasis on cultivating a psychologically safe, no-blame culture where staff feel empowered to raise concerns without fear, alongside the need for better IT systems and infrastructure to support clinical workflows and reduce administrative burdens.

The overall tone of the feedback leans towards urgent concern, with some respondents expressing deep scepticism about the potential for meaningful systemic change despite proposed interventions. While many suggestions focused on practical improvements like better coordination between units and realistic patient expectations, a notable secondary tone of frustration emerged regarding the lack of visible action on previously raised issues. Participants highlighted the necessity for senior leadership to model respectful behaviour and engage directly with frontline challenges to rebuild trust and ensure sustainable improvements.

Other Registered Nurses and Midwives and Nursing or Healthcare assistants

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants described supportive team dynamics and effective leadership as foundational to delivering high-quality, safe, and compassionate care. Responses suggest that mutual trust, collaboration and a willingness to assist colleagues during high-acuity periods are critical enablers. Feedback indicates that approachable managers who actively listen, empower staff and provide visible support, alongside senior staff offering clinical guidance, foster a non-judgmental culture where concerns can be raised without fear of retribution.

A recurring theme was the necessity of adequate staffing levels, appropriate skill mixes and manageable patient loads to prevent burnout and ensure sufficient time for holistic patient interaction. Participants noted that access to continuous professional development, modern equipment and fit-for-purpose resources supports operational safety and clinical confidence. Conversely, some respondents highlighted significant barriers, including poor management communication, insufficient resources, inconsistent leadership and aggressive behaviour from senior figures, which can compromise ward safety and staff wellbeing.

Personal factors such as professional pride, passion for the work and autonomy in managing workloads were identified as significant contributors to care quality. Feedback indicates that continuity of care, facilitated by stable staffing and team working, enhances trust with families. While the overall tone leans positive regarding the dedication of staff, notable secondary tones reflect frustration with structural challenges like staffing issues and a lack of clinical expertise in some management roles.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Participants described chronic understaffing and unsafe patient-to-staff ratios as the primary barrier to delivering high-quality, safe and compassionate care. Responses suggest these shortages frequently force staff to contravene recommended guidelines, prioritising urgent clinical tasks over supportive interactions. Financial constraints and cost-cutting measures were identified as exacerbating factors, limiting recruitment, freezing posts and restricting access to essential equipment and training opportunities.

A recurring theme was the impact of high workloads compounded by administrative burdens and documentation requirements. Feedback indicates these pressures reduce time for meaningful communication with families and increase cognitive load, leading to staff fatigue and elevated error risks. Management failures, including poor leadership and dismissive attitudes toward safety concerns, were noted to create a culture of psychological unsafety and low morale. Additionally, toxic workplace dynamics such as bullying and incivility were reported to erode team cohesion.

The overall tone leans heavily towards frustration and concern regarding systemic failures. Participants highlighted inadequate physical infrastructure, including cramped spaces and outdated IT systems, as hindering operational efficiency. Some respondents noted that conflicting directives and inequitable resource allocation fragment care delivery. The cumulative effect of these factors was described as creating an unsustainable environment where crisis management replaces quality improvement, ultimately compromising patient safety and family experiences.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

A recurring theme across responses was the critical need for adequate staffing levels and safe patient-to-staff ratios to prevent harm and manage cognitive overload. Participants described specific requirements for 1:1 ratio in intensive care and neonatal units, linking safe staffing directly to workload management, realistic expectations and protected break times. Feedback indicates that without these foundational resources, preventing burnout and ensuring clinical focus remains challenging, suggesting that resourcing is the primary imperative for safety.

Responses suggest that strengthening psychological safety through visible, empathetic leadership and robust debriefing mechanisms is essential for addressing moral distress. A shift away from blame cultures toward open, non-judgmental communication was highlighted as necessary. Additionally, participants noted the importance of enhanced training, including simulation and clinical supervision, to support skill development, particularly for newly qualified staff. Improved communication systems, clear escalation pathways and collaboration between multidisciplinary teams were identified as vital for decision-making and continuity of care.

The overall tone leans toward a call for structural and cultural transformation to foster a safe, compassionate environment. Feedback indicates that investment in modern equipment, functional working environments and streamlined digital systems supports efficient service delivery. Addressing workforce wellbeing through fair pay, zero tolerance policies for incivility and accessible mental health support was also emphasised. Ultimately, participants described a multifaceted approach centered on supportive leadership and professional development as key to mitigating workplace trauma and improving outcomes.

