National Maternity and Neonatal Investigation

Queen Elizabeth Hospital King's Lynn 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 Queen Eizabeth Hospital King's Lynn NHS Foundation Trust Hospital 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 Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The National Maternity and Neonatal Investigation team visited the Queen Elizabeth Hospital King's Lynn (from here on referred to as King's Lynn or the Trust) on 25 and 26 November 2025, and on 16 January 2026. King's Lynn has one site that offers maternity and neonatal services.

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 Queen Elizabeth Hospital, King's Lynn maternity services were rated 'good' by the CQC in March 2024.

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

Activity and modes of delivery

Activity:

- In 2024/25, King's Lynn supported 1,755 births.

National published statistics

Modes of delivery:

- In February 2026, 39.1% of deliveries were by caesarean section, compared with 34.6% three years earlier in February 2023.
- In February 2026, labour was induced for 39.1% of deliveries, compared with 42.3% three years earlier in February 2023.

Statistics provide by the Trust:

- In February 2026, 43.97% of deliveries were by caesarean section, compared with 39.73% three years earlier in February 2023.
- In February 2026, labour was induced for 55.77% of deliveries, compared with 48.03% three years earlier in February 2023.

Workforce

As of January 2026, the Trust employed:

National published statistics:

- 105.4 full-time equivalent midwives.
- 29.6 full time equivalent doctors working in obstetrics and gynaecology.

Statistics provided by the Trust:

- 120.45 full-time equivalent midwives.

The number of deliveries per midwife in 2024/25 was 16.7, which is much lower than the national figure of 23.1. King's Lynn is in quintile 1 i.e. the lowest 20% of NHS trusts.

Neonatal services

The Trust's neonatal services were rated 'Good' by the CQC in May 2019.

Unit and care pathway

King's Lynn has a Level 2 Local Neonatal Unit. These are 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 high dependency units (level 2) across the country.

In 2024, babies were cared for in neonatal units for a total of 1,859 days of care, placing King's Lynn in the lowest 20% of providers of neonatal care nationally.

Workforce

As of January 2026, the neonatal service employed 27.3 full-time equivalent neonatal nurses. In the 12 months ending December 2025, 86.7% of neonatal nursing shifts were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (BAPM).

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

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences of feeding their baby were rated average. Experiences in other areas of maternity care, including pregnancy, labour and postnatal wards were rated around average. Experiences of antenatal care were rated somewhat better than average.

In the 12 months ending October 2024:

- A stabilised and adjusted neonatal mortality rate (the number of deaths of live-born babies within the first 27 completed days of life (under 28 days)) of 0.8 per 1,000 live births, higher than comparable trusts.
- A stabilised and adjusted stillbirth rate of 2.6 per 1,000 births, comparable with similar trusts.

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

What families told us

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

When visiting King's Lynn, 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.

Women, birthing people and families repeatedly told us that they raised concerns about their own symptoms or their baby's condition but did not feel listened to at the time it mattered most. Many described situations where they recognised that something was wrong, asked for help, and were reassured that what they were experiencing was *"normal"*. Families described how reassurance was repeatedly given without further assessment or escalation to senior staff even as symptoms continued or worsened.

> *"We flagged all the way through that there are signs this baby is not breathing normally… flaring nostrils, grunting on every breath… but the stock answer every single time was that that's normal."*

[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

Women also described their own symptoms being minimised or disbelieved during labour. Several spoke about severe pain or changes in how they felt, and being told this was not possible at that stage of labour.

"If they'd listened an hour earlier, it wouldn't have ended up as an emergency."

Women and families told us how they often felt powerless in decision making about their care or their baby's care. Many described situations where plans were changed without explanation, decisions were made away from the bedside, or they were told what would happen rather than being involved in discussion. There was no time available for families to ask questions or voice concerns about decisions being made making families feel that care decisions were made about them, rather than with them.

"There was a lot of decision-making for a mother and a father that was done away from the bed, between the teams, not with us."

