National Maternity and Neonatal Investigation

University Hospitals Sussex NHS Foundation Trust

Trust report

Note of acknowledgement

We would like to thank the women, birthing people and families who came forward to share their experiences of maternity and neonatal services at University Hospitals Sussex 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 Sussex NHS Foundation Trust

We visited University Hospitals Sussex NHS Foundation Trust (from here on referred to as Sussex or the Trust) on the 20 and 21 of January and 17 and 25 of February 2026. University Hospital Sussex has four sites which offer maternity and neonatal services: Royal Sussex County Hospital, St Richard's Hospital, Princess Royal Hospital and Worthing Hospital.

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

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

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

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

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

Maternity services

Sussex's maternity services were rated by the CQC as 'Requires Improvement' for St Richard's Hospital and Princess Royal Hospital in May 2023, for Royal Sussex County Hospital in December 2025 and for Worthing Hospital in May 2023.

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

Activity and modes of delivery

- In 2024/25, Sussex supported 8,480 births.

Modes of labour and delivery:

- In February 2026, 48.6% of deliveries were by caesarean section, compared with 39.8% three years earlier in February 2023.
- In February 2026, labour was induced for 28.1% of deliveries, compared with 27.0% three years earlier in February 2023.

Workforce

As of January 2026, the Trust employed:

- 415.5 full-time equivalent midwives.
- 119.2 full-time equivalent doctors working in obstetrics and gynaecology.

The number of deliveries per midwife in 2024/25 was 22.2 which close to the national figure of 23.1. Sussex is in quintile 3 i.e. the middle 20% of NHS trusts.

Neonatal services

Neonatal services at Royal Sussex County Hospital were rated “Outstanding” by the Care Quality Commission in August 2017. Neonatal services at Worthing and St Richard's Hospitals were rated as "Good" in 2026.

Neonatal services have not been inspected as part of any Maternity inspections throughout 2025 and 2026.

Unit and care pathway

The Trust operates a Level 3 Surgical Neonatal Intensive Care Unit (NICU) at the Royal Sussex County Hospital 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 27 Surgical Level 3 Units across the country.

The Trust operates a Level 1 Special Care Baby Unit (SCBU) at the Princess Royal Hospital. They also operate Level 1 Neonatal Units at St Richard’s Hospital and Worthing Hospital. These units are 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 13,112 days of care, placing Sussex in the highest 20% of providers of neonatal care nationally.

Workforce

As of January 2026, the neonatal service employed 129.4 full-time equivalent neonatal nurses.

In the 12 months ending December 2025, 48.5% (Royal Sussex County Hospital), 79.2% (St Richard's Hospital), 52.7% (Princess Royal Hospital), and 96.3% (Worthing Hospital) of neonatal nursing shifts at Sussex were staffed in line with guidelines and service specifications set by the British Association of Perinatal Medicine (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 also rated around average while experiences of triage: assessment and evaluation were rated somewhat above 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) was 2.1 per 1,000 live births, lower than comparable trusts.
- A stabilised and adjusted stillbirth rate of 3.4 per 1,000 births which was 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 Sussex, the first thing the Investigation team did was to hold family panels in locations separate from the Trust's sites. We invited women, fathers and non-birthing partners[1] who received care from the Trust to share their experiences at the panels.

We held three panels with different groups of families: families who had experienced bereavement or loss, families who had been harmed or had a negative experience and families who had had a mix of experiences. We held a further two panels with families who had experienced bereavement later in February.

We also held panels with interpreters to hear from lesser heard ethnic minority communities in Sussex. These were organised through Sussex Interpreting Services with Bengali, Turkish, Arabic and Portuguese speaking families.

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.

Families repeatedly reported that concerns raised during pregnancy, labour, and postnatal care were dismissed, minimised, or attributed to anxiety, even when clinical risk factors were present (e.g. reduced fetal movements). We heard how families were labelled in ways that affected how seriously they were taken.

