

Maternity and Neonatal Update Report

Public Board
25 September 2025

Presented for:	Information
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Previous Committees:	NONE

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	✓
Be in the top 25% for patient experience and efficiency in outpatients	
Support each other to act with kindness and compassion	✓
Reduce our carbon footprint by creating greener patient pathways	✓
Support our staff to manage every £ wisely	
Make best use of our estate, equipment and digital assets	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	✓	Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services	Cautious	Moving Away
Operational Risk	✓	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Minimal	Moving Towards
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 Management & WRP - We will deliver sound financial management and	Minimal	Moving Away

		reporting for the Trust, aiming to at least break even, with no material variances to forecast.		
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

Key points		
1. Now formally in the Maternity Safety Support Programme (MSSP) the Trust are working with NHS England on the Perinatal Improvement Plan. The Trust are addressing CQC regulatory breaches to improve the experience for women, families and birthing people. The Trust is working with the perinatal team to seek assurances, identify key risks and support to mitigate		Information
2. The Perinatal Mortality Review Tool (PMRT) review group reviewed 7 perinatal mortality cases in August 2025. One case was graded a D and escalated to the Trust Weekly Quality Review Group to consider potential for further learning.		Information
3. A Perinatal Improvement Action Plan has been developed, and a task and finish delivery group meet weekly to review progress of actions. Progress is monitored weekly by the Executive team and presented at the monthly Perinatal Assurance Group.		Information
4. The overall compliance across all elements of Saving Babies Lives V3 (SBLV3) via self-assessment and Local maternity and Neonatal System (LMNS) validation, is 88%.		Information
5. British Association of Perinatal Medicine (BAPM) medical staffing standards will be compliant from September 2025, with 18 WTE Neonatologists in post. This will allow separate consultant cover at LGI and SJUH for 7 days per week.		Information
6. The neonatal unit currently has 68% (against a target of 70%) of neonatal nurses Qualified in Speciality (QIS) a Neonatal Nurse qualification. Projections show the target will be achieved by January 2026.		Information
7. The neonatal unit does not currently meet the requirements of the National Neonatal Workforce Tool for neonatal nurse staffing. Following investment in staffing and a phased recruitment process, the service will achieve compliance. Eleven Registered Nurses commenced in post on the 15 th September 2025. The remaining 12 candidates will onboard between October and December 2025.		Information
8. A neonatal peer review lead by NHSE took place between 16th and 17th July 2025. The review team visited both Neonatal Units, hosting a series of staff focus groups and reviewing cases of neonatal mortality. Feedback was given to the senior team at the end of the visit and an initial outcome letter was received by the Trust on 24th July 2025. No immediate risks were identified by the peer review team at the time of their visit. An action plan has been created in response to the serious concerns set out in written feedback and has been submitted to the external review team.		Information
9. The maternity services do not currently meet the 2024 Birthrate Plus recommendations for clinical or non-clinical specialist and management staff. There is a pipeline of 57.86 WTE midwives, starting in post between September 2025 and January 2026 that will enable fill		Information

all clinical vacancies, allowing for backfill of maternity leave and rolling attrition to year end. The nonclinical, specialist, and management deficit has been partially met but further plans are required to close the gap. There are two risks on the risk register related to maternity staffing scoring 16 and 20.	
10. There are obstetric medical vacancies, which may impact the quality of clinical care. Consultant staffing is on the CSU Risk Register, with a score of 16 with controls in place to mitigate the gaps in control. A paper has been approved by Executives with immediate support for two agency locums to support the current 22.65 weekly PA gap to cover current requirements. Recruitment to these posts has been successful.	Information
11. Progress with Year 7 of the Maternity Incentive Scheme is continuously under review with a meeting scheduled in September to prioritise any deficient areas.	Information

1. Summary

This paper provides assurance to the Trust Board on the monitoring and management of perinatal risks. It confirms that maternity and neonatal quality and safety are regularly reviewed using a minimum data set aligned with the National Perinatal Quality Surveillance Model. To ensure there is opportunity for robust in-service discussion and validation of data, there is a reporting time lag. This reduces the significant risk which would be posed by sharing non-validated data and information internally and externally.

