National Maternity and Neonatal Investigation

University Hospitals Leicester 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 University Hospitals Leicester 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 University Hospitals Leicester Trust

We visited University Hospitals Leicester Trust (from here on referred to as UHL or the Trust) on 11 and 12 December 2025. The Trust has two sites that deliver hospital based maternity and neonatal services: Leicester Royal Infirmary and Leicester General Hospital. During the review period UHL also operated a standalone birth centre; however, intrapartum and postnatal inpatient services at this site has been paused since July 2025.

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 rated Leicester's maternity services as 'Requires Improvement' (Leicester Royal Infirmary and Leicester General Hospital) in June 2024.

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

Activity and modes of delivery

National published statistics:

- In 2024/25, Leicester supported 9,465 births.

Statistics provided by the Trust:

- In 2025/26, Leicester supported 9,431 births.

National published statistics:

Modes of labour and delivery:

- In February 2026, 44.4% of deliveries were by caesarean section, compared with 36.5% three years earlier in February 2023.
- In February 2026, labour was induced for 26.7% of deliveries, compared with 27.0% three years earlier in February 2023.

Statistics provided by the Trust:

- In February 2026, 37.1% of deliveries were by caesarean section, compared with 45.8% three years earlier in February 2023.
- In February 2026, labour was induced for 29.8% of deliveries, compared with 29.3% three years earlier in February 2023.

Workforce

National published statistics:

As of January 2026, the Trust employed:

- 410.7 full-time equivalent midwives.
- 122.3 full-time equivalent doctors working in obstetrics and gynaecology.

Statistics provided by the Trust:

- 429.2 full-time equivalent midwives.

The number of deliveries per midwife in 2024/25 was 26.0 which is higher than the national figure of 23.1. Leicester is in quintile 4 i.e. the second-highest 20% of NHS trusts.

Neonatal services

The Trust's neonatal services were rated as 'Requires Improvement' by the CQC in 2020 as part of a wider inspection of Services for Children and Young People.

Unit and care pathway

UHL has a Level 3 Neonatal Unit at the Leicester Royal Infirmary and a Level 1 Special Care Unit at Leicester General, both with the availability of Intensive Care (ITU) and High Dependency Unit (HDU) provision. UHL is additionally one of five neonatal units nationally providing specialist surgical and cardiac services.

A Level 3 Neonatal high dependency unit provides care 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 Special Care Unit is for 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 Neonatal High Dependency Units across the country.

In 2024, babies were cared for in neonatal units for a total of 12,799 days of care, placing Leicester in the highest 20% of providers of neonatal care nationally.

Workforce

In the 12 months ending December 2025, 64.9% of neonatal nursing shifts at Leicester Neonatal Service (Leicester Royal Infirmary and Leicester General 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 and a full explanation of neonatal staffing guidelines and service specifications can be found in the Annex 2: Glossary.

Experience and outcomes for maternity and neonatal services

In 2025, women's experiences of feeding their baby were rated better than average. Experiences in other areas of maternity care, including pregnancy, labour and postnatal wards were rated around 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 2.9 per 1,000 live births, more than 5 per cent higher than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.6 per 1,000 births, within 5 per cent of comparable 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 UHL, the first thing the Investigation team did was to hold family panels in locations separate from the Trust sites. We invited women, birthing people, fathers and non-birthing partners[1] who received care from the Trust to share their experiences at the panels. Most of the families who attended the panels had experienced harm and many had experienced bereavement; their experiences speak to the lasting impact this has had on their lives and the lives of their loved ones. Families told us that they came forward as they did 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 that have emerged remain important in understanding how families felt and what mattered most to them at the time.

Women, birthing people and families described feeling unsafe, unheard and without clear information on their care. Some felt early warning sign symptoms of complications during pregnancy and labour were not recognised or responded to quickly enough. Families told us that they were not always given clear explanations about decisions affecting their care.

> *"No communication… just talk to us… then probably I wouldn't be here today".*

Families described care that felt inconsistent, with better experiences in some areas and poorer experiences in more pressured parts of the maternity and neonatal pathway such as triage and assessment. Several families described long waits to be assessed, limited reassurance about concerns while waiting, and feeling "out of sight" in the maternity assessment unit. We also heard from families about their concerns not being addressed

[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

quickly and this leading to outcomes that were "lucky mistakes" rather than safely planned care.