> *"I was always labelled as anxious because of my history. It was written all over my notes, anxious because of previous losses. I just wanted to advocate for my baby."*

[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.

Women and birthing people described services that were difficult to access quickly when they were worried something was wrong. Some said they struggled to get through for advice, were encouraged to stay at home for longer than they felt safe or felt they had to push to be seen. Demand and capacity pressures affected what happened when families did arrive at maternity triage. Some spoke about delayed escalations to senior staff, limited senior availability and a feeling that the service was stretched too thin.

"They almost, like, they don't want you to come in because they're so overrun they can't deal with any more people … 'We'd rather you stay at home. You'll be fine.' Because they can't deal with it, they can't cope with it."

Families told us that, at times, the experience and availability of staff was not matched to their perceived level of risk. Some described junior or less experienced staff managing complex situations, delays in senior review and difficulty getting the right support during labour or when a baby's condition changed. Families also said they found it confusing and unsettling when risk labels changed or were not updated as circumstances changed. One parent described staff continuing to rely on an earlier assessment of their risk status.

"they kept shouting, 'She was low risk'… like, well, the risk levels can change".

Families felt this meant opportunities to intervene or escalate to senior staff were potentially missed.

We heard from a family member who spent a long time in the neonatal intensive unit with their baby and said it was visibly understaffed. They described how this affected one-to-one care, continuity of care and how involved they as parents felt in decision making about their baby.

"It was evident when we were there that there was understaffing. Both across nurses and the nursing ratios, which should be one-to-one in NICU or HDU NICU … the mix needs to be consistent."

Many families described a lack of cohesive working, particularly between midwives and doctors and told us about delays in calling for senior or consultant review. One parent described midwives and doctors *"arguing with each other in front of me"* and said there was *"no coherent plan"*. Families told us this created confusion and reduced their confidence in the care they were receiving.

Families described repeatedly having to retell their clinical history, with staff unfamiliar with their notes or prior clinical concerns. Handover failures between shifts and between hospitals were common. Birth plans and documented risks were frequently ignored. In some accounts, families felt that having to repeat concerns meant signs of deterioration or changes in clinical risk were not recognised in time.

"I think we had 6 to 7 midwives over the space of like 14 hours and none of them handed over correctly."

Many families experienced interactions that they thought were defensive, dismissive, or blaming, particularly after harm or bereavement had occurred. Families told us this created a sense that the organisation was protecting itself rather than being open with them about what had happened. One parent described feeling blamed for her baby's death rather than being supported after being told shortly after her baby's death that it had happened because *"you just didn't give us enough information"*. There was no recognition of them as a grieving parent.

Some families who were involved in investigation processes after harm or bereavement described being faced with long delays before receiving explanations or being invited for debriefs. We heard from some families that they did not receive sincere apologies. Others said that apologies were delayed or only offered after escalation of their concerns. One parent described not receiving an apology until after going to the media and said that the response felt procedural rather than genuine.

"Two and a half years… the first time we got to talk to them about everything that had happened".

Support after bereavement or harm was widely described as insufficient, inconsistent, or absent. Some families told us that bereavement midwifery support was often unavailable or ineffective and there was limited trauma-informed psychological care. Families felt "*discharged and forgotten"* following the loss of their baby.

"It feels like because you don't have a living baby… you don't get the same treatment".

Families whose first language was not English told us that their experiences of care were shaped by language barriers and differences in how their needs were understood and responded to. In the panel with interpreters present, families told us they were not always able to get professional interpretation when needed, and that this affected their ability to understand their care and communicate concerns.

> *"I wanted to have more involvement in my care… but they kept saying I didn't need an interpreter… they don't actually want to hear what I had to say".*

When interpreters were unavailable, families were often expected to rely on partners, friends or their own limited English. Some said this left them feeling excluded from decision making. Some families told us that these barriers also affected their ability to raise concerns or make complaints.