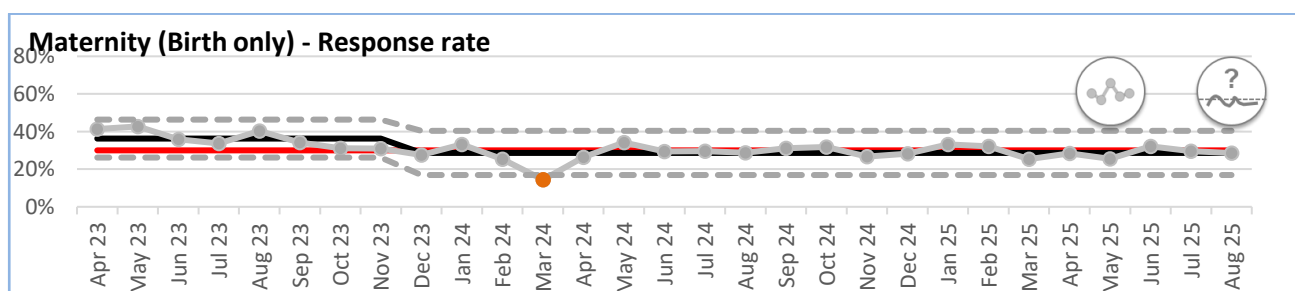
2. Background

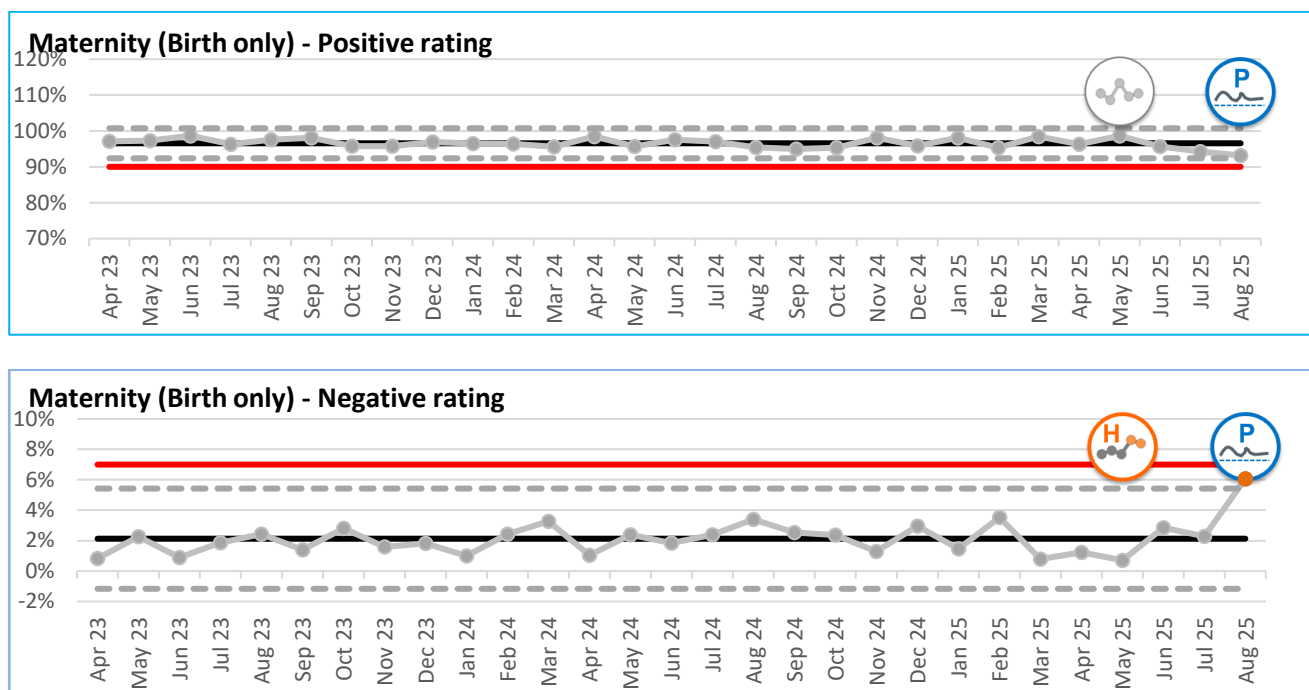
Listening to Women and Families

Friends and Family Test

Friends and Family Test (FFT) responses are monitored monthly and trends and themes analysed using quantitative and qualitative data. During August 2025 there was a significant increase in negative ratings for birth. Analysis of qualitative data highlighted adverse themes associated with communication, compassion, environment, patient mood/feeling, treatment and care, pain management, staffing resources and waiting time.

The other areas not meeting the 90% positive target were the antenatal services at St James University Hospital (SJUH) and postnatal services on both sites. Themes identified related to patient mood/feeling, communication, waiting times, environment, staffing resources and treatment and care and being unable to contact administrative teams for scan bookings. It is important to note that there were low numbers of responses for these areas which are linked to extreme percentage values. All areas of the neonatal services exceeded the 90% positive target.





Maternity and Neonatal Voices Partner (MNVP)

Collaborative work continues with the MNVP chair and service leads to ensure the voice of women and birthing people drives service improvements. A maternity and neonatal stakeholder improvement day was held on the 1 September 2025. This will be followed up with further events and aligned with the maternity and neonatal services improvement board actions and recommendations. The improvement board has an independent chair and multiple stakeholders to support the improvement journey and offer check and challenge.

A 15 steps review of all areas of the maternity service including transitional care was undertaken on the 8th September 2025. The review included a range of professionals, including maternity and neonatal staff, health equity team, Trust EDI lead and the learning disability and autism specialist nurse. There were six LGBT service users with lived experience, services users with English not being their first language, and service users with diverse BME and cultural backgrounds.

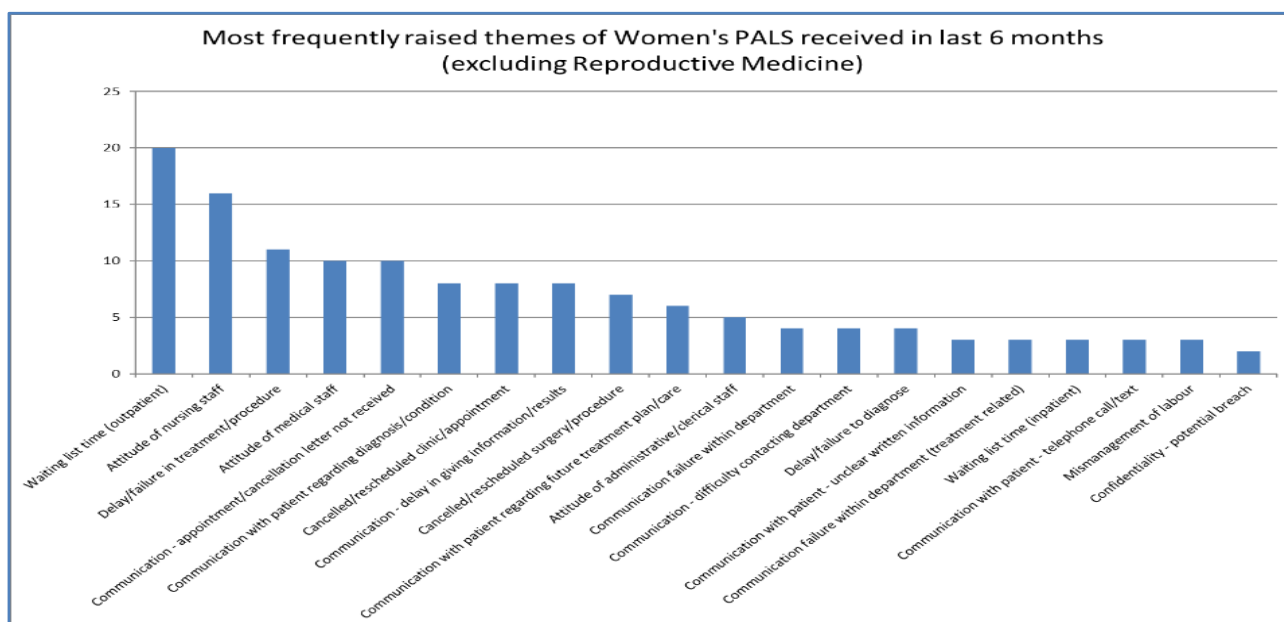
Focus groups continue and the findings are shared through internal governance processes to support development of improvement workstreams. There is ongoing service user engagement with the MNVP chair and Director of Midwifery to listen and understand experiences.

Complaints

There were nine new formal complaints received for maternity services in August 2025 which are currently being investigated. Themes from formal complaints are detailed below.

- Communication related to booking of antenatal, scans and Elective LSCS appointments.
- Induction of labour delays
- Staff interaction and not listening (MDT)
- Postnatal pain relief
- Needing to Repeat story
- Incorrect information in notes
- Listening to concerns and choice of mode of birth

PALS



Compliments

Compliments continue to be received and shared via social media posts. Multiple FFT fabulousness nominations are received across the service every month and are celebrated with the teams. There is direct correlation between some of the themes for complaints and compliments. Use of appreciative enquiry will support understanding of factors that influence compliments which will help to support improvement actions.

Themes from feedback

- Midwives were kind, comforting, empathetic and encouraged a safe environment.
- Felt heard and listened to, with care being personalised to their needs.
- Empowering, calm and compassionate

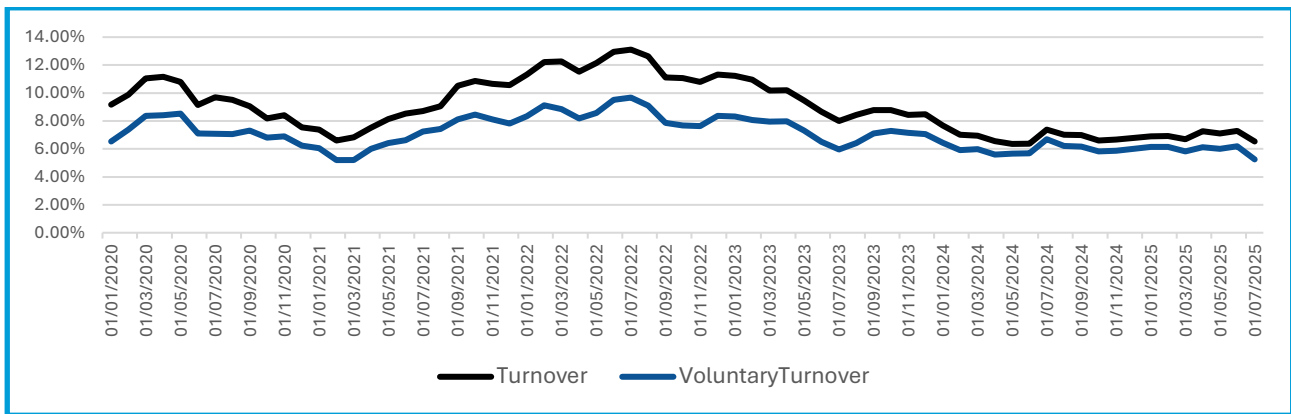
Workforce

Midwifery

Midwifery staffing continues to be a concern.

