

Maternity & Neonates CQC and MSSP Reports and Action Update

Public Board
31 July 2025

Presented for:	Discussion and approval
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Previous Committees:	

2025/26 Commitments	Category	✓
Support our patients to get home a day sooner	Care	
Be in the top 25% trusts for patient experience and efficiency in outpatient	Quality	
Support each other to act with kindness and compassion	Team	✓
Recognise and act upon moments that matter to our patients	Compassion	✓
Support our staff to spend every pound wisely	Finance	✓
Make best use of our estate, equipment and digital assets	Resources	✓
Reduce our carbon footprint by creating greener patient pathways	Sustainability	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	✓	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Moving Away
Operational Risk				
Clinical Risk	✓	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving away
Financial Risk		Financial Reporting Risk - We will deliver sound financial management and reporting for the Trust, with no material misstatements or variances to forecast.	Minimal	Moving away

External Risk	✓	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving away
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Key points		
1. This report provides a summary of the CQC regulatory inspections of Maternity and Neonatal Services and NHS England Maternity Safety Support Programme (MSSP).		For information
2. The Care Quality Commission (CQC) conducted unannounced inspections of the Trust's maternity services from 9 to 11 December 2024 and neonatal services from 14 to 16 January 2025, following concerns raised by families and whistleblowers about the level of care being provided.		For information
3. In January 2025, NHS England held a Rapid Quality Review meeting in relation to maternity services at Leeds. As part of this review, it was agreed that the Trust would take part in an enhanced Maternity Safety Support Programme (MSSP), which involved an onsite diagnostic review visit in March 2025. In July 2025 the Trust received a letter of formal entry into the Maternity Safety Support Programme and the final MSSP Diagnostic report.		For information
4. On 20 June 2025 the CQC final reports were published, these highlighted significant areas where the Trust needs to urgently improve its maternity and neonatal services, and the priority is to make sure the Trust takes action to deliver these improvements. On 20 June 2025 the Trust received formal notification of the regulatory breaches set out within the CQC reports. The Trust were required to respond within 28 days setting out what action the Trust would take in response to where the regulation was not being met, how the Trust will assure completions and effectiveness of the actions and how the Trust is providing safe care until the regulation is met. The Trust responded on 18 July 2025.		For information
5. The Trust have developed an overarching Maternity and Neonatal action plan, which will address all the actions identified in the CQC reports, the MSSP reports, and other recommendations from reviews we have commissioned or are involved in. Alongside this the Trust has been developing plans to establish a Maternity and Neonatal Improvement Programme Board. This board will have an independent chair to support the delivery of sustainable and transformational change across maternity and neonatal care. The Trust has recently successfully recruited to the role of chair. The Trust will be recruiting staff and service users to be part of the programme board and the workstreams which make up the programme. The key priority for this programme will be to make the improvements required to ensure we are providing the highest quality of care for our families, and one of the best places to work,		For information

ensuring this is done by listening and working with our families and our staff.	
<p>6. The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It refunds the Maternity Incentive Scheme payment made to NHS Resolution for Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns.</p> <p>The National Perinatal Quality Oversight Model states each Trust should have in place effective board oversight for perinatal quality and safety. The Trust Board are asked to delegate oversight of the Maternity Incentive Scheme (MIS) Year 7 to the Quality Assurance Committee whilst a full review of the Trust reporting processes is undertaken. The Quality Assurance Committee has oversight of evidence, assurance and emerging risk in relation to maternity and neonatal services, this will be strengthened in year seven.</p>	For discussion
<p>7. Trust Board are asked to:</p> <ul style="list-style-type: none"> • Note the outcome of the CQC Inspections of Maternity and Neonatal Services, changes to ratings and regulatory breaches. • Note the Section 29A Warning Notice received and the Trust response in relation to Midwifery staffing. • Review and note the Neonatal Services CQC improvement action plan and monthly oversight of HRG care days for May 2025. • Note the MSSP final report and formal letter stating the entry to the MSSP programme. • To formally note and approve the delegation of oversight of the Maternity Incentive Scheme (MIS) Year 7 to the Quality Assurance Committee, noting a full review of the Trust reporting processes will be undertaken and reported to Board. • Note that whilst in the NHS England Quality Assurance and Improvement process and CQC inspection process the Trust is moving away from the risk appetite set by the Board for Workforce risk – workforce supply risk, External risk - Regulatory risk and Clinical Risk – Patient Safety and Outcomes. This is reflected in the risk related to the Trust's position regarding CQC Regulation under the Health and Social Care Act 2008 that was added to the Corporate Risk Register as CRRE1 following review at Risk Management Committee on 3 July 2025. • Note that the Trust continues to be responsive to all requests from regulators and stakeholders. 	For decision

1. Summary

This report provides a summary of the CQC regulatory inspections of Maternity and Neonatal Services and NHS England Maternity Safety Support Programme (MSSP).

