National Maternity and Neonatal Investigation

Sandwell and West Birmingham NHS Trust

Trust report

Note of acknowledgement

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

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

Introduction to Sandwell and West Birmingham NHS Trust

The National Maternity and Neonatal Investigation Team visited Sandwell and West Birmingham NHS Trust (from here on referred to as SWBH or the Trust) on 22 and 23 January 2026. The Trust has one site that delivers hospital-based maternity and neonatal services: Midland Metropolitan University Hospital.

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

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

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

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

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

Estate

The trust moved from City Hospital in Birmingham to Midland Metropolitan University Hospital, which opened in 2024.

Maternity services

The Trust's maternity services were rated as 'Requires Improvement' by the CQC in February 2026, unchanged from November 2024.

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

Activity and modes of delivery

Activity:

National published statistics

- In 2024/25, SWBH supported 7,120 births.

Statistics provided by the Trust

- In 2025/26, SWBH supported 5,615 births.

National published statistics

Modes of delivery:

- In February 2026, 43.1% of deliveries were by caesarean section, compared with 33.9% three years earlier in February 2023.
- In February 2026, labour was induced for 19.7% of deliveries, compared with 17.7% three years earlier in February 2023.

Statistics provided by the Trust

- In 2025/2026, 42.35% of deliveries were by caesarean section.
- In 2025/2026, 36.2% of labour was induced at Term plus seven.

Workforce

National published statistics

As of January 2026, the Trust employed:

- 206.3 full-time equivalent midwives.
- 59.4 full-time equivalent doctors working in obstetrics and gynaecology.

Statistics provided by the Trust

- 231 full-time equivalent midwives in 2025/2026.

There were an estimated 31.1 deliveries per midwife in SWBH in 2024/25, which is higher than the national average of 23.1. SWBH is in quintile 5 i.e. the top 20% of NHS trusts.

Neonatal services

The Trust's neonatal services were rated as 'Requires Improvement' by the CQC in February 2026, unchanged from November 2024.

Unit and care pathway

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

In 2024, babies were cared for in neonatal units for a total of 6,661 days of care, placing SWBH in the second-highest 20% of providers of neonatal care nationally.

Workforce

National published statistics

- As of January 2026, the neonatal service employed 60.5 full-time equivalent neonatal nurses.

Statistics provide by the Trust

- In 2025/2026, the neonatal service employed 70 full-time equivalent neonatal nurses, meeting the national target.

In the 12 months ending December 2025, 67.2% of neonatal nursing shifts were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

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

Experience and outcomes for maternity and neonatal services

In 2025, women reported worse than average experiences of care related to their labour and birth, and triage, assessment and evaluation at SWBH. The Trust was around average for the start of pregnancy, antenatal check-up, during pregnancy, staff caring for you, care in ward after birth, feeding your baby, and care at home after birth.

National published statistics

In the 12 months ending October 2025:

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) of 1.2 per 1,000 live births which was over 5% higher than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.0 per 1,000 births, comparable with similar trusts.

Statistics provided by the Trust

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) of 0.72 per 1,000 live births which was over 5% higher than the national average.
- A stabilised and adjusted stillbirth rate of 2.82 per 1,000 births, in line with the national average.

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

What families told us

The Investigation's engagement strategy has been underpinned by a Families First approach. 'Families First' originated as a key principle of the Hillsborough Independent Panel, and has been adopted in several subsequent investigations, including maternity investigations. We held two in-person family panels, and two one-to-one interviews with a family member, one in person and one virtually. One panel included seven families, and the other panel included eight families.

When visiting SWBH, the first thing we did was to hold family evidence panels in locations separate from the Trust's sites. We invited women, birthing people, fathers and partners[1] who received care from the Trust to share their experiences at the panels. Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences speak to the lasting impact of harm and bereavement on their lives and the lives of their loved ones. Families told us that they came forward as they did not want other families to go through the experiences that they did and they wanted to see long term change.

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

As we have heard across other site visits, families told us they were not believed, listened to, or taken seriously. Many families said their worries or fears were dismissed even when they raised clear concerns about pain, babies' movements, labour not progressing, or their health getting worse.