At the end of August 2025 there were 342.80 WTE registered clinical midwives contracted in post against a budget of 367.5 WTE giving a variance of 23.65 WTE. Further gaps are created by unavailability being significantly higher than the 23% built into the establishment budgets. This has been reviewed by the Executive team who have approved backfill of 75% of the maternity leave which equates to an increased uplift to 27% and will increase the clinical midwifery establishment to 382.4 WTE. Maintaining safe staffing levels and appropriate skill mix for a tertiary centre remains challenging and one of the actions required to ensure the right staff are in the right area to optimise safety is to continuously redeploy staff around the unit. This has led to increased pressure on staff, contributing to reduced morale and heightened risk of burnout.

The rolling monthly attrition of Registered Midwives is 2.4 WTE per month. The chart below represents midwifery turnover from 2020 to July 2025. The primary reasons for leaving are relocation and work life balance.



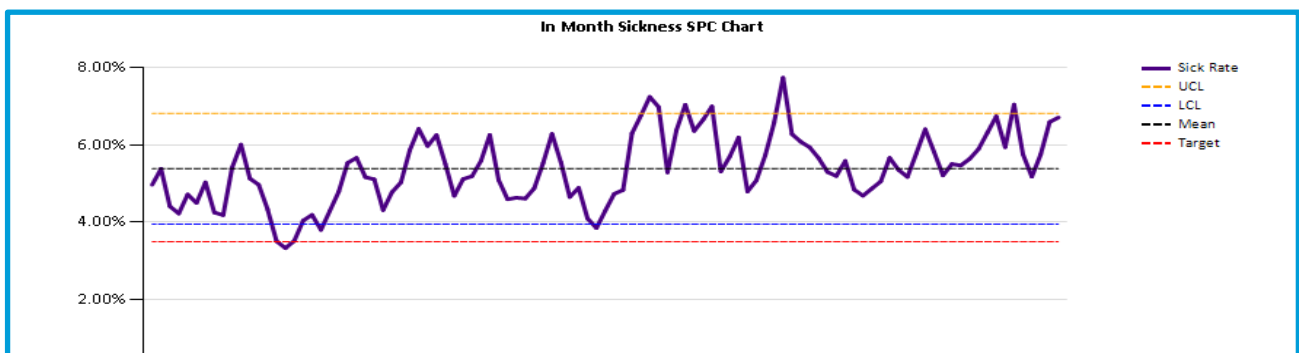
Positive recruitment within midwifery posts continues; 57.6 WTE early career midwives joining the service between September 2025 and January 2026. There is an active recruitment cycle in place for band 6 midwives with interviews planned imminently.

Key actions to support safe staffing in the interim:

- Daily workforce reviews and forward projections to identify and address gaps as early as possible
- Maximising internal flexibility through shift swaps, flexible start and finish times.
- Optimising bank and agency bookings through advanced release of shifts and block booking where possible
- Enhanced payments to increase uptake of additional shifts
- Using registered nurses to support where safe to do so such as caring for women following operative delivery/postnatal under the supervision of a registered midwife.
- Redeployment of nonclinical specialist and management midwives to the clinical areas.

Twice daily staffing meetings and safety huddles are embedded to support decision making and ensure that 1:1 care (for women/birthing people in labour) and safe staffing levels are maintained across all areas of the service. The escalation policy is enacted when workforce availability does not meet the acuity. This results in single site diversions and working with other providers within the region to support activity. In this situation all potential admissions are risk assessed to ensure that those with the greatest need for tertiary services from a maternal or fetal perspective are prioritised to receive their care at LTH. Managing safe staffing is having a negative impact on other operational roles and responsibilities for the midwifery leadership team.

Staffing gaps were primarily caused by vacancies plus increased unavailability due to sickness and maternity leave outside of the Trust target. The SPC chart below represents in month sickness rates with the leading cause (53.3%) being anxiety, stress and depression. Nonclinical specialist and management teams continue to be redeployed from their primary portfolios to support clinical safety. However, this has a negative impact on their primary portfolio and causes low morale due to the frequency of redeployment.



During August 2025 1:1 care in labour was maintained except for one individual on the bereavement pathway who didn't receive 1:1 care in the earlier part of the intrapartum pathway. This has been escalated and is currently under review. Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a safe labour and birth care will not necessarily be given by the same midwife for the whole labour. If there is, an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool; there may be clinical, or management actions taken.

Supernumerary status of the coordinator was maintained 100% of the time. Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff whilst managing activity and workload through the labour ward.

LTHT maternity services use the Birthrate Plus acuity tool to support workforce analysis. During August the acuity on the St James delivery suite met acuity 87% of the time, was up to 2.5 midwives short 12% of the time and 2.5 or more midwives short 1% of the time. The LGI delivery suite met acuity 84% of the time and was up to 2.5 midwives short 16% of the time.

The Birth to midwife ratio was 1:25 in July 2025

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

During August 2025 there were 117 and 110 Red flags raised from the St James and LGI delivery suites respectively. The primary reason was delays in the induction of labour pathway. There is ongoing work to identify improvements to this pathway, which will be multifactorial, but optimising the staffing numbers will improve the flow through this pathway.

Obstetrics

Consultant staffing:

- Current 4 WTE below required number to fulfil core clinical activity.
- Exec supported paper for 2 agency locum posts.
- Exec supported paper for 2 long-term locum posts. Two consultants have been appointed and will commence in role in early November and early December 2025.
- Further paper to establish sustainable three-year consultant staffing model being prepared.

Resident doctor:

- 3 WTE equivalent understaffed. Posts were advertised in August; shortlisting has completed with interviews planned.

