National Maternity and Neonatal Investigation

East Kent Hospitals University 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 East Kent Hospitals with us. By sharing their experiences, families relived deeply painful and traumatic events in their lives, and we are grateful for them for their preparedness to do so. From the outset we have put the voices of women and families at the heart of this Investigation, and that is why our visits to Trusts carried out family evidence panels separate from trust premises.

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

Introduction to East Kent Hospitals University Foundation Trust

We visited East Kent Hospitals University Foundation Trust (from here on referred to as EKHUFT or the Trust) on 11 and 12 November 2025 and again on 25 and 26 February 2026. EKHUFT has two sites: Queen Elizabeth the Queen Mother Hospital and William Harvey 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.

In selecting Trusts to investigate, the Investigation aimed to capture learning from a wide range of provision and experiences, to ensure that findings would be relevant across the system. Trusts were therefore chosen to reflect a variation in case mix, trust type, geographic and demographic coverage. The Investigation also wanted to visit Trusts to follow up on the implementation and the sustainability of implementation of recommendations including those published in 'Reading the Signals', the report following an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

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 Trust's maternity services were rated 'Good' at both the Queen Elizabeth the Queen Mother Hospital and William Harvey Hospital sites by the CQC in May 2025.

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:

- In 2024/25, EKHUFT supported 5,775 births

Modes of delivery:

- In February 2026, 46.8% of deliveries were by caesarean section, compared with 39.2% three years earlier in February 2023.
- In February 2026, labour was induced for 28.6% of deliveries, compared with 40.5% three years earlier in February 2023.

Workforce

National published statistics

As of January 2026, the Trust employed:

- 272.6 full-time equivalent midwives.
- 84.6 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 24.0 which is higher than the national figure of 23.1. EKHUFT is in quintile 4 i.e. the second-highest 20% of NHS trusts.

Statistics provided by the Trust

- 281.44 whole time equivalent midwives (no dates provided by the Trust).
- 88.23 whole-time equivalent doctors working in obstetrics and gynaecology (no dates provided by the Trust).

Unit and care pathway

EKHUFT has a Level 3 Neonatal Intensive Care Unit (NICU) at William Harvey Hospital and a Level 1 Special Care Baby Unit (SCBU) at Queen Elizabeth the Queen Mother Hospital (QEQM).

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

A Level 1 SCBU provides 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.

In 2024, babies were cared for in neonatal units for a total of 6,393 days of care, placing EKHUFT in the second-highest 20% of providers of neonatal care nationally.

Workforce

In the 12 months ending December 2025, 96.0% of neonatal nursing shifts at William Harvey Hospital and 86.3% at QEQM were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

An explanation of neonatal staffing guidelines and service specifications can be found in the appendices on Annex 2: Glossary.

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences were rated around average for the start of their pregnancy, antenatal check-ups, their labour and birth, care in the ward after birth and feeding their baby, for their care during pregnancy and at home after birth, for staff caring for them, for triage: assessment and evaluation, and for complaints.

National published statistics

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 2.2 per 1,000 live births, higher than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.4 per 1,000 births, comparable with similar trusts.

Statistics provided by the Trust

Between January and December 2024:

- A neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) of 1.9 per 1,000 live births, compared to a local 2010 rate of 1.77 per 1,000.
- A stillbirth rate of 2.04 per 1,000 births, compared to a local 2010 of 5.7 per 1,000.

Overall, these figures show a busy service caring for babies with very complex needs.

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.

Reading the signals: report of the independent investigation

In October 2022, '*Reading the Signals*' was published. This followed an independent investigation into the maternity and neonatal services in EKHUFT led by Dr Bill Kirkup.

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 EKHUFT, the first thing the Investigation did was to hold family panels in locations separate from the Trust's sites. We invited women and birthing people, fathers and partners[1] who received care from the Trust to share their experiences at the panels.

Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences 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 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.

Whilst every family's experience is unique, the family panel sessions highlighted issues which we saw and heard about across a range of trusts.

Families described care marked by missed warning signs, delayed interventions, poor risk assessment and inadequate monitoring. These included repeated examples of women and birthing people reporting concerns and opportunities for escalation that were missed. Families described feeling powerless and ignored when asking for help and spending time fighting to get their baby's or their own symptoms discussed despite knowing something was wrong.

[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 in the Annex: Glossary.

"There were five red flags that [my relative] should have been sent in for monitoring… 'Had [name] been sent in on the Monday… what would have happened?'… Would he be alive?' 'Yes, he would.'"