"Being told that your baby could die, and then there's delay for days, it's just unfair really."

Families told us that explanations were not clear, and information was not always shared in a way that was easy to understand; and to allow families to make informed choices. We heard from families that it was difficult to challenge decisions unless they were familiar with healthcare situations. One family was concerned about the effect on those who were less able to speak up and did not have an advocate.

"Think about all the women who aren't here today… these are the people who can advocate for themselves".

Families described how their birth plans were ignored or not read. We also heard that concerns were not always believed when first raised, particularly after birth, and that communication during labour could be limited.

Some women described staff as physically present but said that interactions could feel dismissive or abrupt when they asked questions or raised issues. One woman described repeatedly reporting symptoms after discharge but being told "that's not possible" until her condition worsened and she required further care.

Families linked the delays they experienced to capacity and staffing pressures, and to the way services were organised. Some women said they felt alone at critical moments, or that care became reactive once things worsened.

"I was… left on a chair in a back room for the entire night with no additional monitoring."

Capacity pressures were also identified in neonatal care, including transfers due to bed availability. Some families described gaps between maternity and neonatal services that created extra work and uncertainty for parents. One family member said it was like two "parallel processes", and that when parents asked questions they were told: "Oh well, you'll have to ask the neonatal staff".

Staff shortages were explicitly noted by families. Some felt that staff were doing their best in difficult circumstances but were unable to provide the level of care and attention they needed.

"Just felt like it was completely understaffed… you could never get anybody when you needed to speak to people".

Families described inequalities in care that affected how safe and respected they felt. These experiences were often linked to ethnicity, cultural background, language, personal circumstances, and how confident people felt in asking questions or challenging decisions. Some families said that they were treated differently because of their ethnicity or cultural background and described discriminatory comments or behaviour.

"I experienced what I view as like racist attitudes… it was pretty blatant."

Some described comments that relied on cultural or religious stereotypes, or assumptions about pain tolerance, preferences, or understanding of care, rather than staff taking time to understand individual needs.

"At the end she just made some … remarks that I didn't really appreciate. She asked … when we birth the placenta… what I'd like to do with it. Because apparently some cultures or religiously [sic] people bury their placenta. The way she asked was… almost offensive."

Women and birthing people said that the layout of the wards and hospital added strain at a time when they were in pain, exhausted or recovering from surgery. They spoke about long walks to toilets and showers, too few facilities for the number of people on the ward, and long distances between parking areas and the Women and Newborn Unit.

"There's quite a long walkway down the corridor to get to that toilet and shower. There's one shower and two toilets. And the ward was full. So you were literally queueing, as well, to get into a toilet and a shower."

Some families who had traumatic births felt that debriefs were unclear and did not always answer their questions. Families who went through formal complaint processes or investigations described delays in responses and having to push to see notes about their case. Some families felt that when things went wrong the Trust was defensive rather than supportive.

When care went well

Women described how compassionate and attentive staff made a meaningful difference to their experience, particularly when they felt vulnerable or afraid. Supportive staff were described as those who were present and communicative. Feeling cared for in a human,

empathetic way helped to build trust and provided reassurance during what could otherwise be overwhelming moments.

"The midwife that came in, she was brilliant. She was really supportive and cared really well."

Clear communication, being kept informed and having their preferences acknowledged was repeatedly described as a key part of good care. Even when circumstances meant that birth plans could not be followed exactly, women valued staff who took the time to understand their wishes, respond respectfully, and who explained things step by step and checked in regularly.

One family described a midwife who supported them throughout labour by explaining everything clearly. This helped them to feel reassured, even when the situation became complex.

"She made me assured like, even it's a C-section, don't worry it will be everything for the good."

Some women described individual staff members who showed exceptional commitment, which had a lasting and positive impact on their experience. Continuity of care and staff going out of their way to be present during labour was commented on, we heard how a student midwife who was not on duty travelled a long distance overnight to be present at a birth. Brief, simple acts of communication were appreciated, particularly at critical moments such as birth or when a baby's condition deteriorated.