2. Background

Leeds Teaching Hospitals NHS Trust provides maternity and neonatal care across St James's Hospital and Leeds General Infirmary.

The Maternity service delivers more than 8,500 babies each year and, alongside providing regular maternity care for the people of Leeds, it also provides support for those families from across Leeds and the wider region requiring highly specialised and complex care during their pregnancy.

The Neonatal unit at Leeds General Infirmary is a Neonatal Intensive Care Unit, which provides intensive care, high dependency care, and specialist surgical care for some of the sickest babies from across the region. The neonatal unit at St James's is designated as a Special Care Baby Unit (SCBU). Staff work across both units and are trained to deliver the highest level of neonatal care.

Recent regulatory inspections, and concerns raised by families, have highlighted significant concerns about the services. As a Trust, we have genuinely committed to improving our Maternity and Neonatal services and we are deeply sorry that some families have been let down by the care they have received in our hospitals.

This paper provides an overview of these inspections, the concerns raised, and the actions being taken by the Trust to ensure we provide the highest quality care for our families using these services.

3. Summary of scrutiny of maternity and neonatal services

The Care Quality Commission (CQC) conducted unannounced inspections of the Trust's Maternity services from 9 to 11 December 2024 and Neonatal services from 14 to 16 January 2025, following concerns raised by families and whistleblowers about the level of care being provided.

In January 2025, NHS England held a Rapid Quality Review meeting in relation to maternity services at Leeds. As part of this review, it was agreed that the Trust would take part in an enhanced Maternity Safety Support Programme (MSSP), which involved an onsite diagnostic review visit in March 2025. The Trust has received a draft report following this visit, which has been reviewed for factual accuracy. In July 2025 the Trust received a letter of formal entry into the Maternity Safety Support Programme, included as 10.1 (i) Blue Box MSSP entry letter, and the final MSSP Diagnostic report, included as 10.1 (ii) Blue box MSSP Diagnostic report FINAL.

On 20 June 2025, the CQC published their reports into Leeds Maternity and Neonatal services. Leeds Maternity Services has been rated inadequate from the previous rating of Good, and neonatal services were rated as requires improvement (not previously rated). A copy of the Trust's response to the reports was published on its website on 20 June 2025 and can be accessed here: [Leeds Teaching Hospitals commits to improvements following CQC reports on maternity and neonatal services - Leeds Teaching Hospitals NHS Trust.](#)

The Trust is commissioning an independent external review into the Neonatal mortality figures to gain understanding of the data. The terms of reference for this review are being reviewed by NHS England. In the meantime, the Trust has taken part in NHS England's Peer Quality Review of neonatal services on 16 and 17 July 2025.

In June 2025, the Secretary of State for Health, and Social Care, announced a rapid national investigation into NHS Maternity and Neonatal services at 10 hospitals, and a National Maternity and Neonatal Taskforce. At the time of writing, it has not been confirmed that Leeds Teaching Hospitals NHS Trust will be included in the national investigation, the Trust would welcome the opportunity to be involved and would fully support its focus on improving maternity safety. The Trust remains committed to working closely with partners at NHS England, West Yorkshire Integrated Care Board (ICB), Local Maternity and Neonatal System (LMNS), the CQC, our staff and families who use our services, to ensure the highest standards of care in our Maternity services.

4. CQC report findings and immediate improvements

The full CQC reports can be accessed here:

[CQC reports for Leeds General Infirmary](#)

[CQC reports for St James's University Hospital](#)

The CQC reports highlighted significant areas where the Trust needs to urgently improve Maternity and Neonatal services, the priority is to make sure action is taken to deliver these improvements.