Families felt that they were not listened to, that they were moved on quickly or that their interactions with staff were rushed. Several families said that they were not listened to even when they raised clear concerns about their bodies, symptoms or labour. There were individuals who demonstrated kindness and compassion, but families recognised that took exceptional personal effort from the staff member who had to find that time while balancing a heavy workload.

Families often described not understanding what was happening during their care, labour or while their baby was receiving neonatal care. They felt that there were not proper explanations of what was happening, or what the next steps would be. This left families with unanswered questions heightening their stress.

"Nobody ever had a conversation with me… I didn't really know."

Records were not detailed or shared consistently amongst staff groups which meant that families had to repeat information or explain their clinical history again.

In some cases where families escalated concerns formally after difficult experiences, they described the organisational response as challenging and hard to understand. During formal complaint processes, some families were told by the Trust that their notes had been lost and when they raised questions, they were met with barriers or responses that made it hard to pursue their concerns further. The process didn't give families clarity and gave the impression that things were being covered up.

"To this day, I think, are they trying to almost, I felt like it was just a cover-up. Like, "Don't look here, there's nothing to see because we've done everything right"."

For families who suffered losses, they described the bereavement support as patchy and delayed. Whilst some individual staff members were praised for their kindness and compassion, bereavement support and wider counselling were described as hard to use, inflexible and often retraumatising.

"The bereavement team were good. The NHS counselling service was beyond shocking, they wanted to do it online or for [name] to go back

into the Hospital B and meet her in the maternity suite. Do you think she ever wants to go near there again? No, she doesn't."

The physical locations in which families were given care also impacted upon their experiences. Families felt that they were put into any spaces available by staff members, not because of a lack of compassion but because there were no other options. There were limited quiet spaces for difficult conversations which meant that families felt exposed in some of their most difficult moments. Bereaved families also spoke about how being able to hear other babies being born following their own loss intensified their distress and trauma.

Additionally, the layout of the maternity wards meant that some families were treated in side rooms that were located far away from the main nursing stations. These spaces were physically isolating and families found it hard to speak to staff to share concerns.

"In the end, I got moved because they were too busy on the labour ward, so I got moved to the side room in Ward B, right around the corner, where no one sees you."

Change over time

Following the '*Reading the Signals*' report there are mixed views on whether the report has made any difference in the care families are experiencing. Some families had no confidence that there had been any change, and that the report "*might as well never have happened*". Others recognised that some processes or polices had changed but felt that these were fragmented and were often superficial and reactive rather than aimed at delivering long time change.

"I do think that even since the Kirkup, positive things have come about in the Trust, and that's so important, and I do think it should be recognised. But equally, there's still evidence of areas where they need to do better, and there's still evidence of families being harmed."

What we saw and heard in EKHUFT

The Maternity and Neonatal team spent three days at EKHUFT, visiting both the William Harvey Hospital in Ashford and the Queen Elizabeth the Queen Mother Hospital in Margate. The visit included a full walkaround of all areas where maternity and neonatal care are delivered. On our initial visit we saw the maternity services with an obstetrician from the Investigation team. We visited the trust a second time with a neonatologist.

The community that EKHUFT serves are more likely to smoke in early pregnancy, be aged under 20 and to have had a previous caesarean section or sections. Given the wider socio-economic challenges in East Kent services need to be closely aligned with public health initiatives and proactively work with women to offer support and signposting to services such as smoking cessation. Additionally, care plans need to include risks associated with obesity and smoking during pregnancy.

During our visit to EKHUFT, we met with the executive team who described the transformation plan they have put in place since the 2022 '*Reading the Signals'* report and the changes that the trust has undergone.

We saw staff across maternity services who were motivated and positive about the changes that they felt had been implemented since 2022. The midwifery team described the improvements that had been made to the culture under the leadership of the Director and Deputy Director of Midwifery who had been appointed following the publication of '*Reading the Signals*'. Staff described improvements in managerial visibility and team cohesion as well as robust processes for incident investigation.

The maternity units at both sites were clutter free with clear signage and visible infection prevention measures such as hand gel and sinks. The bereavement room at the QEQM has been relocated down from the labour ward, meaning it can be entered and exited via the main hospital, rather than through the maternity department. The midwifery led birth unit was spacious and was easily entered via a double door. All rooms are large with en-suite bathrooms and two rooms have pools.