We also heard about how birth plans were changed last minute. Families described feeling pressured or overridden when expressing their wishes, particularly around pain relief, feeding choices, or mode of birth.

"It was just, 'This is what's happening', even though it did not feel right."

Women who had a traumatic birth described feeling lost and unsure about what had happened to them or their baby during their delivery. One family told us how they repeatedly had to ask for a debrief.

A lack of continuity of care across staff members meant that families often saw multiple staff members, which resulted in them needing to repeat their history or concerns. Families told us they received inconsistent communication and felt staff did not know them or understand their needs. Families who had experienced a traumatic birth, loss or harm told us that an absence of a single point of contact afterwards made them feel un-cared for.

"There should be a single point of contact when something so catastrophic happens, that you know the person that's going to phone

you, you've got a personable relationship with them, they should come and meet you. We never had any of that."

Women and families recognised that services were under significant pressure, with high demand and staff juggling multiple tasks or patients, and that this affected the care they received. Many spoke about being on busy wards, with cramped layouts, visibly stretched staff and long waits for assessment, monitoring or support. Families often recognised that staff were doing their best in difficult circumstances, but said the impact was still felt through delays and missed care.

"I then was not seen again or assessed… did not have any observations from 6.00 am until 1.15 pm."

Shift handovers were identified as a particularly busy and stressful time. Families described unanswered call bells, being left alone or having to repeat information to new staff on shift.

"When it's a shift change… that gives you a massive window where you just are ignored." Another told us, "We saw probably every midwife that worked in that hospital… none of them spoke to each other."

Families who experienced trauma, bereavement, or complicated births spoke to us about the significant emotional and psychological impacts, including trauma, PTSD and a fear of having more children, some started to avoid healthcare settings.

"I developed quite bad PTSD from it to the point where I couldn't even look at the hospital."

Following cases of harm, bereavement or trauma, families told us about the delays they faced in postnatal and psychological support being organised. They described mental health services that were not in immediate contact and took more time to be in touch than families needed, and for some women and birthing people there was a lack of follow-up after they left the hospital and the follow up that did happen did not recognise their emotional wellbeing.

"So we have no after support from the hospital whatsoever. … there was no thought about the support that we needed."

We also heard from families who were involved in external investigations and legal processes following bereavement or harm. Some families heard new information about the causes of harm for the first time during legal proceedings. These processes were described as long and demanding and with families given limited time to review detailed medical information. These experiences led some families to believe these were deliberate as a way of avoiding admitting any wrong-doing or having to make financial pay-outs.

> *"They mess us around. We have just had Baby A's coroner's court adjourned for the third time because they'd still not given the evidence over."*

When care went well

Although many families described difficult and distressing experiences, they also told us about occasions where care felt kind, compassionate and reassuring. Families valued staff who communicated clearly, provided practical support, kept them informed and took time to explain what was happening during frightening or uncertain moments.

> *"Everyone was really nice. The midwives were really friendly, spoke us through everything… it was really nice to start with."*

Families also described how positive experiences during or after a bereavement had a lasting impression. One family told us that the bereavement suite had private spaces that allowed them to spend valuable time with their baby.

Families with babies in the neonatal unit also described how beneficial hospital accommodation was in allowing them to maximise the time they spent with their baby.

> *"I cannot fault the neonatal unit. They were brilliant. They were communicative. They kept us updated on everything."*

What we saw and heard in King's Lynn

The National Maternity and Neonatal team spent a total of three days in two separate trips to Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, including a full walkaround of all areas where maternity and neonatal care are delivered. The Investigation team in attendance included a neonatologist, midwife and an obstetrician.

The community that King's Lynn serves are more likely to smoke in early pregnancy than the national average. This means that services have to ensure smoking cessation is proactively offered during pregnancy and more social support may be needed for younger women. Additionally, more women using the services have had two or more previous live births than the national average, making it important to staff to be aware that patients might have previous trauma from births to consider or previous complications which may affect their medical care.