Families also recognised when clinical teams acted quickly and effectively in urgent situations. Prompt coordinated responses helped build confidence in the care. One family described how staff clearly prepared them for an emergency response.

"It's going to be a bit frightening now… I'm going to press a buzzer and there's going to be lots of people coming into the room"

What we saw and heard in UHL

During our investigation, we spent two days at UHL, completing walkarounds of all areas where maternity and neonatal care were delivered across Leicester General and the Leicester Royal Infirmary. The Investigation team in attendance included a neonatologist, a midwife and an obstetrician.

The community that the Trust serves is ethnically very diverse compared to national averages. There are more Asian families alongside people from a range of other backgrounds, cultures and ethnicities. The Trust also serves more women with no or only one previous live birth, as well as more women who have had previous caesarean sections.

We met an executive team and staff workforce who were committed to tackling inequalities and spoke in depth about the communities they served, their local challenges and opportunities. The Trust was proud of initiatives aimed at specific patient groups. For example, programmes aimed at teaching parenting skills in low-income areas, and a programme aimed at parents, carers and families to reduce the risks of newborn and infant mortality.

The Trust is currently operating a two-site model, where both sites deliver high volumes of maternity and neonatal care. Whilst there were some advantages to this, such as being able to redirect incoming maternity cases if one site was full, it led to challenges including a complex staffing model. We heard about the new hospital site that the Trust hoped would be built but for many staff it felt like a pipe dream, something that had been promised but not yet committed to. The new model was a one site model delivering maternity and neonatal services for the whole Trust.

When we visited Leicester General Hospital, the maternity services were working at full capacity, and we witnessed a very busy service. There were no available beds into which women and birthing people could be moved into; however, staff were working to progress women and birthing people through the system to get the care they needed.

Across both hospital sites we saw care struggling to be delivered in buildings that were old and not fit to provide 21st Century care. Across both sites, there was evidence of efforts to support women and families on the maternity wards, including family rooms, privacy screens, clear information and spaces for sensitive conversations. However, some parts of the inpatient estate felt cramped affecting privacy and comfort during pregnancy, birth and recovery. At Leicester Royal Infirmary, postnatal rooms were described as very small, with limited bathroom access and showers that could be difficult to use after birth. At Leicester General Hospital, some rooms were also cramped, despite the ward being more spacious overall. The layout of the sites also raised practical concerns about safety and flow, including movement across floors in emergencies and

equipment that was not ideally positioned or ready for use. Taken together, these observations suggest that while support was in place, the design and condition of the estate affected inclusion, privacy and the experience of urgent or sensitive care.

We noted that information was widely available at the hospital sites, but the use of English-only signage at Leicester General Hospital may reduce accessibility for some families in the area.

The neonatal ward at Leicester Royal Infirmary felt orderly, which can help families feel reassured during a stressful time. However, the ward was affected by the age of the estate, which was old and tired.

Efforts had been made to support families within the neonatal setting, including providing space for parents, a parents' lounge and dedicated quiet periods, alongside visible opportunities for feedback. The unit demonstrated flexibility in managing demand through its cot capacity and use of overflow areas. There was also clear evidence of cross team working, including psychological support for both families and staff.

Across the country we heard about the challenges of electronic patient records. However, at Leicester the challenge seemed to be one of the greatest. A new electronic patient system for maternity services had been introduced two months ahead of our visit. Whilst staff were confident that it would lead to long term positive changes, we heard that training was too generic and not sufficiently tailored to individual roles leaving staff feeling unprepared and unsure about how to use the new system.

Across the Trust, we saw and heard about a strong team culture where staff were supportive of one another and wanted the best for their patients. We saw an executive team that were passionate about their community, had made sure that issues of race and inequalities were a routine part of discussion at executive team meetings and where the diversity of the team was seen as key. Robust governance systems and improvement plans were in place. In addition, first-hand accounts of patients' experience are shared at Board level, suggesting families' experiences are being centred in leadership discussions.