Neonatal Nursing

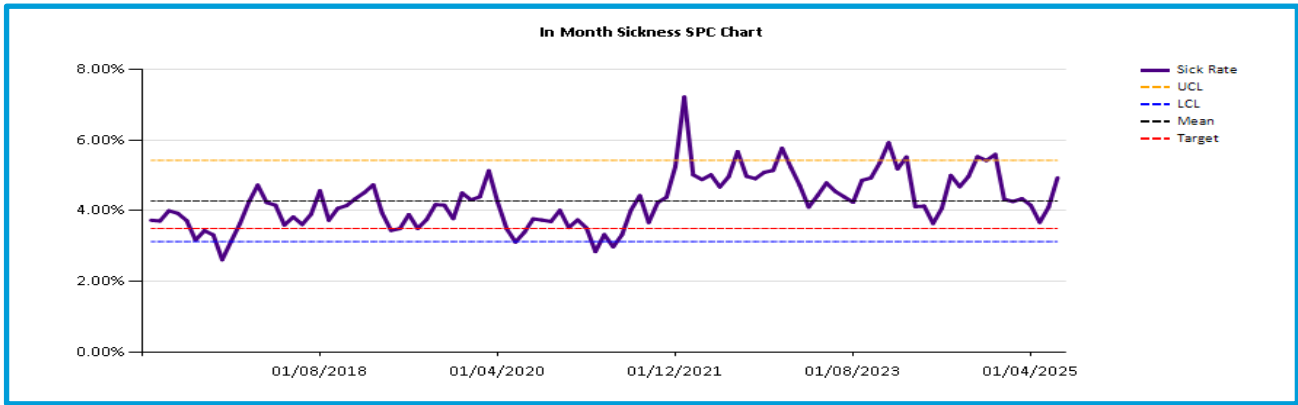
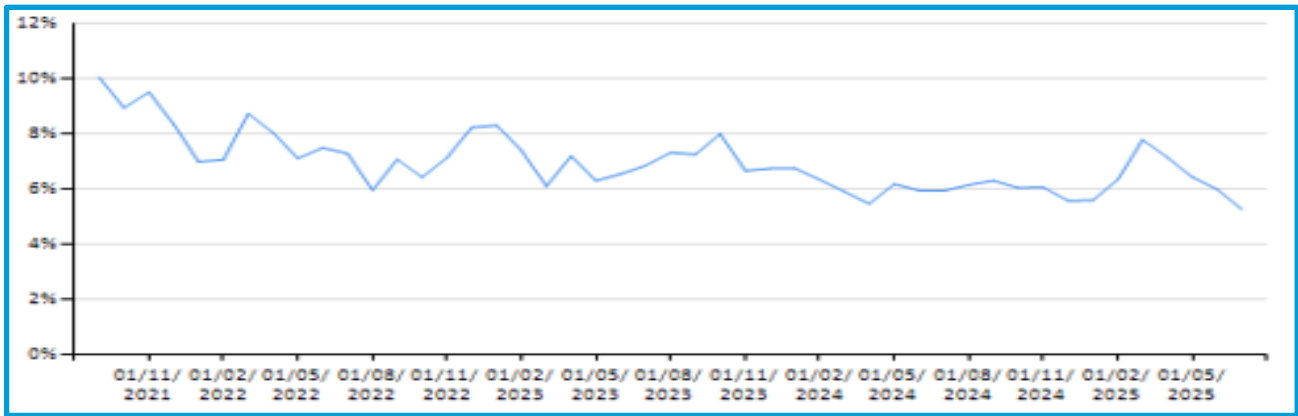
The neonatal unit does not currently meet the requirements of the National Neonatal Workforce Tool for neonatal nurse staffing. A business case to support an increase in the required neonatal nursing establishment by 14.26 WTE to comply with the national standard was submitted and approved on 26.7.24. A phased recruitment was approved enabling the recruitment of 7 WTE from September 2024 and the remaining 7.26 WTE in March 2025.

After a successful recruitment campaign for the Children's CSU between October 2024 and July 2025 a pipeline of 23 Registered Nurses was established; 11 Registered Nurses commenced in post on the 15th September 2025. The remaining 12 candidates will onboard between October and December 2025. Additionally, the neonatal service continues with the work-based learner pipeline and will have 3 Nursing Associates completing their transfer to nursing course to become Registered Nurses in Autumn 2025.

A recent workforce review of Transitional Care services has been undertaken and a paper proposing an uplift of nursing establishment, alongside an increase in transitional care beds is due for submission to NMALT on 25th September 2025.

The Children's CSU has also supported the recruitment of a second Neonatal Matron for the service to provide a dedicated Matron for LGI site and a dedicated Matron for the SJUH site. Recruitment has successfully completed, and the second Matron commenced in post in May 2025.

Neonatal nursing turnover is graphically represented below and sickness data for neonatal nurses. The leading cause of sickness for neonatal nursing is stress anxiety and depression at 32.6%.



Neonatal Medical

British Association of Perinatal Medicine (BAPM) medical staffing standards will be compliant from September 2025, with 18 WTE Neonatologists in post. This will allow separate consultant cover at LGI and SJUH both 7 days per week. Currently there are 17 WTE consultants in post.

Training compliance perinatal specific

Role	Prompt	Fetal Monitoring	Neonatal Resus
Midwives	96%	79%	96%

Maternity Support Workers	91%	NA	91%
Neonatal Nurses	NA	NA	85.7%
Obstetric Trainees	100%	100%	NA
Obstetric Consultants	100%	100%	NA
Anaesthetic Trainees	65%	NA	NA
Anaesthetic Consultants	88%NA	NA	NA

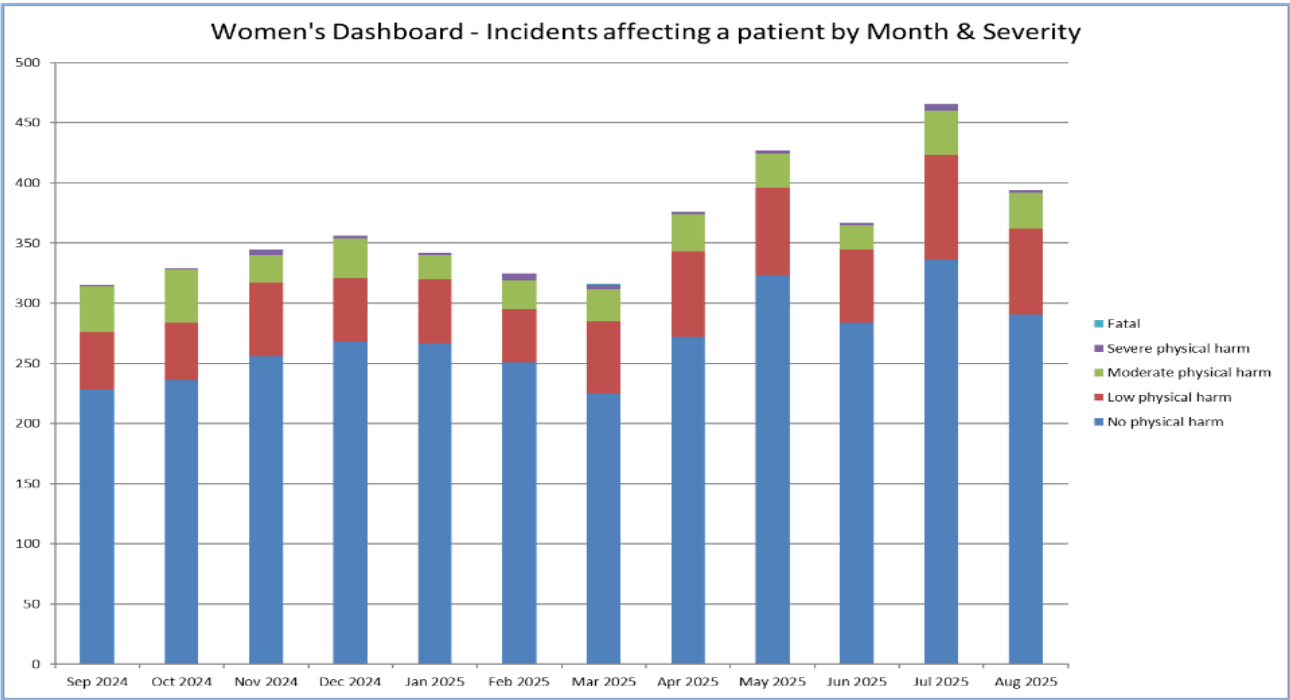
Qualified In Speciality Compliance

Qualified in speciality (QIS) is a Neonatal Nurse qualification. The national toolkit recommends 70% of neonatal nurses to be QIS and/or every HDU and ICU baby to have a QIS nurse allocated to their care. Sixty eight percent of neonatal nurses are QIS 68% following completion of the cohort in June 2025. This is an increase from 61% when the CQC undertook their inspection in January 2025. A further cohort of 14 will commence in September 2025 and are set to qualify in January 2026. Compliance by January 2026 is forecast to be at 70.6%.