We spoke to families who told us about individual staff members who cared for them with care and compassion. However, we also heard from women and birthing people who were traumatised and harmed following their experiences at the Trust. Families felt let down by the Trust in how follow up care and processes, such as complaints and investigations, were handled.

Across maternity and neonatal services, we saw staff who were committed, knowledgeable and motivated to provide good care in a challenging setting. We also saw differences between how services are designed to work and how families experience care day to day.

Staff described the Trust as being on a journey of change because of the ongoing merger of the Trust into a group model with two other trusts in the region. While services, staffing structures and ways of working might change, staff said clear communication would be important throughout the transition, alongside protecting the strengths of existing services in the different geographical area.

We heard consistently positive feedback about changes to the maternity triage service. Staff described better processes, improved patient flow and clearer communication within triage, which they felt had made the service more organised and responsive to women needing urgent maternity care. They also spoke positively about the department being recognised as the "most improved department", saying this had supported morale and signalled that improvement work was being noticed by the organisation.

During our visit to the Trust, although the building itself was old, the services had a welcoming atmosphere and were thoughtfully designed to support women and families during their stay. In the neonatal unit we heard about the Trust having instances of bacteria in the water systems and the steps, such as infection control audits and hand-washing protocols, in place to prevent further cases.

We saw a separate bereavement suite, which opened in July 2022, to improve the care and support provided to families following baby loss. The suite provided a private and sensitive space for families experiencing bereavement and appeared peaceful, appropriately furnished, and designed to offer dignity, privacy, and comfort during difficult circumstances.

The Trust also invited us to visit one of its community hubs where antenatal, postnatal, and home-based services are delivered together. The hubs offer women and birthing people multidisciplinary services such as perinatal mental health support, infant feeding programmes, and includes specialist staff like tobacco dependency advisers. The hub is located alongside other local services, enabling families to "pop in" and use additional support services such as Baby Basics, a charity that provides essential items for newborns.

What staff told us

Whilst speaking to frontline staff during interviews and in panel sessions, we heard about a service that is varied with peaks and lows across services. Workforce and recruitment challenges were discussed by staff. Staff told us that at busy periods, staffing levels were significantly below planned levels. This affected the time staff had to give one-to-one support, and some staff felt it made their roles feel task-focused rather than personalised.

> *"We should have ten midwives… [but] we were working with five or six… which was a real challenge and did feel like it impacted safety."*

The team heard about recruitment challenges at the Trust due to recent staffing changes. We heard of "*a huge cohort that retired all at once*." Staff told us that this reduced the experience within the team and meant there was an increased reliance on newly qualified staff. The rural location of the Trust also affected retention rates. Experienced or specialist staff members were described as leaving for large trusts creating workforce gaps.

> *"King's Lynn is a very quiet town… so we did lose quite a lot of midwives… that have gone to bigger cities."*

The workforce pressures that staff told us about are also impacting on patients' experiences of care as it can lead to delays particularly around inductions of labour.

> *"Not… the capacity to do more than maybe one ARM [breaking of waters] every two days… there has been ladies that have been waiting for a while."*

The complex care that more women and birthing people need are also adding pressures. As we heard at other trusts, the rising number of caesarean sections are impacting what care is needed and, in some cases, requires different staffing models to meet these needs. Staff at King's Lynn told us that their staffing models are not changing in line with care requirements, leading to staff on shifts feeling pressured and busy.

> *"Complexities have increased… Caesarean section rates have increased… [but] our staffing structure is still based on… years ago where women were less complex."*

Community staff described large caseloads leading to concerns about missing clinical issues or safeguarding flags. Some staff told us how clinic times and appointments felt rushed as they had to see a set number of patients in a short block of time. IT systems have added to these pressures as recording requirements are time consuming which is taking away from already limited time with a patient.

"It's absolutely ruined my antenatal clinic because I want to have a conversation with the patient. I do not want to feel pressure to fill in what often seems irrelevant boxes."

The Trust provides care for families across a large catchment area, including three different counties. Staff told this could create challenges as often counties had different processes which could impact what care is available for women and families.