The rating for Maternity services at both hospitals has deteriorated from good to inadequate overall, in addition to inadequate for being Safe and Well-Led. The CQC domains for Effective and Caring have been rated as requires improvement and Responsive has been rated as good.

Neonatal services at both hospitals have been rated as requires improvement overall and for being Caring, Responsive and Well Led. Effective is rated as good and Safe is rated as inadequate.

The Trust's overall CQC rating remains good.

We want to reassure every family due to have their baby with us in Leeds and any new parents that we are absolutely committed to providing safe, compassionate care. We deliver more than 8,500 babies each year and the large majority of those are safe and positive experiences for our families. But we recognise that's not the experience of all families. The loss of any baby is a tragedy, and we are extremely sorry to the families who have lost their babies when receiving care in our hospitals.

Some of the specific areas of concern highlighted following the inspection include:

- **Maternity Staffing:** The CQC issued a Warning Notice under section 29A of the Health and Social Care Act 2008 on 14 February 2025 regarding staffing in the maternity service and the need to meet national standards as outlined in Birthrate Plus 2024. The Trust responded to this letter providing assurance that it was progressing in line with a plan agreed the previous year and had an active recruitment plan to meet this standard.

More detail about midwife recruitment plans is included in the “Immediate improvements” section below.

A weekly report is reviewed by the Chief Nurse and Director of Midwifery and submitted to CQC for regulatory oversight. The report includes a breakdown of the number of midwifery staff for each shift on all maternity wards set against the planned levels and Birthrate Plus 2024 review.

- **Designation of St James’s neonatal unit:** The Trust received a letter dated 27 January 2025 regarding Possible Urgent Enforcement Action under Section 31 of the Health and Social Care Act 2008.

This related to concerns that the St James’s University Hospital Neonatal Service was operating above its current designation of a Special Care Baby Unit. The Trust had previously agreed with the Yorkshire and Humber Neonatal Operational Delivery Network to provide some additional less complex elements of intensive care and high dependency care on this site.

However, the CQC identified some concerns about the equipment provision at St James’s and asked the Trust to stop providing these less complex elements of intensive care and high dependency care at this location. The was put this in place immediately. More details are included in the “Immediate improvements” section below.

- **Culture within the maternity service:** The report highlighted that senior leaders did not always listen to staff about their concerns or when they needed support, and that staff were reluctant to raise concerns as they were worried about blame. They also highlighted that the Trust needed to listen more to families to understand their concerns and address these to ensure everyone’s experience is of the highest standard.
- **Infection prevention and control:** The environment was not always safe, and some areas could put people at risk of infection.
- **Medicines management:** Medicines were not always stored or managed safely to minimise the risk of harm.

Immediate improvements

The Trust has already started making improvements to address the concerns the reports raise. Some of these include:

- Recruiting 55 midwives since autumn 2024 after additional funding was agreed by the Board last year. We are currently 11 midwives short of our nationally recommended target of 367 (Birthrate Plus 2024) but we continue to actively recruit to meet this standard. A further 35 newly qualified midwives are due to start work at the Trust this autumn.
- Immediately responding to CQC concerns about some babies being transferred from Leeds General Infirmary to the SCBU at St James’s when it was not safe to do so due to the equipment available at this location.

- Strengthened our midwifery leadership across both sites of our Maternity service to further support our clinical teams in their delivery of high-quality compassionate care to all our women, birthing people, and families.

Our Neonatal doctors and nursing staff are qualified and trained to treat babies that need all levels of care, and they work across both Leeds General Infirmary and St James's University Hospital sites providing care where it is needed. Because of this we have previously provided some less complex elements of intensive care and high dependency care at St James's. However, the CQC identified some concerns about the equipment provision at St James's and asked us to stop providing these less complex elements of intensive care and high dependency care at this location. We put this in place immediately and implemented an escalation process to ensure appropriate review and consideration of impact on the baby and family is discussed with the leadership team prior to agreement to remain on the unit for longer than the 24-hour standard.

CQC reviewed the action plan and assurances provided and confirmed on 7 February 2025 that urgent enforcement action would not be taken at this time and the assessment of risk would continue to be informed by the CQC's regulatory oversight. The Trust's Quality Assurance Committee will maintain oversight and monitoring of the CQC action plan, reporting to Trust Board.