> *"We don't speak the language or know how to navigate the system".*

When care went well

Some families described positive experiences with staff, and one parent spoke warmly about community midwifery care as they saw the same person throughout. Other staff were noted for their kindness and communication:

> *"The consultant that did the operation, she was very sympathetic and explained to me what was going on as it was happening… They were all very good."*

> *"The doctors and nurses were quite calm and explained everything. Each step, they were very professional, so I'll be forever thankful for that experience."*

Some Bengali-speaking participants felt they had not experienced discrimination in relation to their cultural or religious practices, and described instances where staff were respectful and supportive of their needs. Other families also described positive care where they felt listened to, particularly when interpretation was available and staff took time to communicate clearly.

Other families noted that their feedback had led to positive changes:

> *"Partners are now all allowed on the wards… That's great to know, that's really good… I am so grateful to everyone who gave that feedback because it's helped and, I guess, it's positive to see the feedback that's given is being actioned."*

What we saw and heard in University Hospitals Sussex NHS Foundation Trust

We spent four days in Sussex, visiting all four sites delivering maternity care: Royal Sussex County Hospital (Brighton), Princess Royal Hospital (Haywards Heath), Worthing Hospital, and St Richard's Hospital (Chichester). The visit included a walkaround of all areas where maternity and neonatal care are delivered. The visits included an obstetrician, neonatologist and a midwife.

Compared with trusts nationally, the maternal population at Sussex is more likely to be aged 35 or older or have just one previous live birth, and less likely to have complex social factors or book antenatal care later than 10 weeks into pregnancy.

The higher proportion of women over 35 giving birth means that there are increased risks for women of pregnancy-related complications or developing chronic health conditions such as diabetes or high blood pressure. Women over 35 are more likely than younger women to have a stillbirth.

During our visit we met with the executive team and heard about the trust's priorities for maternity and neonatal care, following the receipt of a CQC warning letter in 2021. The data shared told a positive story of patient experience and we heard about the intent to develop a restorative culture – although it was acknowledged that harmed families have yet to engage with the Trust as part of the process. The positive story was at odds with some of the experiences shared with us in our family panels including recent experiences of bereavement and harm.

Across all four sites, we saw staff who were committed to providing good care amidst widespread negative media coverage in high-capacity sites with workload pressures.

We heard about the geographical complexity of delivering care across four sites and that the practicalities of this are still being worked through. There was variation in terms of the estates. On our first visit we went to The Royal Sussex County Hospital in Brighton and The Princess Royal Hospital in Haywards Heath. While The Princess Royal Hospital was spacious for both neonatal and maternity services, the space at the Royal Sussex County Hospital was inadequate. Maternity and neonatal services are spread across floors 12–14 of a tower block and the basement of a separate building. The Special Care Baby Unit (SCBU) was temporarily relocated but felt spacious, while the Neonatal Intensive Care Unit (NICU) was cramped with insufficient space around the cots. On our second visit we went to Chichester and Worthing.

The phone triage for all four Sussex sites is based in Worthing. Although Worthing Hospital is not a new site, it seemed well maintained and the maternity service was well laid out. All rooms were a good size, with some ensuite facilities. For those rooms that weren't ensuite, toilets and showers were located close by. The neonatal ward was also a good size, with space for some families to stay overnight in their own room if necessary.

St Richard's Hospital in Chichester was less well maintained. There were leaks coming through the ceiling with buckets underneath and there were signs of water damage in the corridors. The postnatal ward felt cramped, partly because five beds were out of use due to a leaking toilet. The only midwifery-led birthing centre is in Chichester. This had two rooms. Both were a good size with birthing pools and were well maintained.

We heard from staff about the challenges of working across the four sites, and a legacy divide between Brighton and Haywards Heath and Chichester and Worthing was apparent. Although staff did highlight positives such as their ability to get advice from a Head of Midwifery at another site if their Head of Midwifery was on leave, we also heard that there are variations and inconsistencies between sites. Staff told us that working across the trust is geographically challenging and it is a long drive between sites. The geographical spread is a particular issue for neonatal care because the trust is covered by two different neonatal networks.

