National Maternity and Neonatal Investigation

Somerset NHS Foundation Trust

Trust report

Note of acknowledgement

We would like to thank the women, birthing people and families who came forward to share their experiences of maternity and neonatal services at Somerset NHS Foundation Trust 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 and evidence, and for their honesty and openness in interviews and panels.

Introduction to Somerset NHS Foundation Trust

The National Maternity and Neonatal Investigation team visited Somerset NHS Foundation Trust (from here on referred to as SFT or the Trust) on the 27 and 28 November 2025. SFT provides maternity and neonatal services at Musgrove Park Hospital in Taunton and Yeovil District Hospital.

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

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

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

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

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

Maternity services

The CQC carried out inspections at SFT hospitals in November 2023 and rated SFT's maternity services overall as 'Inadequate' (Musgrove Park Hospital and Yeovil District Hospital) and 'Requires Improvement' (Bridgwater Community Hospital). This was published in May 2024.

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

The Trust is currently part of NHS England's Maternity Neonatal Intensive Support Team. This programme provides extra support to those services identified by NHS England as requiring it.

Activity and modes of delivery

Activity:

- In 2024/25, SFT supported 4,400 births.

National published statistics

Modes of labour and delivery:

- In February 2026, 43.9% of deliveries were by caesarean section, compared with 30.0% three years earlier in February 2023.
- In February 2026, labour was induced for 24.6% of deliveries, compared with 33.3% three years earlier in February 2023.

Statistics provided by the Trust

Modes of labour and delivery:

- In February 2026, 50.2% of deliveries were by caesarean section, compared with 38.1% three years earlier in February 2023.
- In February 2026, labour was induced for 26.6% of deliveries, compared with 34.9% three years earlier in February 2023.

It is important to note that the transition to a new electronic record system in February 2023 occurred mid-reporting cycle, which impacts comparability of certain time periods.

Workforce

As of January 2026, the Trust employed:

- 212.9 full-time equivalent midwives.
- 57.8 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 18.8 which was much lower than the national figure of 23.1. Somerset is in quintile 1 i.e. the lowest 20% of NHS trusts.

Estates

The midwifery-led birthing centre at Bridgwater Community Hospital is currently closed to births due to staffing challenges. Yeovil District Hospital was temporarily closed to inpatient Maternity care and Neonatal care in May 2025 due to safety concerns and staffing pressures in children's services, including neonatal care. CQC reported that the paediatric service lacked enough qualified and experienced staff during its busiest times to meet people's needs. Inpatient services reopened in April 2026.

Neonatal services

Neonatal services have not been independently inspected by the CQC.

Unit and care pathway Musgrove Park Hospital operates as a Level 2 (Local 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.

Yeovil District Hospital operates a Level 1 Special Care Unit providing care for babies who do not need a high level of medical care. This could include giving babies additional oxygen, treating their low temperatures or supporting them with feeding. There are 39 Level 1 Units across the country.

National published statistics:

In 2024, babies were cared for in neonatal units for a total of 4,145 days of care, placing SFT in the second-lowest 20% of providers of neonatal care nationally.

Statistics provided by the Trust

Validated data from the South West Operational Delivery Network indicates that total care days are 5,348 (including Transitional Care).

Workforce

As of January 2026, the neonatal service employed 32.2 fulltime equivalent neonatal nurses. In the 12 months ending December 2025, 72.9% of neonatal nursing shifts at Musgrove Park Hospital were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

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

Experience and outcomes for maternity and neonatal services

In 2025, women's experience of feeding their baby was rated average as well as other areas of maternity care, including antenatal check-ups and pregnancy. Postnatal wards and labour and birth was rated somewhat better and better than average respectively.

In the 12 months ending October 2024:

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

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

What families told us

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

When visiting SFT the first thing we did was to hold two family engagement panels in a location separate from the Trust's site. We invited women, birthing people, fathers and partners[1] who received care from the Trust to share their experiences at the panels, and the second panel also included community organisations. Most of the families who spoke to us had experienced harm and many had experienced bereavement; their experiences are situated in the context of 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 didn't 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.