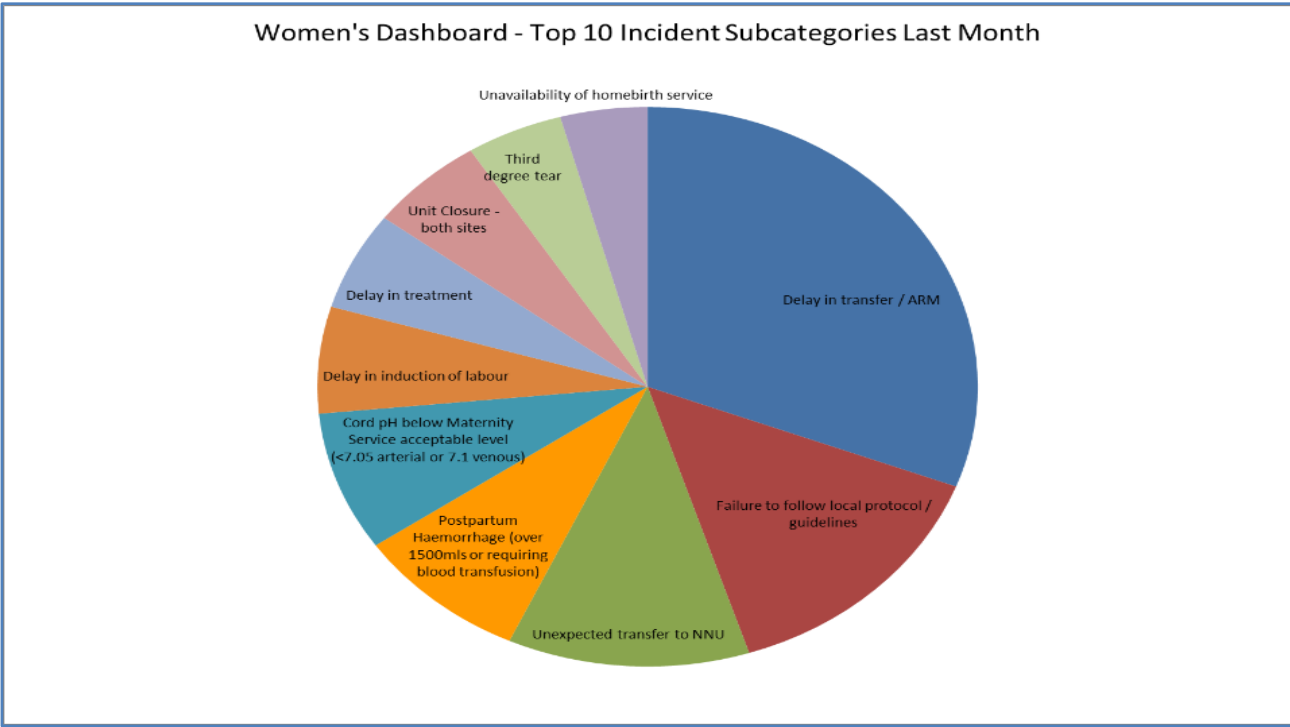
Culture of learning safety and support

During August, eight patient safety rapid reviews have been undertaken to identify any immediate learning from adverse outcomes and support escalation to review whether patient safety incident investigations are required or patient safety learning reviews. Following review two cases are being undertaken as patient safety learning reviews.

Incidents affecting a patient by month and severity



Top 10 incidents by category



All incidents are reviewed to identify learning and improvement opportunities and are being reviewed using quality improvement methodology.

Scorecard

The NHS Resolution claims scorecard was due to be published in August 2025 but is not yet available. An update will be provided when it is published.

SCORE Survey

The SCORE survey was undertaken in 2024 as part of participation in the national perinatal culture and leadership programme. Key themes are summarised below:

- Working together consistently as a perinatal team
- Ensuring all members of the team feel valued and respected and have time and space to support psychological safety
- Increased visibility of the leadership team
- Staff engagement and communication
- Clear understanding of decision making
- Burnout climate high
- Positive feedback and celebrating success need to be balanced with negative feedback.

Ongoing actions in response to SCORE survey:

- Organisation wide review of the formation of a perinatal service
- Expansion of leadership structure to support increased visibility and capacity
- Culture and leadership workshops
- Increased staff engagement
- Optimising use of quality improvement methodology
- Recruitment to close vacancy gaps and increase of unavailability allowance

Maternity and Neonatal Safety Investigations (MNSI)

MNSI undertake investigations where the following criteria are met:

- Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term.

There have been no referrals to MNSI in August 2025.

There are 3 cases currently under review by MNSI, 1 is at the draft stage, and the other 2 are at earlier stages in the investigation process. Any safety recommendations will be shared when available.

Maternity Safety Support Programme (MSSP)

LTHT maternity services are formally in the Maternity Safety Support Programme (MSSP) the Trust are working with NHS England on the Perinatal Improvement Plan and the CQC regulatory breaches to improve women, families and birthing people's experiences.

CQC

Following inspection of the maternity services in December 2024, A section 29A warning notice was issued to the Trust on the 14 February 2025 due to concerns over midwifery staffing. Weekly returns are submitted to the CQC comparing fill rates to the 2024 Birthrate Plus recommendations.

Between 14-16 January 2025 the Neonatal Services at LTHT underwent a three-day onsite CQC inspection. The designation of care at SJUH has been aligned to Special Baby Care designation (HRG3) following this inspection with monitoring and assurance processes to provide fewer than 500 combined intensive care and high dependency days per annum, and escalation of neonates breaching the 24-hour care standard for HRG 1 and 2 level care.

The immediate actions below to ensure care delivered at SJUH is provided at HRG3 level (Special Care Baby designation):

- Designate care to HRG3 level at J01 no longer operating to previously agreed SCU+ criteria issued in 2020.
- Daily review of cot occupancy and acuity established via twice daily SitRep reporting completed and circulated by Neonatal Nurse in Charge to the Children's CSU triumvirate team and deputy triumvirate team, Operational Delivery Network, Neonatal senior nursing and medical team.
- Escalation process for the management of babies requiring HRG1 and HRG2 level care against the 24-hour standard established.
- Children's triumvirate team submit a weekly report to Trust Weekly Quality Meeting that includes the number of babies, and assessment of their care, that have received greater than 24 hours care on J01.
- Reprovision of 2 x HRG2 level cots on L43 with a loss of 4 x HRG3 cots as a result of this re-provision

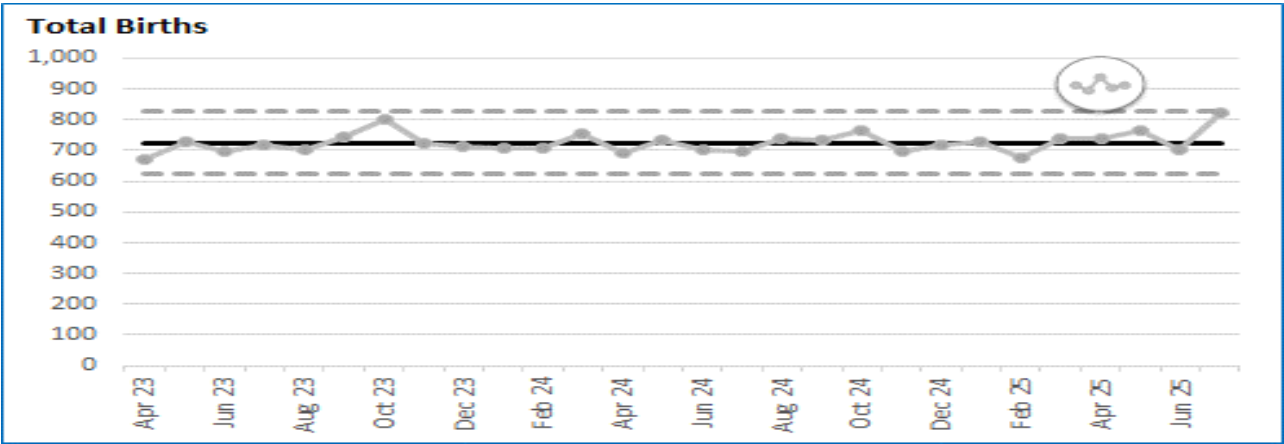
For the August 2025 reporting period all breaches of the 24-hour care standard were reported, escalated, and assessed appropriately. A total of two babies receiving HRG1 care equating to three care days and a total of six patients received HRG2 level care equating to 25 care days.