Across all sites we heard about stretched staffing, difficulties navigating the digital systems and varied accounts of the visibility of senior managers. We were concerned that a strong learning culture did not appear to be embedded. More than one senior clinician in neonatal services had not heard of important changes to the national investigation framework called Patient Safety Incident Response Framework (PSIRF). Although staff talked about case reviews, some senior clinicians did not seem to have actively participated in investigatory processes, such as PSIRF.

What staff told us

In addition to meeting with the executive team, we also met with front line staff across all four sites in Sussex. They spoke to us about low staff morale and demand on the services. They also described practical challenges presented by the trust geography, estate and IT systems which made their roles more difficult. While there was consistency in some aspects of the staff experience, in others there was large variation between the sites.

Across Sussex, staff described a strong commitment to women, babies and families, and told us that teams often relied on each other to keep services going under sustained pressure. Staff spoke positively about teamwork and multidisciplinary working across all four sites, and many said their immediate leaders and clinical managers were approachable and supportive during difficult periods. At the same time, staff told us that ongoing negative media coverage had affected morale and added to the emotional weight of their work.

> *"You can think you've done the best job in the world... then you are reading all these things in the press, and you can't help but feel so negative about the work you've done as a whole."*

Staff based in Worthing described it as *"a really nice place to work"* with an open, approachable culture where *"the door's always open"* and hierarchy feels less pronounced. This contrasted with the other three sites, where although staff were positive about team relationships and immediate line management, morale was generally lower. In Chichester, staff spoke of feeling "very disheartened" and we heard how staff members, "*get burnt out, they get anxiety… it's breaking people*".

Staff across the Trust described inconsistencies in leadership and governance. They provided examples of strong local leadership alongside concerns about visibility, consistency and wider organisational support. Staff working on postnatal and antenatal wards described limited engagement from the executive team. This contributed to a sense of being overlooked or less supported within the wider service.

> *"In five years, I've never seen [them] step one foot on postnatal ward."*

Although staff told us that leadership within their own teams often felt supportive and approachable, this was not always their experience beyond their division. Some said it was harder to get timely support for trust-wide safety concerns or when issues involved other departments, which left feeling that concerns were less likely to be heard and acted on. A number of staff contacted us to raise concerns about patient safety, unsafe staffing levels and issues such as bullying of staff when they tried to raise matters of patient

safety. The main patient safety issue they raised with us was that they considered maternity staffing levels were not safe.

Staff told us there were clear processes for responding when things went wrong, including debriefs, incident reporting and formal reviews, and that efforts had been made to involve staff more openly in investigations. However, staff also said that learning was not consistently embedded across services.

Staff described services operating under sustained pressure, with demand sometimes exceeding the capacity available to respond safely. We were told that there was very little flexibility in the system, meaning that even small increases in demand could have a significant impact on patient care. In addition, waiting for assessment, treatment and theatres had become normal.

> *"It is a regular occurrence for patients to be waiting… we have normalised the fact that that's how we now operate… it's incredibly challenging."*

Staff also described how workforce shortages were compounded by recruitment and retention issues in some areas and how staffing pressures affected the experience and development of new staff. We heard from staff that they had raised concerns that newer midwives were not able to gain enough experience due to the way services were operating.

> *"We have people drop out not for the love of the job, but for just the inability to be able to provide the care they want."*

Staff told us that they were caring for increasing numbers of women with complex health and social needs, including women experiencing homelessness, substance abuse, language barriers or previous trauma. They described efforts to provide more tailored and accessible support but said this was not always possible consistently because of limited time, space and resource constraints across services.

The delivery of services across four hospital sites shapes women's and families' experiences of care. Staff also told us that working across four sites created practical and emotional pressures for them. They described being asked, sometimes at short notice, to travel to other hospitals which could mean working in unfamiliar wards and feeling out of their comfort zone. This geographical spread made it harder to coordinate care, reach colleagues quickly and maintain consistency across teams.