While many families received care from individual midwives, consultants, and bereavement staff who were kind and compassionate, these positive experiences sat within a service that is inconsistent, poorly coordinated, slow to respond and too often dismissive of their concerns.

Families did not feel listened to, were dismissed and not taken seriously even when they presented with warning signs. Families told us about making repeated phone calls to triage and raising concerns about reduced or absent foetal movements but were not asked to come in but instead told to wait an hour and see what happened.

"They're still being told, "Have a shower, go and have a rest, call us back in an hour if nothing has changed, have some food, have a cold drink". That's completely incorrect information; it can -- in the context of someone being in hospital while they're on a monitor,

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

they can do those things, but actually, in a rural county, that might lead to two, two-and-a-half-hour delays in someone going to the hospital."

One woman told us that she had been made to feel like she was going mad when she made repeated visits to triage and requested treatment because she was bleeding.

"I tried to fight for it and they just completely ignored me."

Families told us that they been treated differently and judged based on their race or ethnicity, impacting the care they are receiving, how their visitors and partners are treated and how staff react to a patients or partner requests for pain relief.

"We've actually heard on the ward many of the nurses and midwives calling Asian people, women, birthing people, "princesses", and it goes on and on".

"The dad was African, dad was away, and it was just the language and the assumptions that this African man had hundreds of kids"

In addition to being treated differently based on race, we also heard about how neurodivergences were not well understood and this led to patients struggling and their needs not being met.

"The staff on the ground did not understand why being in the NICU is difficult for someone with sensory processing difficulties… the breastfeeding each time stopped because of their experiences in the neonatal unit."

Families who suffered harm or a loss did not feel supported or treated as individuals by the Trust. Care dropped away quickly and there was little help provided in finding specialist counsellors. Some families were still sent antenatal appointment reminders after the death of their baby and fathers and partners were largely overlooked for counselling support, despite witnessing traumatic events and carrying their own grief.

"You [partner] had to witness all of it and there was no support for you. I kept worrying about him and I kept being told, you are the one going through it. I'm like, but there's no one supporting him."

Communication between staff and parents was highlighted as a problem by families. Explanations given were complicated and rushed without consideration of whether families understood the complex information they were being given about diagnoses or abnormal scan findings.

One family whose baby spent time on the neonatal unit highlighted the lack of communication to parents.

"They should be introducing themselves, saying what they're doing and why they're doing it, and it would've made the whole experience less traumatic."

Families described patient notes that were filled in inconsistently and sometimes were missing pieces of key information such as when drugs had been administered or earlier visits to triage.

We heard that some women with high-risk pregnancies, who were told they were on consultant-led care, never saw a consultant, dealing instead with community midwives, triage staff or resident doctors (most of the resident obstetric doctors at Yeovil District Hospital were non-training grade doctors). We heard that they were not well supported by consultants at Yeovil District Hospital prior to its closure. This led to families feeling anxious and as if their care was not important.

When families were involved in formal investigations or complaints, due to harm or bereavement, their experiences were mixed. Some families had to go through legal processes to even have a meeting with staff in maternity services. Others were not given clear explanations about what had happened to them or their baby and had to carry out their own research online to try to figure out what had happened.

"Literally hours after losing my son, I'm sat in the bereavement room, obviously scared like hell because I've just lost my son and I'm there on my phone. I know Google's the worst place [to Google.] I know it is. But when you go on the NHS website and on the NHS website, they tell you, oh yeah, you're at risk of potential

eruptions and things like that. But none of the team had warned us about it. We weren't warned. It was just, it was horrendous."

Others felt the Trust were defensive and unwilling to acknowledge mistakes and apologise.

"They do not want to admit mistakes because they're frightened that somebody's going to go and sue them or they're going to end up being viewed negatively. Whereas if they actually owned their mistakes or were genuinely sorry and didn't try and palm you off, you will not be in these predicaments."

Other families described positive experiences of investigations and felt the governance team did all they could to gather as much information about their case as possible.