> *"It got to a stage when I said to the midwife, "I am going to tear out all these tubes and I'm literally going to walk out because I've had enough… I'm going to walk out because you're not listening to me. I'm telling you that I'm in pain"."*

Families described feeling powerless when trying to raise concerns or escalate care, with staff dismissing it as anxiety. Families told us how birth plans were ignored and women and birthing people were excluded from making choices about their care. We heard that

[1] This report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services identifies as a woman or mother. Further information on our approach to inclusive language and terminology is provided at Annex: Glossary

some families were sent home, left waiting, or told symptoms were “normal,” only for serious problems to occur later.

“I was just being ignored to the point that when I asked one of the midwives, is it normal because I was just trying to understand what's going on. So I just said... "Is it normal after the water breaks for the baby to move differently?" She just looked at me, and she just left the room”

In cases where families experienced harm or bereavement, we were told that responses afterwards were often brief and dismissive. We heard that families were not treated with compassion and did not receive apologies or explanations when things had gone wrong. Families told us that formal investigation and complaint processes were complicated, excluded family voices and decisions were made without family involvement.

“They hadn't read our complaint that we wrote about the whole treatment by the hospital... she didn’t know anything about me. She barely knew my name.”

The pressure and demand on services impacted how quickly families received care and the overall standard of care. As in other trusts we visited there was a lack of clarity about whether GPs or maternity assessment services are responsible for providing aspects of care whilst a woman is pregnant. For example, there appeared to be confusion over who should care for women and birthing people with minor medical conditions in the antenatal period such as colds or diarrhoea.

Families did not feel that maternity and neonatal services were sufficiently staffed to respond to emergencies, sudden deterioration in wellbeing, or baby loss at any time.

Families said that they experienced long waits for review or escalations when there was a problem. This caused fear about safety, especially when decisions were delayed or it was unclear who was responsible, particularly at night or at weekends.

“There was no consultant on site overnight. The registrar was doing other things on delivery suite...There are no appropriate clinicians on site qualified to give a specialist obstetric second opinion out of hours. We've now experienced that on a night, and we've experienced that on a bank holiday weekend”

While we heard some praise for bereavement services, some families stated support was limited to working hours rather than being round the clock, information was lacking on

how to get support, and there were delays to being able to use bereavement services. Junior or overstretched staff were sometimes left to manage complex or highly distressing situations without enough senior support.

"The midwives did their best, but they're not the specialists in bereavement, especially the ones on triage... [they] looked like rabbits caught in headlights, to have to deliver the news."

Families described how bereavement care was inconsistent and its staffing models did not match their needs. Families experienced delays in follow-up contact and counselling and often had to chase support themselves.

"We then had to go home again, and then...it wasn't till Monday that we had any specific bereavement care because the bereavement midwives work just office hours"

Women and birthing people described being placed on "standard" postnatal wards after their babies had died or after a traumatic birth. Being placed in a shared bay or noisy area with other babies increased their trauma and undermined emotional wellbeing and recovery.

"...and I was put up on the ward with everybody else, you know, crying babies and that, I thought I was going out of my mind"

As we have heard in other locations the estate, and how they are staffed, affected care experience. In SWBH a lack of ward clerk staffing meant that there was no one available to enable safe and timely entry to the unit. Security measures combined with delays answering intercoms meant women and birthing people had to wait outside the locked doors while unwell. Families described this as embarrassing and said it created a negative first impression.

"I wouldn't say it was traumatic, but it definitely wasn't nice because my trousers were all wet. I literally looked like I wee'd myself. I called the buzzer. The person just looked up at me, and then they made us wait like 5 or 10 minutes."

In addition to physical issues with the estate, some families described how information and digital systems were hard to use. Important information, such as test results, were uploaded onto electronic records without families being informed the information would

be there and some services, included bereavement, felt out of reach for women and birthing people not confident in navigating the system as it required a digital system to use it.

"I've gone to the bereavement suite and I've tried to reconnect with them but...have to be digitally literate to get access to that".

Families reported inconsistency in the quality of care they received at SWBH. They noted that their feelings of being safe and supported were dependent on which members of staff were attending to them and the service they were receiving. Families described the difference that staff could make in whether they felt protected or unsafe.

"...an amazing midwife came on board who I just felt like, you know what, this is the person I needed who was advocating for me. I absolutely trusted her. She helped me to give birth. She was just amazing. She came in and she took charge. I just felt like that's my person, that's my trusted person. She was just absolutely amazing - - So it's constant like this battle, this contrast of good care, excellent care versus really horrific care -- That kind of inconsistent care."