What staff told us

The executive team described a clear shift in their approach to leadership and culture. They said the Trust is listening more, sharing patient stories at the Board, and being open when care has gone wrong. They described the organisation as "a learning organisation"; they wanted staff to feel safe to speak up and be honest with families. They reported high staff engagement and a better staff experience than four years previously seen via the results of the NHS Staff Survey. They described a focus on equity, with better use of data to understand and act on differences in care, and more work with communities through listening events and a "you said, we did" approach.

In maternity care, the executive team set out a focus on building trust with women, birthing people and families, improving communication, and reaching people at an earlier stage in their pregnancy. They highlighted work with public health and community partners to address risks such as late booking and pre-term birth. They also described ongoing challenges including services split across sites, high demand, and more women needing complex care.

Staff consistently described maternity and neonatal services as working under sustained pressure, with demand, clinical complexity and staffing shortages affecting care across wards, delivery suite, assessment areas, theatres and neonatal services. They said pressure in one area quickly had an impact in another and that staff were often moved between teams to cover gaps, leaving services feeling persistently "busy" and stretched.

> *"There were no beds in the unit… which then backed up to delivery suite… and then it's pressure for all areas"*

Staff said shortages across midwifery, medical, nursing and support roles affected both their wellbeing and the care they could provide. They described starting shifts short staffed, missing breaks, working beyond their contracted hours and struggling to protect training time, which contributed to exhaustion, sickness absence and difficulties in staff retention. They also discussed how this could lead to tensions across sites as colleagues lacked local insight on the pressures affecting staff. This led to staff feeling unsupported.

In neonatal care, staff said the Trust's role as a tertiary centre added further strain. Staff told us that UHL would often accept babies "at the detriment of our own capacity" because of regional responsibilities. Staff also identified ongoing gaps in specialist neonatal staffing, emphasising that "the gap is the specialist knowledge" rather than a lack of intent or goodwill, and that neonatal services remain "very thin" in terms of dedicated senior nursing expertise despite recent improvements.

Frontline staff spoke with pride about teamwork and their commitment to women, birthing people, babies and families in their area. They described strong, mutually respectful collaboration and effective communication mechanisms such as huddles. They described their colleagues as hardworking and supportive, particularly where multidisciplinary teams worked closely together, but said the service relied too heavily on goodwill.

> *"When we work as a team, we are amazing".*

Staff were also proud of the bereavement service provided by midwives. There is a bereavement suite on each delivery suite, and the Trust has increased the size of the bereavement team, enabling them to cover seven days a week. Families can choose whether to share any concerns about their care via the bereavement midwife or directly to the patient safety team. The Trust has also introduced bereavement training for all neonatal nurses.

Staff working in maternity services described a mismatch between the expectations set by the executive team and what care they could safely deliver. Midwifery staff reported that:

> *"There's quite a gap with the expectations that are placed on us as clinical care givers versus the care that we can actually give with the resources that we're provided with"*

Communication from senior and nonclinical teams was frequently described as inconsistent and overly reliant on electronic communication. Maternity staff reported that the executive team were "not being seen on the shop floor by the clinical staff" and that contact was largely through "emails, saying things that we need to be doing".

Neonatal staff described much better managerial support. Neonatal matrons reported that leadership arrangements had strengthened neonatal voices, describing leadership as "approachable, really supportive" and stating that "when concerns are raised, they are here to support".

Staff raised concerns about inequalities in care, particularly timely interpretation in urgent situations, and about inequalities affecting the workforce itself, including reports of "racist incidents" at work. Staff said the Trust serves a highly diverse community and, while many saw this as a strength, it also created additional challenges in delivering equitable care. Staff expressed a strong desire to improve the service and its culture for women, families and colleagues. Clinic inequalities and have developed the Janam App, a pregnancy advice app designed to improve perinatal health, reduce health inequalities,

and improve maternity outcomes for women and birthing people from a South Asian background.

Staff said formal processes for complaints, incidents and governance were in place but were difficult to implement properly alongside clinical pressures and could feel reactive or like a "tick box exercise". Some described limited guidance or support, particularly for those new to management responsibilities, and spoke about the emotional impact of reviewing distressing accounts from families while already under pressure. Staff continued to emphasise the importance of learning and improving care, but questioned whether learning was always embedded when delays, staffing shortages and leadership changes persisted. While some staff described the executive team as responsive and supportive, this was not felt consistently across the organisation.