All families supported by the Maternity and Neonatal Independent Senior Advocate (MNISA) for Somerset ICB described how valuable this support had been and lamented the withdrawal of the role, following a national decision to withdraw the role across Trusts.

The physical estates at Somerset also shaped families' experiences. Most care took place in shared clinical areas where space was limited. The environment was noisy, with visitors, monitors and other patients, impacting how well a woman could recover. Additionally, the lack of space meant that private, sensitive conversations were taking place in earshot of other patients.

"We were in the transitional care bay: it was totally overcrowded... I was overhearing lots of confidential conversations with Social Services. The only way to actually even have [name] next to me was to be encroaching, pushing into the curtain of the next bay with the bed."

Families felt that their care was shaped more by available space rather than clinical or emotional need.

"We weren't on the bereavement suite because somebody else had it... it felt like we were very much in the way. Like we were just kind of, they just wanted to get rid of us really."

We also heard from families about staff who were kind and compassionate which made them feel valued. One couple described their experience being cared for by the maternity bereavement team when their baby was stillborn.

"Overall we were met with the most outstanding love and compassion... It felt really person-centred to me. I had a lot of hugs and kisses, which I can not get enough of. I was at my most vulnerable and that was met. Sometimes you do not really expect it to be met in some situations, and it was."

What we saw and heard in Somerset

The National Maternity and Neonatal team spent two days at Musgrove Park and one day at Yeovil District Hospital, including a walkaround of all areas where maternity and neonatal care are delivered, meeting with the executive team, and conducting staff panels and interviews with individual staff. The Investigation team in attendance included a neonatologist, an obstetrician and a midwife.

The size and type of area that the Trust covers are challenging, with some women and birthing people being based in rural locations and having to travel significant distances for appointments from areas with limited public transport options. The community that Somerset serves is predominantly white and has somewhat fewer families living in the most deprived areas. The community also has higher rates of smoking in early pregnancy compared to the national average. The higher rate of smoking in pregnancy means care needs to include smoking cessation plans.

At Musgrove Park Hospital, we met committed, hard-working staff who were having to work in the most challenging estate of all the trusts we visited. A post-war building not designed for current patient volumes or complexity of care. At the same time staff were managing heavy workloads and dealing with staff shortages. However, we also heard evidence of poor culture within and across teams, including racism and bullying. The range of problems discussed during staff evidence panels led to us to having to pause two of our panels after several attendees broke down in tears. Staff we spoke with at this Trust demonstrated significant emotional distress, more than any other Trust we visited. The main source of this distress was their concern for patient safety.

The Estate

The estate at Musgrove Park presents a significant challenge to providing safe, dignified and compassionate care and there was clear concern about how this was affecting women, birthing people and families. Many parts of the estate at Musgrove Park are old and not designed to deliver twenty-first century care. There were leaking roofs, poor temperature control with rooms often too hot or too cold, and the ceiling of the antenatal ward was propped up by metal poles.

"They include the weather report in their handover on labour ward because they have to be ready for heavy rain because of the numerous leaks".

The space inside the estate is cramped, even more so during the temporary closure of the Yeovil District Hospital site, and care is mainly delivered in shared areas where staff have limited space to have private conversations. Long corridors and isolated areas were also

raised by staff as risks that could delay support in emergencies and left staff feeling unsafe and unsupported.

These issues directly relate to challenges to patient care and safety risks. For example, the cramped neonatal unit is a barrier to delivery of Family Integrated Care, a model of neonatal care which promotes a culture of partnership between families and staff.

Room closures are adding pressure to a site that is already working beyond capacity with cramped conditions for women and birthing people. The temperature of the estates are also risks for neonatal babies who are very sensitive to hot or cold conditions.

> *"You go to walk from the neonatal unit to maternity, and the roof is leaking. You got to look after a baby that is premature, that you do not want to become hypoglycaemic, you've got a hat on, you're trying to manage it, and the estates are cold."*

Staff described how two recovery rooms on the labour ward could not be used during poor weather and had to be taken out of use when it rained, increasing pressure on accommodation even further.