The care that families received was varied depending on their ethnicity or background. Some families said that their care would have been better if staff had not judged them or delivered care based on their race. A white family told us about witnessing an Asian family being treated differently and spoken down to by the same staff members who treated them with respect and kindness.

"Why are we being treated with one rule and, obviously, such disrespect shown to someone else? that needs to change."

Women and birthing people also felt judged about the decisions they had previously made, for example aspects of their birth plan.

"it was like now she is a criminal, saying, "You chose to have a vaginal birth, so it's your fault." "That's how we felt instead of supporting her for what she had gone through."

Women and birthing people also told us that they had to exaggerate the pain they were in to be listened to or be treated seriously.

"Whatever you feel, make it twice and three times worse, otherwise they don't believe you, they wouldn't believe you, they wouldn't give you a room".

"That's really sad; it shouldn't be like that. They should believe you when you say, "I'm feeling pain, I'm in pain".

What we saw and heard in Sandwell and West Birmingham NHS Trust

We spent two days at the SWBH including a full walkaround of all areas where maternity and neonatal services are delivered. Our team included a neonatologist, a midwife, and an obstetrician. Following concerns about racism raised in our first visit, we re-visited the site to speak with staff from minority ethnic backgrounds.

SWBH serves a very diverse community. Compared to the national average, the Trust provides services to more Asian and Black mothers, alongside a wide range of other backgrounds, cultures, and ethnicities. Some families live in some of the most deprived areas in England. Additionally, more women using the service have had previous caesarean sections affecting the likelihood of future caesarean sections. This means that the services must plan and deliver care that is suitable for families who may need more medical or social care during pregnancy, birth, and after birth such as translation services, details of how to use care and practical support getting to appointments.

We heard evidence of widespread racism and discrimination and even witnessed an incident of racism on our visit. During our staff evidence panels there was visible tension in how staff spoke to each other, causing distress amongst staff. Inequality and racist behaviour were sometimes spoken about casually as if it was part of the day-to-day at the Trust. We heard that the executive team were not always seen as visible or responsive to issues of racism and discrimination.

> *"I've been racially abused basically; I've made complaints formally. The trust hasn't acknowledged that."*

During the introductory meeting we noted that the executive team did not fully reflect the communities they serve, in terms of ethnicity, something they themselves referenced in senior interviews. Trust staff told us that the Trust did not know how to talk about racism and because of this, there was a culture of avoiding dealing with discriminatory behaviour rather than challenging it. While there are improvement strategies in place, such as a People Plan launched in 2022, the executive team lacked confidence that it addressed the root problems.

Staff told us they care for people with high clinical and social needs. This included socio-economic deprivation, safeguarding concerns and language needs. Some of the language used by staff suggested that women, birthing people and families using services were viewed as outsiders and as if they did not belong. People were spoken about as it they were to blame for the circumstances facing them. We heard and saw breakdowns in communication within and between maternity and neonatal teams. Many staff told us that they did not feel safe to speak up. They feared negative consequences and felt Human Resources advice and governance systems did not help with the investigation

and resolving of complaints. Staff described low morale, lack of mutual respect and behaviours that were sometimes described as bullying.

> *"I can see poor behaviours, and I think staff are not well-equipped with training to manage those poor behaviours properly, and I do not get adequate support from HR."*

The hospital had recently moved to a newly built facility, and the maternity estate was the newest we visited. It was modern, clean and welcoming with space and privacy for families. However, despite it being a new estate, this did not lead to consistently better care. Staff and families told us the layout was difficult and signage was poor. Views differed on whether the new site improved culture. Some saw it as an opportunity for a fresh start, while others felt poor culture and behaviours had moved from the old site to the new one. It was recognised that the move to a new building with new equipment on its own could not resolve the deeper problems in maternity and neonatal services at SWBH.

Most staff, however, spoke positively about the new estate, which they said helped them to provide care more smoothly. Patient flow had improved. It has rooms and good facilities which has improved the quality of the care they provide.

> *"Yes, it is a lot better in that respect, you've got rooms now we can walk in and nine times out of ten you'll have an observation sheet. You'll have a CTG machine that's ready. The rooms are lovely and well stocked"*

However, there were still some issues such as security systems creating delays. Locked doors, intercoms and limited ward clerk cover which meant parents were sometimes left waiting outside triage for long periods.