- Addressing the concerns regarding culture within our maternity services by increasing the number of Freedom to Speak Up Champions and encouraging staff to report concerns; holding regular Time to Talk meetings for each staff group and monthly open meetings with the Chief Executive, Chief Nurse and Director of Midwifery/Deputy Chief Nurse.
- Listening to families by holding listening events with our Chief Nurse, Director of Midwifery/Deputy Chief Nurse so we make can do things differently and make immediate improvements.
- Reviewing our complaints process to ensure we are listening and understanding our families' experiences and identifying ways to improve their care.
- Improving infection control and cleanliness by having a greater presence of matrons on our wards; increasing the visits and inspections in wards areas; and replacing damaged furniture and equipment.
- Improving our medicine storage and management with a full stock audit and comprehensive checks implemented.

Actions to address regulatory breaches

On 20 June 2025 the Trust received formal notification of the regulatory breaches set out within the CQC reports. The Trust were required to respond within 28 days setting out what action the Trust would take in response to where the regulation was not being met, how we will assure completion and effectiveness of the actions and how the Trust is providing safe care until the regulation is met. The Trust responded on 18 July 2025, the Trust response is included within *10.1 (iii) Blue box* Report on improvement actions to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation in relation to Maternity and Neonatal Services CQC inspections 2024/25.

Management of maternity and neonatal improvement actions

We have developed an overarching Maternity and Neonatal action plan which will address all the actions identified in the CQC reports, the MMSP reports, and other recommendations from reviews we have commissioned or are involved in.

Alongside this we have been developing plans to establish a Maternity and Neonatal Improvement Programme Board. This Board will have an independent chair to support the delivery of sustainable and transformational change across maternity and Neonatal care. We have recently successfully recruited to the role of chair. We will be recruiting staff and service users to be part of the Programme Board and the workstreams which make up the Programme.

The key priority for this Programme will be to make the improvements required to ensure we are providing the highest quality of care for our families, and one of the best places to work, ensuring this is done by listening and working with our families and our staff.

This Programme Board will focus on specific workstreams, including:

- Providing safe and compassionate care for families
- Transforming our culture and leadership
- Listening to staff and patients
- Understanding the needs of our local communities
- Wellbeing and development of our workforce
- Health inequalities

The Trust has established a monthly Perinatal Assurance Meeting, which will report on the quality and safety of maternity services, services delivery and progress against the associated action plans. The Trust's Quality Assurance Committee (QAC) and Trust Board have received regular updates of the progress of the inspections and any associated action plan or regulatory action.

QAC and the Board have also received regular assurance related to the NHS England Rapid Quality Review and Maternity Safety Support (MSSP) diagnostic.

Regular updates on the Trust's Maternity and Neonatal Improvement Programme Board's progress against the improvement plan will be reported in public through our Trust Board meetings.

Maternity Incentive Scheme year seven

The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It refunds the Maternity Incentive Scheme payment made to NHS Resolution for Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns. The role of the Trust includes statutory responsibility for high-quality services which are safe, effective, efficient and take account of health inequalities and effective system working and delivery of our contribution to system strategies and plans.

The National Perinatal Quality Oversight Model states:

Each Trust should have in place the following to ensure board oversight for perinatal quality and safety is robust:

1. A Board Safety Champion Non-Executive Director (NED) is visibly working alongside the Board Safety Champion for perinatal (midwifery, obstetric and neonatal) to provide objective, external challenge and enquiry.

The Trust has a Non-Executive Maternity Safety Champion, Laura Stroud supporting the Chief Nurse, Rabina Tindale as the Board Maternity Safety Champion.

2. Each trust must also have an identified frontline midwifery, obstetric and neonatal safety champion who meet on a regular basis with the board safety champion(s)

The Director of Midwifery, Rukeya Miah is the frontline Maternity Safety Champion.