Structures and standards underpinning safer more personalised, equitable care
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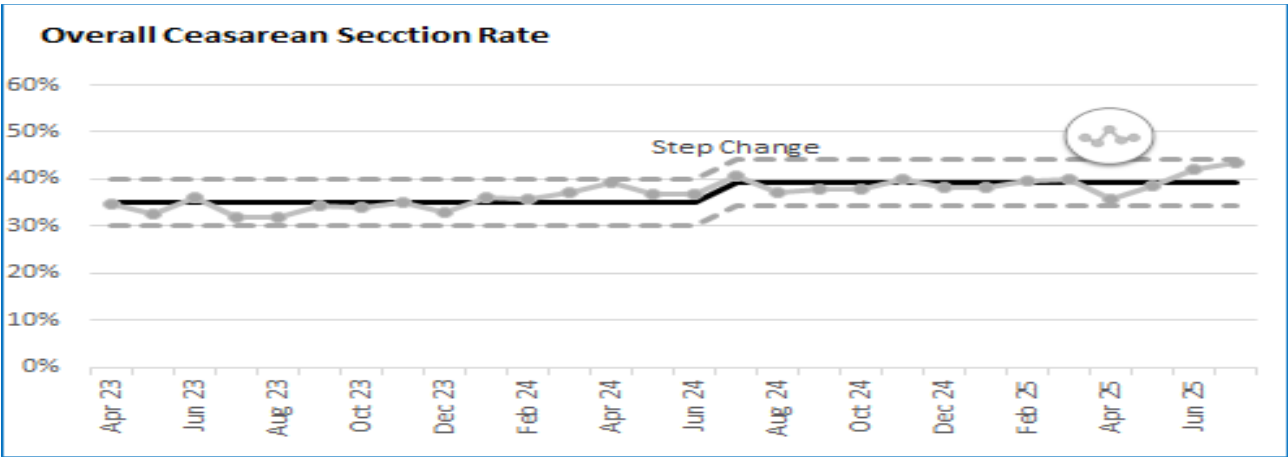
Perinatal surveillance data is monitored consistently via the maternity services dashboard. Key areas to highlight are detailed below and graphically represented in SPC charts where possible:

- The total birthrate shows common cause variation and no statistically significant changes.
- The operative birth rate due to Caesarean Sections was 43.5% in July 2025. This is being continually monitored to ensure responsive strategise are developed to ensure service needs are met.
- There has been an increase in calls to the maternity assessment centre and attendances to maternity assessment for review. Further work is in progress to understand factors influencing the increases. This correlates with qualitative feedback from maternity assessment staff around the challenges of ensuring timely review without additional resource or physical capacity.
- Obstetric Anal Sphincter Injuries and Post Partum Haemorrhage rates remain stable, but further improvement work is ongoing.
- The Induction of labour rate was 34.9% in July this was a decrease of 4% from the previous 2 months.
- The number of women with a planned homebirth at the start of labour who were requested to attend the hospital site due to insufficient numbers of staff was 44.44%. This doesn't support the choice of place of birth. The incoming pipeline of midwives, and closure of vacancy gaps, should see this improve by December 2025.