We saw a large operating theatre for caesarean sections within the maternity unit at Musgrove Park Hospital. A much smaller procedure room, opening out onto the general ward area, was used as a second operating theatre for elective caesarean sections. The only double doors to the theatre opened directly onto the main delivery suite corridor used by women, visitors and staff. Due to this arrangement, it was not possible to have an 'exclusion' zone around the procedure room doors which would protect privacy and support infection control. The procedure room had basic equipment but lacked many of the facilities expected in an operating theatre.

The triage service had moved following the Yeovil District Hospital closure and, at the time of our visit, was in a former antenatal clinic at the Trust, with single rooms available for women and birthing people. We were told that the triage service could not stay in the private medical facility and at the time of our visit, it was not clear where it would be moving to. We did see the previous facilities for triage which were clearly unsuitable for the requirements of women and birthing people using the service and staff working in it.

The bereavement facilities were sited opposite the male changing rooms and beside a storage area, far from the other maternity areas. This made families feel *"shut away"*.

The executive team recognised the estate challenges that front-line staff were working in and the risk of not relocating services to a better suited site is identified on the Trust's risk register.

The hospital is in the national New Hospital Programme, but its expected construction start date has been delayed until at least 2033, as a result of national programme decisions. The Trust is also exploring other options including whether maternity and paediatrics services, could be separated from the rest of the rebuild programme to enable work to begin earlier

Yeovil District Hospital's inpatient maternity and neonatal services were closed at the time of our visit due to safety concerns. The Trust's risk register of December 2025 did not identify any issues regarding the structure, age or layout of the facilities.

What staff told us

We met with the executive team and discussed the pressures the Trust are experiencing. This included the temporary closure of the Yeovil District Hospital and the impact this was having on staff morale because of the increase in patients at Musgrove Park Hospital.

We held five staff evidence panels that included clinical staff from different disciplines and interviewed 13 members of staff individually. We also had contact with two whistleblowers who provided the Investigation team with information about their concerns about the Trust and the lack of action when they had raised serious issues. From these different sources we heard about sustained workforce pressures, ongoing concerns about safety, the poor quality of the estate and long standing challenging cultural issues across teams at the Trust. We also heard that the executive team were aware of these long-standing cultural issues but had struggled to deal with them.

Staff were aware of the concerns that families had about how busy and rushed services were at the Trust. We were told that increased demands on the service meant that even when staffing levels are at full capacity, families are not consistently receiving personalised, compassionate care despite staff's best efforts.

The increased capacity demands on the service means that there are delays when women need to move between services and wards. This creates pressures in the postnatal wards and in the community team. One staff member described the postnatal ward as *"a cattle market"*, with the pressure leading to women and birthing people leaving the ward sooner than staff would have liked, which then creates additional work for the community team who need to conduct more home visits.

Issues with the estate at Musgrove Park were heightened when we visited due to the closure of Yeovil District Hospital's maternity and neonatal services. This increased the number of patients at Musgrove Park despite the estate already being cramped and struggling to deliver care in appropriate settings.

"With the recent closure of the [Yeovil] site, we have experienced a massive increase in demand of women using our services. We've reshuffled as best we can, but we can only polish the building that we've got, which is a 1952 building."

The service pressures are leading to staff burnout. Staff told us how long-term sickness was a problem, with some staff needing time off due to work-related stress and anxiety. One staff member, who had left the Trust and later returned, told us that morale had

noticeably decreased while she was away. Maternity units were *"almost always"* not fully staffed and midwives routinely missed breaks.

> *"I find midwives in tears or support workers in tears because they have not had a break, they have not been able to go to the loo when they needed to go."*
>
> *"What we hear from women, what we hear from feedback when we talk to service users about people who've been involved in safety events, what comes up all the time is they're not listened to. And I think that that is, you know, they're not listened to because as much as we want to, we do not have the time."*

There are initiatives in place to improve staff wellbeing such as wellbeing champions and a midwifery advocacy service, but staff told us this was *"fledgling"* as staff had not been given dedicated time to run it.

