

23 July 2025

Prof. Phil Wood  
Chief Executive Officer  
Leeds Teaching Hospitals NHS Trust

Dear Phil

**Neonatal critical care**  
**Notification of quality peer review visit findings**

Firstly, I would like to extend my thanks to you and your colleagues for accommodating the quality peer review of neonatal services delivered by the Trust at both the LGI and SJUH sites last week.

I had the privilege of accompanying the reviewers during the site visits conducted on the 16th and 17th of July. The service was exceptionally welcoming and constructive throughout, and we greatly appreciated the open and supportive approach taken to the quality peer review process. I would also like to acknowledge the presence and engagement of your executive team at both the briefing and feedback sessions, which clearly reflects a strong commitment to service quality and continual improvement.

The reviewers were mindful of the inspection burden the service has faced in recent months, over and above the ongoing challenges of delivering care and treatment to some of the most vulnerable patients and their families. Nonetheless, they were impressed by the patient-centred and compassionate care demonstrated by staff, the evident mutual respect and support across all roles and backgrounds, and the inclusive approach to leadership and service delivery. In addition, the reviewers commended many of the service's developments, particularly the approach to surgical care, which is notably underpinned by a robust governance structure, consistent daily ward rounds, and an effective surgical outreach model. The reviewers also recognised the service's responsiveness to previous external feedback, citing as an example the establishment of a tier 3 doctor rota following the compliance review conducted in 2024.

The purpose of this letter is to bring to your attention any immediate risks or serious concerns identified by the reviewers, and to request that you provide an action plan in response. I am pleased to report that the reviewers identified no immediate risks within the service.

However, the reviewers did identify several serious concerns that warrant your attention, specifically:

1. An externally driven review has led to the closure of cots at SJUH. This has significantly compromised overall capacity at SJUH and is having a wider impact across the network.
2. There is a lack of clarity regarding the number of cots commissioned by ICBs/NHS England, and how this relates to the number of currently operational cots, and the underpinning budgeted nursing establishments (including those roles focused on quality enhancement). This uncertainty impacts the ability to accurately understand the required workforce and skills mix and poses a challenge to effectively plan and build future capacity.
3. There are significant gaps in AHP provision, with current staffing levels falling short of the required standards. The team is understaffed across all AHP disciplines due to persistent underfunding. This shortfall not only affects compliance with NICE guidance for the neonatal follow-up programme but also results in non-compliance with the service specification for inpatient neonatal care. As a result, there is likely to be a negative impact on long-term neurodevelopmental outcomes for patients and reduced support for families.
4. The absence of accessible psychological support for all disciplines within the neonatal team is contributing to increased levels of staff burnout and moral distress. Staff are frequently exposed to emotionally demanding situations, and without appropriate mental health resources, their ability to cope diminishes over time. This not only impacts individual staff wellbeing but also has wider implications for the service and may affect recruitment and retention.
5. The neonatal team are providing mutual aid to paediatric services. Whilst this is supportive during staffing shortages, the units may become understaffed, leading to delays in care, increased workload for remaining staff, and potentially poorer outcomes for patients. The service should reconsider the neonatal capacity and support safe staffing on the units.

An action plan addressing the serious concerns is required within 20 working days from the date of this letter. Upon receipt, the quality team will review the content in collaboration with myself and the quality lead from the Yorkshire and Humber Commissioning Hub. If deemed appropriate, the action plan will then be formally handed over to the Commissioning Hub for ongoing monitoring of its implementation.

The Trust will have the opportunity to review the draft reviewers' report and verify the factual accuracy of its contents in approximately four weeks. Once this process is complete, the report will be finalised and shared with both the Trust and the Commissioning Hub for follow-up through contracting meetings.

Should you have any specific queries about the quality peer review, or the issues raised, in the first instance please contact Jayne Wilson, Quality Manager at [jayne.wilson17@nhs.net](mailto:jayne.wilson17@nhs.net).

Yours sincerely

A handwritten signature in blue ink, appearing to read 'M. Lambert'.

Dr Mark F Lambert  
Regional Medical Director (Commissioning) North East and Yorkshire  
NHS England

cc. Magnus Harrison, Chief Medical Officer, LTHFT  
Rabina Tindale, Chief Nurse, LTHFT  
Beverley Geary, Director of Nursing, WY ICB  
James Thomas, Chief Medical Officer, WY ICB  
Annesha Archyangelio, Regional Director of Nursing, Direct Commissioning, North East and Yorkshire, NHS England  
David Purdue, Chief Nurse, North East and Yorkshire, North East and Yorkshire, NHS England  
Tracey Cooper, Chief Midwife for North East and Yorkshire, NHS England  
Hamish McLure, Regional Medical Director, North East and Yorkshire, NHS England  
Sarah Halstead, Head of Specialised Commissioning, Yorkshire and Humber, NHS England