Staff described how the estate and available resources affected both safety and experience for women, babies and families. They told us that limited space, equipment shortages, overcrowding and delays in moving women between areas could make care

more difficult and, at times, less personal. Some buildings and layouts were outdated or not designed for current levels of demand or modern models of care.

Across sites, staff said estate limitations were not only a practical issue for staff but also shaped how women and families experienced care, particularly when it did not support a sense of safety.

"We're in a building that's literally falling down."

"They come in here… and the building is the way it is… it devalues birth, it devalues women."

What this means for families and services in Sussex

For families in Sussex, the evidence suggests that women and birthing people, babies and families are not always being listened to, treated with kindness and experiencing safe, consistent care wherever they use services. We heard concerns about not being listened to, delays in escalation, poor handovers and defensive responses after harm. In a context of significant family concern and sustained media attention, these experiences can make it harder for families to feel safe, heard and supported at some of the most important moments in their care.

For maternity care, the evidence suggests that families' experiences may be shaped by both the site they attend and the level of pressure services are under at the time. Staff described burnout, low morale and ongoing capacity pressures, including the challenge of working across multiple hospital sites, sometimes at short notice. This can make it harder to provide consistent care and continuity for women and families. We also heard that there are clear differences between sites. Worthing was described more positively by staff, with a more open culture, while staff in Chichester spoke of feeling disheartened and burnt out. Maternity services were rated good at Worthing, but required improvement at Royal Sussex County Hospital, Princess Royal Hospital and St Richard's Hospital.

The estate also matters because it affects privacy, dignity, comfort and how care is experienced. Princess Royal Hospital was described as spacious, while parts of Royal Sussex County Hospital were described as inadequate, with maternity and neonatal services spread across multiple floors and some areas feeling cramped. Across sites, staff said that outdated buildings, overcrowding and limited space could make care more difficult to deliver well and more difficult for families to experience as supportive.

For neonatal care, the evidence suggests a busy service caring for babies with complex needs, but with important differences across sites. Royal Sussex County Hospital provides the Trust's Level 3 neonatal intensive care unit, while the other units have Level 1 special care baby units. Staffing levels and requirements in neonatal services varied considerably between hospitals. In the 12 months ending October 2025 at the Royal Sussex County Hospitals only 50.1% of shifts were staffed according to BAPM guidelines and service specifications versus at Worthing Hospital where 95.1% of shifts met those guidelines and specifications.

Families told us that understaffing could affect one-to-one care, continuity and how involved they felt in decisions about their baby's care. Staff also said that working across four sites created additional pressure, and that this was especially difficult in neonatal care because the Trust works across two neonatal networks.

Across both maternity and neonatal care, the evidence suggests that the improvement work being conducted by the Trust needs to deliver real change for families and staff. It is not just about plans and performance data. At the initial executive meeting, leaders

highlighted positive data, but this did not fully reflect the pressures, inconsistencies and concerns raised by frontline families and frontline staff. Staff did not show strong involvement in the wider transformation work, and experiences of leadership visibility beyond immediate teams were mixed.

In May 2026, then Secretary of State for Health and Social Care confirmed that an external review of the Trust's maternity services will be chaired by Donna Ockenden. This review is expected to be a wide-ranging process to assess the cases of more than 1,000 families, from 2018 onwards.

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
- 9 family evidence panels with women and families
- Interviews with 6 women and families
- 6 listening events across different staff groups and grades
- Interviews with 15 members of staff

- 8 additional pieces of information were sent to the Investigation email box which were submitted as evidence for University Hospital of Sussex NHS Foundation Trust.

Recruitment for and promotion of the family evidence panels with women, birthing people and families was supported by the University Hospitals Sussex Maternity and Neonatal Voices Partnership (MNVP) Leads, who also worked with local third sector organisations to ensure widespread involvement. Local MPs were approached to help promote the events and support recruitment. Additional events were held with families who had approached the Investigation directly. Sussex Interpreting Services held a further four listening events with families from lesser heard communities comprising of Bengali, Turkish, Arabic and Portuguese speakers on behalf of the Investigation.

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