> *"We are struggling to get it off the ground because we are not being given time above our substantive posts. We're expected to do it within our substantive roles."*

In addition to staff burnout, there are inconsistencies in how well teams work together across the Trust, impacting both multidisciplinary team working and individual staff. Some teams spoke positively about how well they worked together and supported each other as a team. Staff described the neonatal unit at Musgrove Park as having a team ethos, with consultants, nursing staff, Advanced Nurse Practitioners and Allied Health Professionals working together effectively.

However, there were tensions between teams and a sense that some lacked understanding about the pressures facing some teams. We heard about the unwillingness of some staff to work flexibly across sites, of services and teams focusing on their own workloads and not what the whole service and women and families needed.

> *"There's a definite... divide of how areas view each other's workload, their expectations of what that ward area should be able*

to help them do and overall a lack of willingness ...and a resistance to go and help where the workload is heaviest."

While Yeovil District Hospital was closed, staff were relocated to work at Musgrove Park Hospital. However, we were told that a group of obstetric consultants from Yeovil District Hospital chose not to relocate. As a result, none of them had delivered any inpatient maternity care during this period. In recognition of this the lead obstetrician from the Maternity Safety Support Programme had prepared a programme of return to practice for obstetric inpatient treatment. Staff had continued to keep up their Prompt training, foetal monitoring training, obstetric emergency days and had continued to run antenatal clinics. Return to practice days for all consultants were also scheduled prior to reopening.

Prior to Yeovil District Hospital's closure, midwives felt unsupported by medical staff. Staff on the neonatal unit felt they had *"zero back-up"*. One requested the support of a paediatric resident doctor, previously known as a registrar, to help with an emergency situation and was met with questions about why they were needed rather than being trusted to have made the right judgment call.

"You know, at the time of the emergency, I got called out of that emergency to talk to those reg [Registrar], rather than having that respect or kind of trust that actually I'm calling them for a bloody good reason."

We also heard concerns about medical cover, with consultants at Yeovil District Hospital being on call 24/7 for a week at a time, an arrangement known as *"hot weeks"*. Consultants were told to switch their working pattern to four days on and three days off. One staff member told us that this was unpopular with some consultants who wished to remain working seven days, despite potential risks to patient safety.

We heard about incidents of exclusionary and racist behaviour, with one staff member being told they were *"the diversity hire"*. We also heard of staff being afraid to speak up:

"Many doctors have been just bullied out if they try to challenge or the working environment just becomes so difficult that people just leave."

The Investigation team requested a set of documents from each Trust that we visited. One of the pieces of information we requested were Freedom to Speak Up reports. For

this Trust there were 34 Freedom to Speak Up reports between 22/12/2023 and 27/10/2025, relating to maternity and neonatal services. These covered such issues as patient safety, allegations of bullying, sexism, racism and poor professional relationships between staff.

The executive team acknowledged the cultural issues of concern in some teams and, in preparing for Yeovil District Hospital's reopening, had set up a workstream on culture. The Trust had also produced a Behaviour Charter for obstetric and paediatric consultants at Yeovil District Hospital to adhere to. However, staff groups criticised the executive team for tolerating the poor behaviour and not tackling it.

"I think it's been unmanaged for quite a long time, although recognised for a long time."

When we visited the Trust in November 2025, Yeovil District Hospital's inpatient maternity services had been closed since May 2025 due to concerns about the safety, quality and fragility of the paediatric service. The hospital could not safely care for newborn babies who required additional care**.** We heard from tearful staff who told us that they were concerned about maternity services reopening, due to their experiences prior to closure.

"We've all raised our concerns, and I do feel like, as I mentioned before, we get to a certain level and then no one listens above. And I worry about that."

When we discussed staff concerns with members of the executive team, they acknowledged these concerns and said they had taken action to address the issues raised by staff.

Across the Trust we heard about efforts to improve learning after incidents. As part of a new programme introduced by the Trust, under a Chief Registrar-led programme, a dedicated doctor spends one day a week running quality improvement and leadership work. This includes training staff on 'Team Immediate Needs' debriefs to support staff wellbeing, and huddles to review learning. In the past staff had struggled to find the time to review events but those involved so far were positive about the new approach.