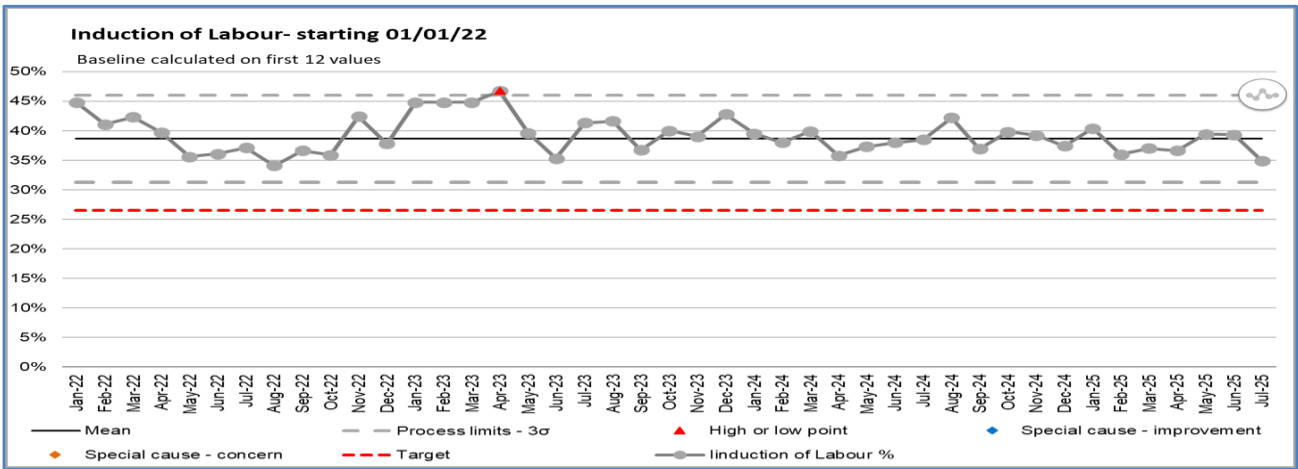
Total Births



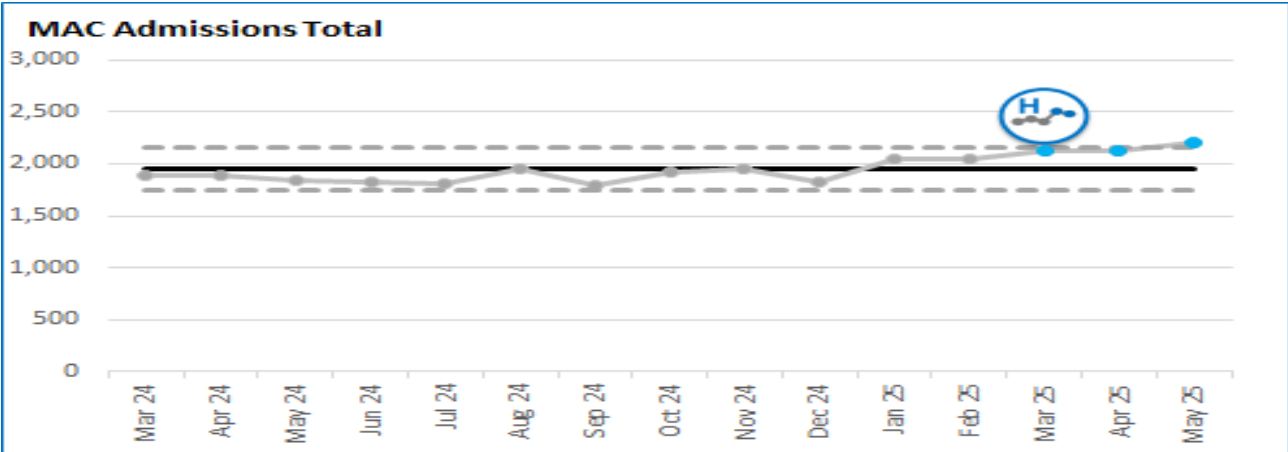
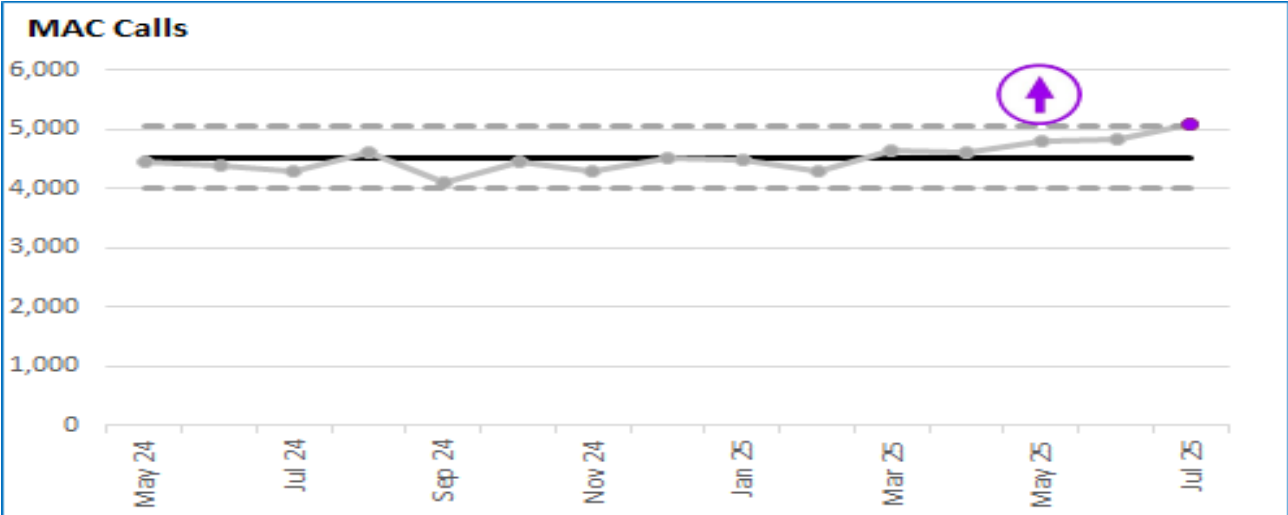
LSCS



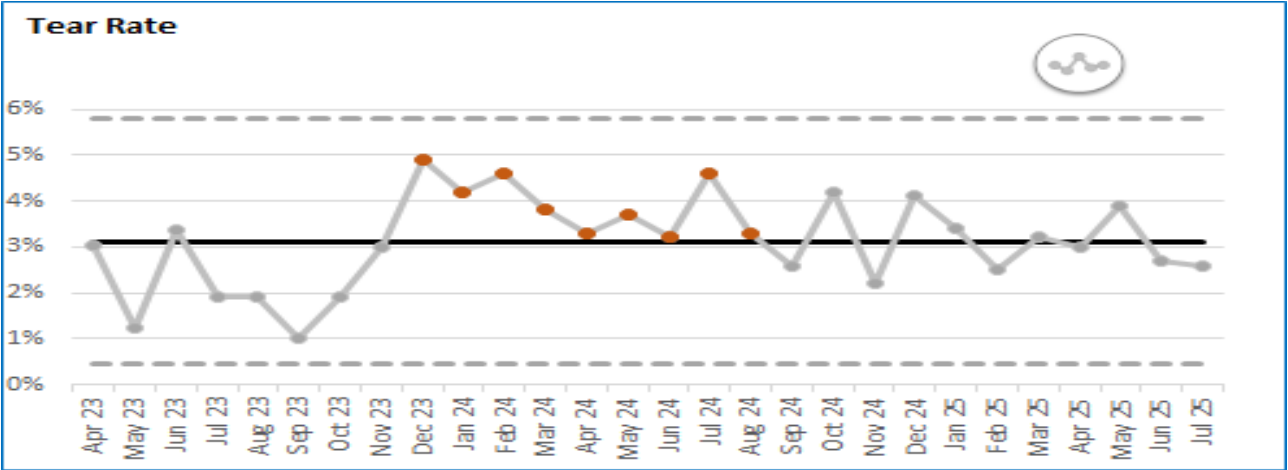
Inductions of labour

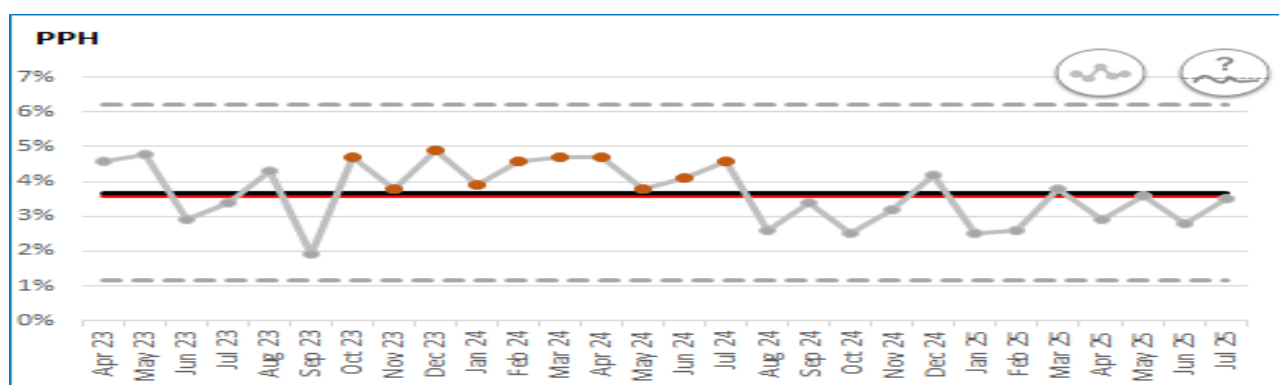


MAC calls and Attendances SPC



Obstetric Anal Sphincter Injuries and Post Partum Haemorrhage





Perinatal Optimisation

Optimisation measures are monitored monthly via the maternity dashboard, with performance summarised in the table below. All data are reviewed by the multidisciplinary preterm team to identify risks and opportunities for improvement.

- Steroid administration: Lower performance was due to clinically necessary expedited births before the second dose could be given.
- Cord clamping: Early clamping (<1 minute) was undertaken in response to neonatal condition, maternal haemorrhage, placental abruption, as directed by the medical team.
- Place of birth (St James' site): The 0% compliance reflects specific cases:
 - A woman already on site and bleeding.
 - An intended birth at SJUH due to maternal comorbidity requiring tertiary specialist services.

The learning from place of birth not documented will be implemented through multi-disciplinary education and training

Outcome	LGI	SJUH
Intrapartum antibiotics less than 34 weeks administered	80%	NA
Magnesium Sulphate less than 30 weeks administered	100%	100%
Missed opportunities to administer Magnesium Sulphate	0	0
2 doses of Steroids within 7 days of birth less than 34 weeks administered	15%	0%
Missed opportunities to administer steroids	0	0
Delayed Cord Clamping for 1 minute <34 weeks	54%	50%
Admission to neonatal unit temperature	92%	100%
Maternal Breast Milk within 24 hours of birth	100%	100%
Correct place of Birth	100%	0%

Attain

ATAIN was created in 2017, as part of the Maternity Transformation Programme. This was a national initiative to identify harm leading to term admissions. The focus is on reducing harm and avoiding unnecessary separation of mothers and babies. Unexpected term admissions are all reviewed by a multidisciplinary team as part of the ATAIN workstream. During August there were three cases assessed as avoidable admissions. The reason for admission were unavailability of transitional care cots (2) and correct pathway not followed (1).