We revisited both hospitals at EKHUFT with a focus on their neonatal services following concerns raised by staff members. As with maternity, the neonatal units at both sites had clear signage and visible infection prevention measures.

On this second visit, we were told that collaboration between neonatal and maternity services was limited and the strong maternity leadership described by staff on our first visit was not replicated in neonatal services. We also heard concerns about poor working relationships between medical and nursing staff and a lack of support from the executive team. On speaking to Trust leadership, it was clear that they are aware of the issues and they reported ongoing development work to improve team working and culture.

Across maternity and neonatal services, many areas of the estate were light and welcoming, with murals and with noticeboards and information designed to support

women and families. However, the estate is old with small rooms and inadequate space. In the consultant-led delivery unit at William Harvey Hospital, screens are placed across doorways to create privacy for assisted vaginal births and in the neonatal unit there was limited space around cots.

During both visits, staff raised concerns about fragmented IT systems, the outdated estate and equipment and resource shortages which can impact care. The Trust advised us that there is a medical equipment replacement strategy in place to address these issues.

"We've not been able to offer telemetry… for months… because the equipment is out of date… women are losing out"

More broadly staff also raised the need for continued investment in maternity services to sustain the improvements made, for example, appointments to specialist midwifery roles.

What staff told us

During our visit to EKHUFT, in addition to meeting with the executive team, we also spoke with front line staff who told us about practical issues, such as estates and IT systems, which made their day-to-day working lives more challenging. There were mixed responses from staff about staff morale, team working and how the service was performing since the publication of *'Reading the Signals'*.

On our initial visit we heard from midwifery staff that morale had improved significantly since 2022, and we heard about the importance of staff being included and engaged with the change process.

> *"Now that the staff feel kind of included in... the governance things and being able to contribute to guidelines, there's been a massive shift. Like now I'm really, really hopeful and I feel really confident that this trust is massively improving and I'm excited to see what the future holds as well."*

Staff spoke positively about the capability and visibility of maternity leadership as well as about some of the initiatives that had been introduced, such as a phone call to all patients at six weeks following birth. Midwifery staff told us that from their perspective the investigatory approach had also improved and they felt that this was no longer something to fear.

> *"Historically, knowing that you were going to be involved in an investigation was pretty terrifying. You were scared that you might not keep your job, that you may get the blame for the stuff that happened... we now include rapid review... we'll be encouraged and see that the process is fair. That people aren't judged."*

Staff told us that the current leadership of the Trust had created an atmosphere where concerns are more likely to be raised internally, with staff describing how issues that might previously have escalated externally, were now being addressed within the organisation. We heard that senior clinical staff were routinely involved in reviewing events and complaints. However, staff acknowledged that the volume of reporting requirements and investigations can add pressure to already stretched services.

Some neonatology staff were less positive about leadership, team cohesion and change. They felt that neonatal services are often *"lumped in"* with maternity services but felt that neonatal services have not been properly recognised in the response to the *'Reading the Signals'* report, the Trust's Maternity and Neonatal Improvement Programme.

"It's the maternity and neonatal improvement plan. I have no idea which bit of the improvement plan is for neonatal and what we've seen of that."

We heard from neonatal staff who felt ignored by the executive team and about high rates of staff sickness due to stress and problems with staff retention. Staff described tensions in how some teams worked together, for example some staff felt the relationship between medical and nursing colleagues was difficult with some poor behaviours. The relationship between neonatal nursing and maternity teams was viewed more positively.

"Because we're a very large care group and I think there are things that get imposed on us by the senior management and we have to just abide. If you raise or question, it just doesn't get listened [to]."

"Staff sickness is increasing because of the stress load on the staff. People are leaving."

Staff talked about demand and capacity as central pressures shaping maternity and neonatal services at EKHUFT. This was driven not only by the number of women and birthing people using maternity services but also by the care they require becoming more complex. Staff emphasised that women and birthing people are "*becoming older, they're becoming sicker*" and often need "*to be an inpatient for longer and longer*," with the result that "*we do not have the capacity*." This was described as having real operational consequences, with services needing to transfer women and birthing people between hospitals or frequently have "*mutual aid calls*" with nearby trusts to discuss issues.

Staffing pressures were described as one of the biggest pressures affecting staff's ability to give safe, kind and responsive care to patients. They told us that although staffing has got better in recent years, it was still challenging.

"It's not very often you come in and we're fully staffed and the acuity is okay."