"People like having the opportunity to get the team together after these stressful events. Knowing where they can get more support

and there's a lot more learning to be identified from talking about an event as soon as it happened."

What this means for families and services in Somerset NHS Foundation Trust

The size of SFT's geographical reach means that it manages multiple hospitals, with some areas being relatively remote. It is challenging to consolidate services as commissioning responsibility sits with NHS Somerset ICB. Service configuration therefore cannot be changed individually by the Trust.

In Somerset, these issues are compounded by the poor state of the estate of maternity and neonatal services at Musgrove Park's Hospital. Its age and layout do not facilitate the delivery of quality, compassionate care. Families have little privacy and staff have extra challenges to navigate in what is already a high-pressured service. While there have been improvements, such as the installation of air conditioning to regulate temperatures, the overall quality of the building does not support the delivery of high-quality, safe care.

Some teams work well together and give each other motivational support, but this is not always the case, with concerns about limited support from medical staff at Yeovil District Hospital in particular. Since our visit, Yeovil District Hospital reopened in April and the Trust has appointed five additional paediatric consultants, expanding rota coverage and aligning with national standards. We have not revisited Yeovil District Hospital since it opened. However, from the evidence we collected during our visits and the concerns expressed by staff, we remain concerned about patient safety at Yeovil District Hospital. We are not convinced that actions taken to address the CQC concerns around insufficient paediatric consultant staffing will provide the necessary expertise to delivery neonatal emergency cover.

We are troubled by the fact that a group of obstetric consultants refused to provide services at Musgrove Park Hospital during Yeovil District Hospital's period of closure. We were not convinced by the explanation that these staff maintained clinical skills during the closure of Yeovil District Hospital. We are also concerned about whether the cultural problems that previously existed have been resolved, particularly given the disengagement of this group.

We also heard from staff at Musgrove Park about longstanding cultural issues. We do, however, recognise that the temporary relocation of many of Yeovil District Hospital's staff to Musgrove Park has enabled staff from both sites to experienced different ways of working, which may go some way to challenging some of the cultural issues that existed previously. Now that Yeovil District Hospital has reopened, we hope that the positive learning some staff experienced from working at Musgrove Park can be built on going forward at both sites. Overall, to achieve the consistently safe care which SFT is striving for. Long-term solutions to estate, staffing, cultural and leadership challenges are required.

How we gathered and analysed our evidence

How we gathered evidence

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

- Trust documents and data reviewed:
    - Quality Committee (or equivalent) minutes
    - Finance Committee minutes
    - All maternity and neonatal performance and service data that goes to the Trust Board
    - Any CQC warning notices or other formal or informal actions related to maternity and neonatal services
    - Complaint documentation relating to maternity and neonatal services
    - Any Freedom of Information requests received by Trusts in relation to maternity and neonatal services
    - Patient Safety Incident Investigations Reports (PSII) related to maternity and neonatal services
    - Patient Safety Incident Response Plan
    - Maternity and Newborn Safety Investigation (MNSI) data
    - Maternity Safety Support Programme (MSSP) documentation reports
    - ICB performance reports
    - NHS Resolution reports and activity
    - Improvement strategies for Maternity and Neonatal Services
    - Maternity and Neonatal risk register
    - Staff disciplinary data
    - Freedom to speak up occurrences
    - Prevention of Future Death Reports
- Three family evidence panels with women, birthing people and families
- Six listening events across different staff groups and grades
- Interviews with 15 members of staff
- Two additional pieces of information were sent to the Investigation email box which were submitted as evidence for Somerset NHS Foundation Trust.

The listening events with women and families were supported in the recruitment and promotion of them, by both the Maternity and Neonatal Voices Partnership (MNVP) Lead for Somerset and the Maternity and Neonatal Independent Senior Advocate (MNISA) for Somerset ICB. In addition to these activities, a further virtual engagement panel was convened to broaden participation. To ensure widespread involvement, local third sector organisations, local MPs and the Yeovil local Sands support group were approached to help promote the events and support recruitment.

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