Neonatal nurses, midwife or assistant

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants consistently identified robust staffing levels, appropriate skill mixes and adherence to safe staffing guidelines as foundational enablers for delivering high-quality, safe and compassionate care. Responses suggest that adequate resourcing, including functional equipment, sufficient time for breaks and access to specialised facilities, is critical for efficient service delivery. Conversely, feedback indicates that insufficient staffing, high workloads and resource constraints are significant barriers that

compromise safety and compassion, with some respondents noting that systemic pressures threaten the sustainability of high-quality outcomes.

A recurring theme was the importance of strong multidisciplinary teamwork characterised by open communication, mutual respect and a non-blame culture. Participants described supportive leadership, including approachable managers and senior clinical staff, as essential for providing guidance, mentorship and emotional support. Effective governance systems, transparent incident reporting and opportunities for staff to influence practice changes were noted as reinforcing a safe environment. However, some respondents highlighted challenges such as perceived management favouritism, micromanagement and inconsistent management support, which can undermine morale and safety.

Continuous professional development through regular training, education teams and access to evidence-based guidelines was cited as vital for maintaining clinical competence and confidence. A positive organisational culture that values staff wellbeing, recognises individual contributions and prioritises family-integrated care models significantly enhances care quality. While personal passion and professional pride serve as internal drivers, external organisational support is frequently noted as inconsistent. The overall tone leans towards a strong commitment to care, tempered by concerns regarding chronic understaffing, excessive bureaucracy and resource limitations that impede compassionate practice.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Chronic understaffing and unsafe nurse-to-patient ratios emerged as the most pervasive barrier to delivering high-quality, safe and compassionate care. Participants described how insufficient staffing levels force reliance on inexperienced personnel, agency staff and redeployment to unfamiliar units, often exacerbating clinical risks and workload complexity. This workforce instability, compounded by high sickness rates and recruitment challenges, frequently compels staff to prioritise task-oriented duties over holistic patient support, limiting time for direct interaction, parental education and compassionate activities.

Resource constraints and management practices were also significant impediments cited in the feedback. Responses indicate that financial pressures result in shortages of essential equipment, outdated infrastructure and inadequate physical space, which compromise safety standards and family-centred care. Leadership disconnects were frequently noted, characterised by a lack of visible support, dismissive attitudes toward staff concerns and micromanagement. These factors contribute to a toxic workplace culture marked by bullying, poor interdepartmental relationships and a lack of accountability, eroding psychological safety and staff morale.

Systemic inefficiencies further disrupt care delivery, with participants highlighting excessive administrative burdens, fragmented documentation and poor communication

between multidisciplinary teams. The cumulative effect of these factors creates an environment where staff operate beyond safe capacity, leading to burnout, high turnover and a diminished ability to maintain recommended care standards. While the feedback suggests these issues are widespread, the qualitative nature of the data indicates these findings represent directional insights from the respondents rather than statistically representative conclusions.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

A recurring theme across responses was the critical need for adequate staffing levels aligned with patient acuity and national standards to prevent burnout and ensure safe care. Participants described the necessity of increasing workforce numbers, optimising skill mixes and adhering to specific nurse-to-patient ratios, particularly for complex cases. Feedback indicates that insufficient staffing exacerbates workload pressures, leading to compassion fatigue and potential errors, while protected breaks and realistic job plans are essential for maintaining staff resilience and focus on clinical duties.

Enhanced management support and a psychologically safe culture were identified as vital for preventing workplace trauma. Responses suggest that leadership must demonstrate genuine engagement, transparency and clinical visibility to foster trust and open communication. Participants emphasised the importance of zero tolerance policies for abusive behaviour, robust psychological support systems including debriefing sessions and a non-punitive environment where staff can raise concerns without fear of retribution. Training in human factors and trauma-informed practices was also highlighted as necessary for managers to better support team well-being.

Infrastructure improvements and professional development opportunities were noted as key enablers for high-quality care delivery. Feedback indicates a need for purpose-built units, adequate equipment and functional IT systems to support operational efficiency and family-centred care. Participants described the value of continuous education, simulation training and protected time for skill refreshment to maintain competence. Addressing administrative burdens and implementing flexible working arrangements were also suggested to help staff balance work-life demands, ultimately enhancing patient safety and staff retention.