> *"And whilst it does fix some of the flow, it fixes some of the comfort, and it fixes some of the, you know, some of the operational day-to-day problems, it doesn't fix the people of, you know, that are working within it, the cultures, the processes, etc."*

An ex-employee contacted us to talk about their experiences of working in the maternity service at the Trust. They acknowledged that their experience had been before the Trust moved premises but commented that;

"...Attitude, you could nearly say kind of life was cheap. It was so many things went wrong that it was kind of a mixture of firefighting, understaffing, burnout, unsupported. That's why my great concern is to this very day that, it might be a swanky new hospital with a big airport hall, but I don't think the atmosphere has changed..."

What staff told us

During our visit to SWBH we met with the executive team and spoke to front line staff. We heard experiences of discriminatory treatment of staff from their colleagues and the challenges of providing care for a community with increasing social needs and clinical complexity. The executive team described plans to improve communication, services and support for families including work with faith groups and to increase understanding of practical support such as sim cards and signposts to food banks for families in need.

> *"They've actually just drawn up a sort of a little, we call it the Yellow Pages, of all the various places that our midwives can refer to for -- to offer our families support."*

Staff told us that culturally sensitive care was described as difficult to provide due to system pressures making it hard to meet the different needs of women, birthing people and families. The pressures were described as stemming from two main factors: rising demand and increasing medical and social complexity among those using the services. Many patients needed more time, support or follow up work such as safeguarding referrals.

> *"The community we serve here is so significantly different to anywhere else I've worked... ... We are overloaded, and I would almost use the word suffocated by the sheer volume"*

The executive team described these pressures as structural with the time needed to provide safe, personalised care no longer matching the staffing and funding available.

We observed some staff directing blame towards the women, birthing people and families they cared for.

> *"With the cultural belief and all those things, very much reticent for any intervention. Declining induction, declining caesarean section".*

Staff also told us that they witnessed their colleagues blaming poor outcomes on the women, birthing people and families they cared for.

> *"I've looked after many, many foetal growth restriction babies and they should not be dying at this rate because we are meant to be monitoring them and providing evidence level care for them... And they would constantly say, oh, it's not us, it's the demographics. Oh, it's the women,*

they're not coming. It's the capacity issues. It's we don't have the capacity to deal with these women in the way the guideline expects us to"

"...I also kept getting told it was because English wasn't their first language and because and because of their social circumstances."

Some staff recognised this was happening but didn't know what to do about it.

"I am saying the problem aloud, I don't have a solution for that. These are the means that we have tried now, giving them more time, trying to talk to them in their own language. Trying to give them information in their own language. I don't think we're still connecting to them the way we should connect. I don't know how to bridge that gap".

We heard from clinical staff who had left the organisation because they did not consider the service they were providing to be safe.

"There was not just me who said, look, this isn't safe. The midwives were up in arms. Especially those ward midwives who were totally out of their depths and totally understaffed. There was just, it just was physically impossible to keep safe."

There was particular concern about the way the service was organised how local guidelines had been developed and the impact this was having on high risk women, birthing people and babies. We heard from one clinician about established guidance for what to do when a baby had been identified as having a slow heart rate in labour.

"I then questioned that and said, so the guidelines are at 3 minutes, you call an obstetrician, at 6 minutes, you have tried all your conservative measures, at 9 minutes you move. So, what am I supposed to do at 9 minutes? And they were like, you stay in the room. And I said, well, and just watch the baby die. And they're like, well, that's what it is. And it's on the risk register and it's been identified and the trust is willing to take that risk."

When we shared this evidence with the Trust, it disputed there was a local guideline reflecting the described practice.

We also heard about a lack of availability of theatre staff after midday to respond in a timely way to escalating emergencies.

> *".....So there was the obstetric team present, but there wasn't a theatre space, a theatre team available for it. So that was, I guess, a funding issue, but that was also a cultural issue because they were willing to just take that risk."*

The investigation team was provided with a copy of the 2025 Risk Register for maternity and neonatal services, and this risk was listed on the register. The Trust subsequently confirmed to us that the issue of lack of theatre availability after 1pm had been resolved.

Another clinician also expressed concerns regarding how they had seen high risk pregnancies being managed.

> *"So high risk women with high-risk pregnancies being parked in a ...six bed bay, ... I don't think there was significantly more staff on that ward, which also had other antenatal patients that just wasn't safe ... I was really, really worried. Lo and behold, there was deaths on that ward..."*

We also heard from staff about what they considered to be financially motivated decisions. They stated that women and birthing people were prioritised for treatment from outside of the Trust's geographic boundary for financial reasons.