Saving Babies lives

In late 2015, the Department of Health announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. Saving Babies Lives care bundle (SBL) was introduced in 2016 as a package of care that could be implemented at scale to reduce stillbirth and early neonatal death rates in England and to support with achieving the ambition of the Department of Health outlined above. Version 3 of the Saving Babies Lives care bundle published on 31 May 2023 and has had further updates, with further updates in 2025. Providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element, as detailed below, to achieve compliance with the Maternity Incentive Scheme.

Element 1: Reducing Smoking in Pregnancy

Element 2: Fetal Growth: Risk assessment, surveillance, and management

Element 3: Raising awareness for reduced fetal movements.

Element 4: Effective fetal monitoring during labour

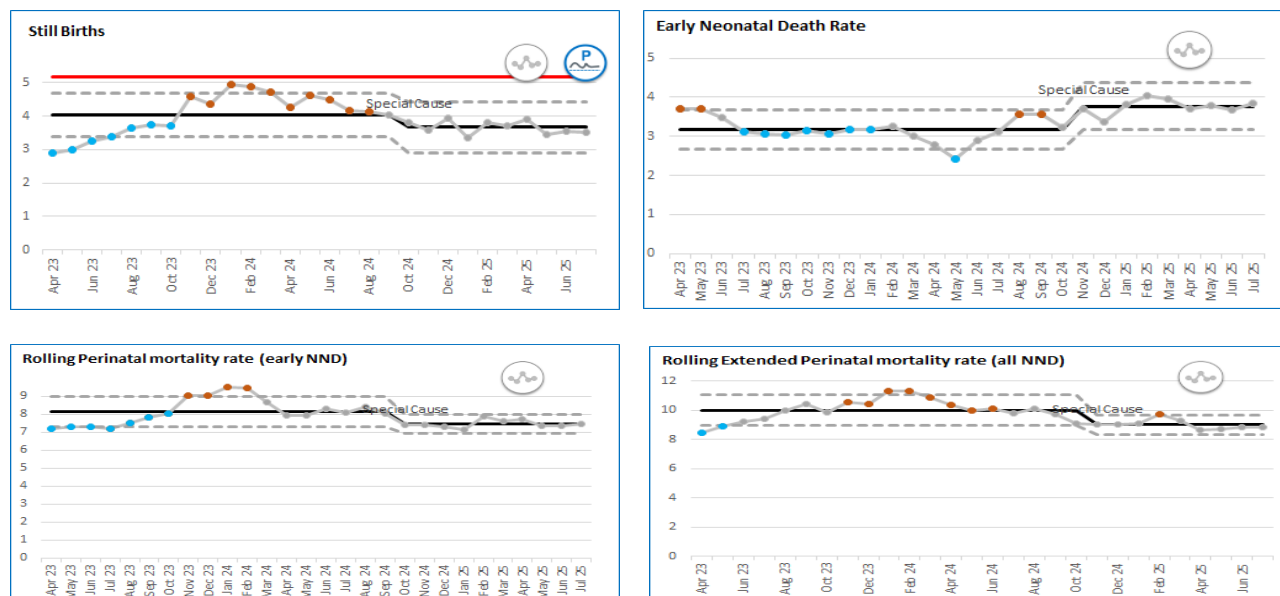
Element 5: Reducing pre-term birth and optimising perinatal care.

Element 6: Management of Pre-existing Diabetes in Pregnancy

Compliance with the care bundle is assessed through review of the SBLV3 tool each quarter, and data and compliance validated by the LMNS. Compliance is also discussed through the Leeds Perinatal Quality Surveillance Meetings with LMNS and ICB representation. A review by the LMNS has been undertaken and the overall compliance is 88%. A copy of the full board report has been shared with this paper.

Perinatal Mortality

The SPC charts are detailed below, the stillbirth rate is consistently hitting the target, but further improvements are needed to reach a statistically significant improvement. The remaining 3 charts show common cause variation. All cases continue to be reviewed using the national perinatal review tool. All cases graded as C or D are escalated to the Trust Weekly Quality Review Meeting for further review. Actions are developed to support shared learning. During August 2025 seven cases were reviewed by the multidisciplinary PMRT team. There was one case graded as a D for care up to the birth and further review and actions are ongoing. Learning from themes of all reviews centred around ensuring routine enquiry is completed if antenatal care has predominantly been undertaken by another provider, ensuring timely review to specialist teams and ensuring all parents receiving bereavement care are given the choice of taking their baby home.



Stillbirths August

There were four stillbirths during August 2025 which will be reviewed through the PMRT process and any learning shared.

Neonatal Deaths August

There were four inborn neonatal deaths in August. All four babies had known anomalies or complications and were referred to LTHT for tertiary services. There was one baby, not born at LTHT, who was transferred to LTHT for tertiary care due to anomalies. All cases will be reviewed through the PMRT process.

NHSE Peer review

A neonatal peer review lead by NHSE took place between 16 and 17 July 2025. The review team visited both Neonatal Units, hosting a series of staff focus groups and reviewing cases of neonatal mortality. Feedback was given to the senior team at the end of the second day and an initial outcome letter was received by the Trust on 24th July 2025. The outcome letter (appendix 4) highlighted areas of good practice as well as outlining five serious concerns as listed below:

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.

No immediate risks were identified by the peer review team at the time of their visit. An action plan has been created in response to the above concerns and has been submitted to the external review team.

Maternity Incentive Scheme

Year 7 of the Maternity Incentive Scheme (MIS) was published on 2 April 2025 and applies to all acute trusts delivering maternity services under the Clinical Negligence Scheme for Trusts (CNST). A working group led by the improvement team has been established to ensure all the evidential requirements are met prior to submission to NHSR. Safety actions 2,6 and 10 are fully on track. There are several midwives that need to complete mandatory training, but all are booked on a training day within the reporting timeframe. The remaining safety actions require presentation of evidence to the Trust Board, Quality Assurance Committee and the West Yorkshire and Harrogate LMNS. A further review of progress is planned in September 2025 to identify any areas that remain off track and ensure where possible mitigating actions are enacted.

3. Financial Implications

Financial implications are included within the Board paper 10.2 Maternity Investment.

4. Risk

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 – Workforce Supply risk, External risk - Regulatory risk and Clinical Risk – Patient Safety and Outcomes.

The Quality Assurance Committee provides assurance oversight of the Trust's Patient Safety and Outcomes risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories however it was noted that as a result of the CQC regulatory breaches related to Maternity and Neonatal Services, and in light of the NHSE support programme, the Trust was moving away from the Board's established risk appetite in the areas of Workforce, External, Regulatory, and Clinical Risk, Patient Safety and Outcomes. A risk has been added to the Corporate Risk register and this is reviewed monthly by the Risk Management Committee.

5. 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.

6. Equality Analysis

The Trust are developing a Maternity and Neonatal Improvement Programme which will have a workstream focused on working with families including focus on equity.

7. Publication Under Freedom of Information Act

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

8. Recommendation

The Trust Board are asked to receive the information within the report, discuss areas of risk and mitigation and note improvements in progress.

9. Supporting Information

Appendix 1 2024/25 Q4 PMRT Board Report
Appendix 2 2025/26 Q1 PMRT Board Report
Appendix 3 Saving Babies Lives Board Report
Appendix 4 LTHFT - Neonatal QPR - Outcomes Letter