General and specialist midwives

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants consistently identified adequate staffing levels, appropriate skill mixes and manageable workloads as foundational enablers for delivering high-quality, safe and compassionate care. Responses suggest that sufficient time for patient interaction, relationship building and protected breaks are critical for maintaining safety standards and preventing burnout. Conversely, chronic understaffing, excessive administrative burdens and unsafe patient-to-staff ratios were frequently cited as significant barriers that compromise care delivery and staff wellbeing.

A recurring theme was the importance of supportive team dynamics and leadership. Feedback indicates that effective multidisciplinary collaboration, mutual respect and a non-hierarchical culture foster psychological safety, allowing staff to escalate concerns without fear. Approachable line managers who actively listen, advocate for resources and provide visible support were described as pivotal for morale. However, some respondents noted a disconnect between senior leadership and frontline realities, with instances of toxic management or lack of engagement undermining confidence and safety.

Access to functional equipment, reliable IT systems and continuous professional development were highlighted as essential operational supports. Continuity of care models, such as caseload midwifery, were valued for strengthening relationships with families and improving outcomes. While personal passion and professional commitment often drive staff to maintain standards despite systemic gaps, the overall tone leans towards concern regarding resource constraints and the sustainability of care. Participants emphasised that a holistic ecosystem aligning staffing, resources, and culture is necessary to support both staff wellbeing and patient outcomes.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Chronic understaffing and unsafe patient-to-staff ratios emerged as the primary barrier to delivering high-quality, safe and compassionate care, with participants describing excessive workloads that force staff to prioritise task completion over patient interaction. Responses suggest that high patient acuity, rising sickness rates and reliance on agency or junior staff exacerbate these pressures, leading to missed breaks, fatigue and burnout. The feedback indicates that these resource constraints often necessitate the redeployment of specialists to cover gaps, disrupting continuity of care and compromising safety standards.

A recurring theme was the impact of systemic resource limitations, including outdated IT systems, malfunctioning equipment and inadequate physical infrastructure, which divert clinical time toward administrative burdens and equipment searches. Participants described excessive documentation requirements and defensive practices as significant distractions from direct patient support, with some noting that paperwork consumes a substantial portion of their shift. Financial constraints and budget cuts were frequently cited as limiting access to essential supplies and preventing necessary infrastructure improvements.

Leadership and organisational culture were identified as critical factors undermining staff morale and psychological safety. Feedback indicates a pervasive disconnect between senior management and frontline realities, characterised by micromanagement, a lack of clinical understanding and a culture of blame or incivility. Some respondents noted that toxic workplace environments, including bullying and hierarchical tensions, discourage staff from raising safety concerns. The overall tone leans heavily toward frustration and exhaustion, reflecting a workforce that feels undervalued and unsupported in meeting professional standards.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

Participants consistently identified chronic understaffing as the primary driver of workplace trauma and harm, describing a critical need for increased workforce numbers across midwifery, obstetric and support roles. Responses suggest that safe staffing levels, aligned with patient acuity rather than simple birth rates, are essential to reduce burnout, ensure protected breaks and allow time for compassionate, individualised care. Feedback indicates that current resource constraints force unsustainable shifts and compromise patient safety, with many respondents calling for ring-fenced funding to secure permanent posts and reduce reliance on agency workers or redeployment strategies that deplete clinical capacity.

A recurring theme was the urgent need for a cultural shift in leadership and management practices. Participants described a demand for visible, clinically engaged leaders who actively listen to frontline concerns and foster a psychologically safe environment free from blame, bullying or intimidation. Responses highlight the necessity of moving away from micromanagement and target-driven approaches toward supportive leadership that prioritises staff wellbeing. Specific recommendations include implementing robust debriefing mechanisms, accessible psychological support and transparent governance to address toxic behaviours and encourage open escalation of safety concerns without fear of reprisal.

Operational improvements were frequently cited as vital to supporting safe practice and reducing administrative burdens. Feedback indicates that functional IT systems, reliable clinical equipment and fit-for-purpose facilities are currently lacking, hindering efficiency and contributing to staff fatigue. Participants emphasised the importance of investing in infrastructure to streamline documentation and communication, alongside enhancing training in trauma-informed care and continuity of care models. Overall, the tone leans toward a call for systemic reform, suggesting that sustainable improvements depend on aligning service design with physiological birth principles, ensuring equitable pay and valuing staff expertise to prevent harm for both clinicians and service users.