> *"And I found that really difficult ethically that we were doing this because we were not able to, we had to take them on and we were not able to provide service to our own women."*

We heard about a refusal to admit a woman with safeguarding needs who was in a potentially dangerous medical situation that could have got worse at any point. This was contrary to a clinical decision being made that the admission was required.

> *"So I asked for a bed and was blatantly told by the coordinator, "Nope, I haven't got one. Too bad, you're going to have to send her home."*

Staff who told us about these examples said that they had tried to raise concerns internally, without success and rather than continue working at the Trust they chose to leave.

> *"That's why I left. I just could not go to work and think I'm doing a good job and the women that I'm going to look after are going to have safe care."*

The investigation team witnessed a racist incident between staff during an interview at the site visit. After witnessing this racist behaviour between staff, we returned to the Trust to speak with staff from ethnic minority backgrounds at their request. They described unequal treatment and racism within the Trust. Internationally trained staff also described being treated differently, dismissed or looked down on.

> *"They will, kind of, just brush you off as if you don't even know what you are saying, you don't even know what you are doing... I've been doing this before for the past three years and some of them still don't see me as one of their own."*

The decision to set up a follow-up session resulted in distress for some Trust staff members because they felt that they had been left to explain to White colleagues why a separate panel for only ethnic minority staff was needed. They felt they should not have had to defend the need for a safe space in which to speak openly.

> *"I found that I had to justify why there was a need for this event which really was heartbreaking for me because these are my colleagues ... I found myself having to explain the need for a safe environment for us today to speak openly because there are certain conversations that we can't have."*

Across staff groups and the executive team, there was uncertainty about how to talk about racism and a culture that does not address it. In interviews and evidence panels we heard that the Trust lacks the confidence or approach needed to address these issues, allowing toxic behaviour to continue.

> *"I do think that is something we need more awareness and understanding of, and I would say that no-one feels comfortable talking about it because of these issues."*

Staff also described how SWBH was seen as a second-class unit by some people in the region. Neonatal staff said that the neonatal network regarded Sandwell as a "*disaster area*" and used phrases such as another "*Typical Sandwell Baby*" when babies were transferred out for ongoing care.

As in other trusts, maternity and neonatal services were described as not having enough staff for the level of activity, risk and complexity. Across maternity and neonatal services, teams reported being frequently short staffed, with one team reporting being six midwives short. This level of pressure was described as common. When staffing was stretched, we heard that care focused on "*just keeping it safe*," leaving little time for supporting women, babies and families. Missing breaks and working beyond contracted hours appears to have become normal across maternity and neonatal care in community and hospital settings. Midwives described coming to work expecting not to have a break "*98 per cent of the time*".

"We are short of midwives and medical staff consistently and persistently… Too often, we are left firefighting, trying to keep people safe rather than being able to provide the quality of care we know families deserve."

"Long term it affects our own health, doesn't it. We come to work, we're not eating, we're not going to the bathroom, you're not having any drinks, long term it's not helpful for the individual. But I think because we've done it for so long, it's almost become expected now."

Staff reported that high workloads and staff shortages made it harder to respond to safety concerns, complaints and family distress in the way in which they wanted. They felt that complaints and investigations outcomes were sometimes responded to too quickly and were focused on protecting reputation rather than on learning by involving staff in discussions about the changes needed.

"I can say probably there's a lot of kneejerk reactions to complaints, which again I appreciate you do need to react and you might need to make some changes, which is fine. But sometimes if you're just making a change overnight, it's not allowed time to filter down to the staff or to give them the background knowledge of why we're doing this and why we're making these changes and give them an opportunity to be involved in that change."

We were told that the executive team were not visible, and many staff felt that some members of the executive team were distant from day-to-day clinical work and did not understand the reality on the ground. Decisions about how to respond to incidents and concerns were seen as being shaped by worries over potential criticism, leaving staff feeling less supported and less safe to raise issues.

"I think they [the executive team] are very removed from the clinical area and what actually happens on the clinical…. on the floor, yeah. So often the plans and the ideas that they come with up here are…. they're just not realistic or…. they're just not part…. they haven't got those ideas from the floor. So it might be beneficial for them to come and see how we do things and what we do."

Some individual members of the executive team were spoken of positively by staff for their support and approach.