3. The Trust Board (or an appropriate sub-committee with delegated responsibility) discusses perinatal safety intelligence at least quarterly, demonstrates professional curiosity and is responsible for shared learning across the organisation. Discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). For neonatal incidents, the Trust should work with the relevant Neonatal Operational Delivery Network (ODN) to identify and manage risks alongside the ICB

The Quality Assurance Committee has historically provided oversight of evidence, assurance and emerging risk in relation to Maternity and Neonatal services. In light of the reviews of the process, evidence, and feedback from MIS this will be strengthened in year seven. The Trust Board are asked to formally note and approve the delegation of oversight of the Maternity Incentive Scheme (MIS) Year 7 to the Quality Assurance Committee, noting a full review of the Trust reporting processes will be undertaken and reported to Board. For assurance for the remainder of year seven, this will be a dual reporting processes with all details and assurance reports to QAC, also provided to the Board for its own assurance both of details and revisions to the process moving forward.

The Trust reports externally to the Local Maternity and Neonatal Service and to the ODN.

1. A locally agreed Board report which should consider including the recommended measures set out within the guidance should be presented by a member of the Perinatal Leadership Team to provide supporting context.

The Quality Assurance Committee will receive reporting and evidence against the Maternity Incentive Scheme year seven presented by the Perinatal Leadership Team. The flow of this information and assurance to Board members will be established.

5. Regional implications

The CQC has asked the Trust to stop providing additional less complex elements of intensive care and high dependency care at St James's University Hospital, and instead provide all intensive care and high dependency care at Leeds General Infirmary, as a designated neonatal intensive care unit.

Individuals are still able to give birth at St James's University Hospital and babies will receive the appropriate level of care in the Special Care Baby Unit, but if babies need more than 24 hours of intensive care or high dependency care, they will be transferred to Leeds General Infirmary or another unit.

The Trust Board are asked to support the training and development of key staff in the criteria for admission and transfer, clinical risk and wellbeing of all family members who may be processing this development differently.

6. Financial Implications

There are no financial implications within this paper.

7. Risk

Whilst in the NHS England Quality Assurance and Improvement process and taking actions to address the CQC regulatory breaches the Trust is moving away from the risk appetite set by the Board for Workforce risk – Workforce Supply risk, Finance risk – Financial reporting risk, External risk - Regulatory risk and Clinical Risk – Patient Safety and Outcomes.

The Risk Management Committee will receive monthly reporting against corporate risk CRRC13: CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services and will monitor progress against completion of regulatory breach actions, controls in place and further mitigating actions.

8. Communication and Involvement

The Trust have produced communications for members of the public to provide assurance regarding using maternity and neonatal services at LTHT.
Regular communication and update is also provided to all staff.

9. Equality Analysis

Not applicable.

10.Improving Health Equity

The Trust is committed to improving health equity meaning reducing the unfair and avoidable differences in health some groups experience. The Trust have established a Maternity and Neonatal Improvement Board. Workstream 4 engagement and communications and workstream 5 culture, leadership and inclusion will ensure all improvement work is aligned to the Trust Health Equity Strategy.

11.Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

12.Recommendation

Trust Board are asked to:

- Note the outcome of the CQC Inspections of Maternity and Neonatal Services, changes to ratings and regulatory breaches.

- Note and receive assurance on the report on improvement actions to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation in relation to Maternity and Neonatal Services CQC inspections 2024/25
- Note the Section 29A Warning Notice received and the Trust response in relation to Midwifery staffing.
- Note and receive assurance on the Neonatal Services CQC improvement action plan and monthly oversight of HRG care days for May 2025.
- Note and receive the MSSP final report and formal letter stating the entry to the MSSP programme.
- To formally note and approve the delegation of oversight of the Maternity Incentive Scheme (MIS) Year 7 to the Quality Assurance Committee, noting a full review of the Trust reporting processes will be undertaken and reported to Board.
- Note that whilst in the NHS England Quality Assurance and Improvement process and CQC inspection process the Trust is moving away from the risk appetite set by the Board for Workforce risk – workforce supply risk, External risk - Regulatory risk and Clinical Risk – Patient Safety and Outcomes.
- Note that the Trust continues to be responsive to all requests from regulators and stakeholders.

13. Supporting Information

The following papers make up this report:

- 10.1 (ii) *Blue Box MSSP entry letter*
- 10.1 (iii) *Blue Box MSSP Diagnostic report FINAL*
- 10.1 (iv) *Blue Box Report on improvement actions to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation in relation to Maternity and Neonatal Services CQC inspections 2024/25*

Rukeya Miah, Director of Midwifery & Lucy Atkin, Head of Quality Governance
18 July 2025