Nursing auxiliary/Nursing assistant/Healthcare assistant (including Health/Clinical/Nursing Support Worker)

Q11 - What supports you to provide high-quality, safe and compassionate care at work?

Participants described effective teamwork and supportive leadership as foundational enablers for delivering high-quality, safe and compassionate care. Responses suggest that collaborative environments characterised by mutual respect, open communication and a willingness to assist during high-pressure periods are critical. Feedback indicates that approachable managers who actively listen and provide hands-on support significantly enhance staff morale and confidence, fostering a non-hierarchical culture where all roles are valued.

A recurring theme was the necessity of adequate staffing levels, sufficient time for patient interactions and access to functional equipment and up-to-date training. Some respondents noted that realistic scheduling and protected time for professional development prevent burnout and allow for meaningful engagement with patients. Conversely, feedback highlights that chronic understaffing, insufficient breaks and resource discrepancies create systemic barriers that compromise care quality and staff wellbeing.

While personal passion and professional dedication drive many to maintain standards, the overall tone leans towards a dependency on structural support to sustain these efforts. Participants emphasised that a balance of robust team dynamics, resource adequacy and an organisational culture prioritising staff wellbeing is essential. Despite challenges such as administrative oversights and feelings of being undervalued, the desire to make a positive impact on patient outcomes remains a powerful motivator for the workforce.

Q12 - What prevents you from providing high-quality, safe and compassionate care at work?

Chronic understaffing emerges as the predominant barrier, with participants describing excessive workloads, unsafe patient-to-staff ratios and the necessity to cover multiple roles. Responses suggest this forces employees to forgo breaks and perform duties beyond their training, directly compromising patient safety and the capacity for compassionate interaction. High patient acuity and volume exacerbate these pressures, creating time constraints that prioritise urgent clinical tasks over holistic support and meaningful communication.

Resource constraints significantly impede care delivery, characterised by outdated or insufficient equipment, stock shortages and inadequate physical environments including overcrowded wards. Feedback indicates that management failures frequently exacerbate these issues through perceived inaction, dismissive attitudes toward staff wellbeing and inconsistent leadership. Some respondents noted that professional development is impeded by budget cuts and role creep, where lower-banded staff perform advanced duties without appropriate remuneration or supervision.

The cumulative effect of these factors creates a reactive, high-stress environment where staff burnout is prevalent. Team dynamics suffer from poor collaboration, inconsistent handovers and instances of incivility, while communication breakdowns disrupt continuity of care. The overall tone leans heavily towards frustration and concern, with participants indicating that the convergence of workforce shortages, resource deficits and unsupportive management structures systematically compromises the delivery of safe, high-quality, and compassionate care.

Q13 - What actions would help improve outcomes and prevent trauma and harm at work?

Participants described adequate staffing levels as the predominant factor influencing outcomes and preventing harm, with consistent calls for increased numbers across all roles to ensure safe patient-to-staff ratios and mitigate burnout. Responses suggest that resourcing extends beyond headcount to include reliable equipment, sufficient bed spaces and functional working environments, such as maintained IT systems and basic necessities, which are essential for delivering unhurried, compassionate care. A recurring theme was the need for management practices to evolve, requiring visible leadership that actively listens to frontline concerns, addresses bullying and ensures follow-through on raised issues rather than maintaining disconnected, hierarchical structures.

Feedback indicates that staff wellbeing is prioritised through guaranteed breaks, flexible shift patterns and access to emotional support services, alongside the reduction of administrative burdens to allow clinical focus. Enhancing teamwork and communication involves standardising training, clarifying role expectations and fostering mutual respect to bridge divides between different staff groups. Some respondents noted the necessity of addressing systemic issues such as racism, sexism and financial constraints, alongside the need for government support and trauma-informed care approaches to manage patient expectations and reduce conflict.

The overall tone leans towards urgent advocacy for structural and cultural change, emphasising that a holistic approach combining safe staffing, empathetic leadership, robust training and adequate funding is essential. While specific operational improvements like reducing reliance on agency staff and optimising administrative tasks were highlighted, the feedback underscores that mitigating trauma and enhancing staff wellbeing requires addressing both immediate operational gaps and broader systemic challenges to deliver high-quality, person-centred services.

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