In neonatal services, some staff described more specific concerns about safe staffing, particularly at the Queen Elizabeth the Queen Mother Hospital in Margate. In this unit, we heard that staffing was reduced when sickness, maternity leave and training were not backfilled. They described how a small unit that usually worked with three staff could be left with two and to them this did not always feel safe. In response to raising these concerns with the Trust we were advised that these levels met national guidance.

> *"It doesn't make it safe, practical or fair for the families or the babies to work with two [nurses]."*

Staff explained that the Trust serves a coastal community with high levels of deprivation, and this shapes how families engage with maternity services. Staff highlighted that these inequalities are creating additional pressure on services and requiring more targeted approaches to care. Staff also described a lack of trust in healthcare services among some communities, particularly following the COVID-19 pandemic and the *'Reading the Signals' report*.

> *"There is a huge portion of individuals who don't trust healthcare given, following COVID and following the maternity investigation as well."*

This lack of trust was described as a significant barrier to patients using care, and as something that requires sustained effort to rebuild through consistent, compassionate engagement.

In response to these challenges, some staff described roles and services specifically designed to address inequalities and improve engagement. For example, specialist roles focused on health inequalities were described as working to rebuild trust with the community and to support those who might otherwise not use the care they need.

Practical challenges

The estates that staff are having to deliver care in are creating daily practical challenges. Spaces are limited, the facilities are ageing and repairs are slow to happen meaning that some rooms or equipment might be out of action putting more pressure on an already pressurised system. In direct contrast to the midwifery-led unit, birth areas are cramped on the consultant-led unit and the way they were designed does not reflect the needs of modern-day maternity care.

> *"Most of our rooms are so small and most of my colleagues, they will prefer to go and do an instrumental delivery in the theatre. Not because we specially need to go to theatre because the room is too tiny to do this."*

Staff also acknowledged that the poor estates affected families' experiences. Ward layouts offered little privacy for women and families. Families told us how the lack of private toilets impact women and birthing peoples' privacy and dignity as they need to walk longer distances to use bathroom facilities.

Staff find the IT systems equally constraining. They highlighted that maternity and neonatal services use a mix of electronic records and paper notes, which do not always operate well together. This can lead to duplication of work and challenges in having complete information for decision making as information is spread across different platforms rather than held in a single, consistent record.

What this means for families and services in EKHUFT

It is our view that the physical estate and facilities in EKHUFT are impacting staff's ability to deliver good care as well as affecting the experience of women, birthing people and their families.

Overall, the evidence we heard suggests that estate and facilities restricted dignity, privacy and emotional safety for families and influenced how easily staff could deliver compassionate, family-centred care. Families described how layout, ward placement and the availability of quiet spaces affected their experience. Staff described limited space and ageing infrastructure as persistent constraints that interacted with workforce pressures and could reduce time available for compassionate care. The executive team are aware of the issues and described them as structural and requiring long-term investment and planning. EKHUFT did place a bid to be included in the New Hospital Programme but was not successful.

Reporting and governance systems are being effectively used to support learning and improvement, and staff noted the positive changes in how investigations and complaints are dealt with internally. However, there is still a gap between staff and leadership experiences and those of families. Families report handling of complaints and investigations that are slow, dismissive of their concerns and traumatic. To support rebuilding trust between the Trust and families, communications need to be consistent and sustained over time.

The improvements that we saw at EKHUFT among the midwifery staff in terms of morale and initiatives to improve care following 'R*eading the Signals*' were very positive. On our visit and in subsequent interviews we repeatedly heard that strong and stable midwifery leadership was driving the improvements.

Additionally, the Trust informed us about restorative efforts that were being made with families. This includes a new bereavement pathway named 'Small Steps' by families, Restorative Circle events with harmed or bereaved families and a restorative improvement log.

However, it is a concern that the sense of team and purpose expressed by midwifery staff is not consistent in neonatal services. In addition, the sustainability of the Trust's improvement plan could be at risk, based on the current instability in the executive team structure and the fact that the Director and Deputy Director of Midwifery have both left the Trust.

How we gathered and analysed our evidence

How we gathered evidence

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

- 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
- Two listening events across different staff groups and grades
- Interviews with 13 members of staff
- Six additional pieces of information were sent to the Investigation email address which were submitted as evidence for EKHUFT.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the Local Maternity and Neonatal System (LMNS) Co-Production, Engagement and Equity Programme Manager as well as the Maternity and Neonatal Voices Partnership (MNVP) lead. To ensure widespread involvement, an additional event was held with families who had approached the Investigation directly. Local MPs were also 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 to 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