The executive team told us that the leadership and governance systems in SWBH were undergoing changes. Some improvements were said to be underway to address Trust wide issues such as communication breakdowns with patients, discriminatory behaviour, inequitable support for some patients or recurring safety concerns.

As in other trusts we visited, maternity and neonatal IT systems in SWBH were not integrated. This made information sharing between teams difficult and meant families often had to repeat what had happened to them. The executive team recognised digital exclusion as a concern. Heavy reliance on online communication was seen to disadvantage families without internet access, smartphones, or language support, adding to unequal treatment rather than reducing it.

"lots of our patients are not digitally literate…they haven't got a phone that will pick it up and they don't grasp that issue. I think that's a real problem because you know how deprived the area is, but also for so many of them English is not their first language, or they don't speak English at all."

What this means for families and services in Sandwell and West Birmingham NHS Trust

The evidence gathered during this Investigation presents a deeply concerning picture in SWBH. The Trust's neonatal mortality rate exceeds that of comparable Trusts by more than 5%.

The reports of high workloads and staff shortages were consistent with what we heard from across the country and the impacts on safety and patient experience were clearly reported to us. The concerns about service organisation and local guidelines had clear patient safety impacts for the whole community that SWBH serves.

Families at SWBH described consistent experiences of discriminatory treatment and unequal care based on their ethnicity. The pattern of evidence raises serious concerns about whether all families are receiving equivalent standards of care. Staff also reported witnessing or experiencing racist behaviour from colleagues within maternity and neonatal services. The attitudes and behaviours of staff towards one another can shape how care is delivered and received. Staff told us that being treated unfairly or feeling excluded made it harder to raise concerns about discriminatory and exclusionary behaviours. Poor team working without effective multi-disciplinary relationships impact the care of everyone in the service, especially in a discipline which relies on timely handover of patient information. Some felt their worries were ignored or played down, increasing the risk of problems not being escalated. The Investigation team regards racism and discrimination as a safety critical matter, whether this is experienced by women, birthing people and families or by staff.

Several families told us that they would not return to the Trust for future care. Avoidance of maternity and neonatal services can have serious consequences for the health and safety of those who need medical support and advice.

SWBH serves an area that is more deprived than 91% of neighbourhoods in England (based on the Index of Multiple Deprivation) and 28.9% of adults in Sandwell have no formal qualifications. Midwives told us families often asked for help with housing or for childcare advice because they struggled to navigate the support systems available to them. The executive team recognised the diversity of local communities and the workforce and had put in place strategies to reduce inequality and improve care. At the same time, the executive team told us they were unsure how well existing systems could identify, measure or address racial inequality. Whilst the executive team recognised the inequalities which persisted within the trust, they lacked confidence in how to tackle those inequalities consistently.

Some staff members expressed frustration in the system for not giving them the tools or time to work in a consistently compassionate way addressing the different needs of a diverse community. Staff described a culture in which some staff treated their peers badly and spoke about their patients as though they did not belong.

Families consistently described experiences of racism and discrimination while using maternity and neonatal services. Discriminatory care creates conditions in which concerns go unheard, warning signs are missed and families lose confidence in the services they depend upon. Staff too reported experiencing racism and discrimination from colleagues, pointing to cultural problems that are deeply embedded and which a change of location alone would not resolve. Clinical staff raised direct concerns about the safety of women, birthing people and babies in their care – these are concerns that this investigation takes seriously and that are reflected throughout our findings.

Taking the evidence we collected, we are concerned about safety for women, birthing people and babies at this Trust. Serious patient safety concerns were raised by credible individuals who had worked at this Trust. These concerns related to instances where harm had occurred. We did not have the opportunity during this Investigation to review these reported harms. However, we remain concerned about cultural issues, local procedures and how they impact on the safety of women, birthing people and babies in SWBH.

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How we gathered and analysed our evidence

How we gathered evidence

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

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

- Two family evidence panels with women, birthing people and families
- Interviews with two women, birthing people and families
- Four listening events across different staff groups and grades
- Interviews with 13 members of staff

- 31 additional pieces of information were sent to the Investigation email address which were submitted as evidence for Sandwell and West Birmingham NHS Trust.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by both the Maternity and Neonatal Voices Partnership (MNVP) lead for Birmingham and West Sandwell and through engaging with local third sector organisations and local MPs.

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

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

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

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

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

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

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

How we analysed the evidence gathered

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

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

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

National Maternity and Neonatal Investigation