Staff also told us that tobacco cessation services, aimed at pregnant people, are managed differently across counties and ICBs creating what staff described as a postcode lottery of support. This impacted whether families were able to get free vapes as a way of stopping smoking or whether smoking support was available for partners.

"We also have that with the vapes: we cannot get the Lincolnshire ladies free vapes, … the Cambridgeshire ones get them now."

Despite challenges and fluctuating pressures, staff consistently described a supportive culture and the Trust as a friendly place to work. Due to its rural location, a number of the staff had worked at the Trust for a long time. Some had been there since completing their training.

"A small county in kind of the middle of nowhere… it's more of like a grow your own [workforce]".

"I honestly can say I really enjoy working here. I get on well with my colleagues. I like the fact it's a small hospital and it's very, very friendly."

Staff described a culture of learning and supporting each other after incidents. We heard about safety bulletins and multidisciplinary meetings where staff groups across teams came together and discussed incidents or did simulation training that used real cases to create learning opportunities. Some staff described this as a welcome shift away from what they described as a 'blame' culture.

"We've moved to a system where it's a no blame, let's look at it, let's learn from it."

The estates that staff are working in were described to us as ageing and constraining, and there are ongoing concerns about water safety and infection control, which leads to facilities having to be taken out of use.

"It comes and goes, and I think it's from an old building. So it's really inconvenient as well, because we can't use a sink… before it's been our shower room, so our parent shower room has been out of action, unfortunately. We've had another sink in the nursery where we've had to condemn."

Staff told us that some areas, such as community and neonatal spaces, were not family-friendly, had limited space for private conversations and were not compatible for people with accessibility needs.

King's Lynn is part of the new hospital programme, and the executive team informed us that a new hospital site has been identified and is currently planned to be opened in the early 2030s.

As well the new planned estate, the Trust is also moving to a group model that will have one set of leaders across three trusts. Whilst staff recognised that this could lead to improvement, with a more consistent leadership team and closer collaboration across the geography, staff were also concerned that it would make leaders less visible and they would be less involved in decision making.

"Out of sight, out of mind… people forget about [us]."

What this means for families and services in King's Lynn

In maternity services, families said their experiences depended not only on the care they received, but on whether care feels timely, well explained and joined up across pregnancy, birth and the postnatal period.

Families described poor communication, mixed messages, delays in care and having to repeat their history, particularly during labour, after discharge and following traumatic events.

Staff described pressures that affected the care they could provide. They linked these to staffing shortages, theatre capacity, heavy workloads and issues with digital systems. Staff said these pressures could affect one-to-one support, continuity of care and the time available for conversations with women and families.

Being involved in the New Hospital Programme will mean a completely new estate for the Trust, offering the opportunity to reduce current patient and staff concerns around lack of privacy and cramped conditions.

However, whilst the estate can create the right space for families to be given compassionate care, it also needs a workforce that is experienced and flexible enough to meet fluctuating demands and an IT system that reduces administrative burden. These factors can support staff in having the time and capacity to deliver family-centred care with kindness.

Across both maternity and neonatal services, the evidence showed committed staff, some positive signs of improvement and clear processes for review and learning. However, families' experiences following incidents or harm or bereavement point to an inconsistent system where there is not a singular lead point of contact on follow up care. This has led to inconsistent messaging for families and unresolved questions and trauma.

The Trust's move to a group model also creates uncertainty for staff about how empowered and involved in decisions they will be, we have seen in other trusts where mergers have occurred staff feeling 'change' happened to them rather that feeling a part of the process. Staff hope the move to the new model will reduce administrative burdens and will have clear leadership; from our observations in other areas, we feel it must be a process that engages staff and they feel like their voice is heard in any join up activity.

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

- Seven additional pieces of information were sent to the Investigation email box which were submitted as evidence for Queen Elizabeth Hospital King's Lynn NHS Foundation 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) leads for King's Lynn. In addition to these activities, a further virtual engagement panel was convened to broaden participation. To ensure widespread involvement, local third sector organisations and local MPs 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