Practical challenges

The estates across both sites are creating daily challenges for staff, with longstanding constraints around space and bed capacity significantly impacting their ability to deliver compassionate care.

> *"You can't give compassionate care because it feels like a conveyor belt... you're trying to kick people out the door as soon as they're medically well enough because you've got someone else that needs their bed."*

Staff told us that "we're constantly bed blocked", explaining that increasing induction rates, caesarean births and inpatient needs have outgrown the available estate. Staff also emphasised that while there has been targeted investment, such as a new theatre, this has not been supported by an increase in the recovery area or ward space.

Staff consistently highlighted problems with IT systems following the implementation of the new system in Autumn 2025 including duplication, poor usability and training that was insufficient and not tailored to specific roles. Observations and medications need to be entered into two different systems, which is creating duplication and taking additional time, however the Trust informed us this is a transitional period and there are plans to consolidate onto one system.

> *"We've got two digital systems... so duplication, it's not saving time. It's actually created extra work,"*

Staff also described impacts on care delivery, noting that:

> *"Nurses don't have the time to keep an eye on the baby, cos they're at the computer screen, putting in all the data" and that the new system was "literally the biggest frustration at the moment".*

From a maternity perspective, IT infrastructure was directly linked to care quality as midwives focused on recording information rather than on spending time with families.

What this means for families and services in UHL

Families told us they needed to be listened to, believed, and treated with kindness, especially when they were frightened, in pain, recovering from birth, or grieving. When people felt their concerns were not taken seriously, or they struggled to get clear answers, they often felt unsafe and alone. They described long waits, mixed messages, and times when it was hard to get help.

Our impression during the visit was that the leadership understood, and were facing up to the challenges they faced, and were implementing solutions which had the potential to drive meaningful improvements. However, these solutions have yet to deliver the change required on the ground.

Meanwhile, the estate, staffing levels, digital systems and leadership all shape how families experience care. Both hospital sites are old and tired. Some wards are cramped, while consultants have to work across multiple floors at Leicester Royal Infirmary. As a result, the facilities struggle to support modern care needs, such as the rising number of caesarean births and inductions of labour. The condition and layout of some buildings make providing care challenging, especially where rooms are small, facilities are limited, or urgent care means moving between sites or floors. Staff told us that women and babies needing longer stays can lead to 'bed-blocking', which then has a knock-on impact on other wards and how quickly families can be seen.

The estate presented the same challenges for neonatal services. This was compounded by Leicester's role as a neonatal tertiary provider and ongoing concerns about the availability of sufficient senior neonatal nurses to meet demand. Staff described services under constant pressure, with staffing gaps and limited space. Together with the issues with the estate, these pressures can make it more difficult to provide care that feels personal, orderly and responsive.

Alongside these issues, both families and staff described ongoing concerns about communication, cultural sensitivity, ability to use interpreters at the right time, digital systems, and whether learning from adverse events has led to real change.

Trust leaders talked about their commitment to improvement, strong teamwork and determination to reduce inequalities. However, improvements are yet to be consistently felt by families and staff on the ground, despite the detailed plans and regular oversight meetings that are in place.

Families need care that is safe, respectful, that they can understand, and is responsive to their needs. For the Trust, progress will be judged not by improved governance processes but by the improved experience of families. Change takes time, and the fact that the leadership has identified and begun to address the issues is a welcome start. But it is only when families experience kind, joined up and safe care that the changes will be considered a success.

How we gathered and analysed our evidence

How we gathered evidence

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

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

- 11 additional pieces of information were sent to the Investigation email address which were submitted as evidence for University Hospital of Leicester NHS Trust.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the Maternity and Neonatal Voices Partnership (MNVP) Lead for Leicester, Leicestershire and Rutland. In addition to these activities, further virtual engagement panels were offered to broaden participation. To ensure widespread involvement, local third sector organisations and local MPs were approached to help promote the events and support recruitment, with particular focus on reaching those who may otherwise be underrepresented.

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