Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Perinatal Integrated Workforce Report Quarter 3 and 4**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This report sets out the staffing position across maternity, obstetric, anaesthetic, perioperative and neonatal services for Quarter 3 and Quarter 4 2025/26. Staffing was monitored through daily operational review, twice daily safety huddles and Trust-wide safe staffing governance, with workforce data triangulated against acuity, activity and patient safety outcomes.
2. Midwifery fill rates exceeded 95% in every month against the 90% safe staffing threshold. One to one care in established labour was maintained at 100% in the Spires Midwifery Led Unit and between 95.16% and 100% on Labour Ward, with all shortfalls short in duration and mitigated in real time. Supernumerary labour ward coordination was maintained throughout. The birth to midwife ratio exceeded the 1:22.9 Birthrate Plus benchmark in five of the six months, reflecting variation in birth activity and acuity. A new Birthrate Plus assessment commenced in November 2025 and will report by the end of Quarter 2 2026/27.
3. The Birthrate Plus Live Acuity Tool was reinstated across intrapartum and inpatient areas from March 2026, replacing an interim manual process that limited the completeness of acuity and red flag data for most of the period. Compliance is audited weekly and is on track to exceed 85% by 31 July 2026. Improving red flag capture is an action arising from this report.
4. Community midwifery staffing remained below establishment but improved from 76.16 WTE in October to 87.69 WTE by March, with the NICE recommended visit schedule maintained across the county throughout. Obstetric medical staffing carried a shortfall at Specialist Registrar level, covered through consultants acting down; six additional SpR posts are approved with recruitment underway. Anaesthetic and perioperative staffing were fully compliant in every month.
5. Neonatal services maintained BAPM nurse to baby ratios and 100% SafeCare compliance, with a fully compliant consultant rota and a clear trajectory to full resident establishment by October 2026. Qualified in Specialty compliance stands at 49% against the 70% standard, with the training pipeline growing from 6 qualifiers in 2020 to a predicted 23 in 2026/27.
6. Taken together, staffing risks during the period were identified early, escalated and mitigated, and recruitment, training and establishment review activity is strengthening resilience and long-term sustainability.

Recommendations

The Trust Board is asked to note the staffing position across perinatal services, note the areas of continued focus and the actions in place to address them.

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Perinatal Integrated Workforce Report Quarter 3 and 4

1. Purpose

1.1. This paper provides assurance on workforce oversight, staffing compliance and key workforce risks across maternity, obstetric, anaesthetic, perioperative and neonatal services for Quarter 3 and Quarter 4 2025/26.

2. Background

2.1. The report forms part of the Trust's routine workforce assurance arrangements, in line with the Maternity and Perinatal Incentive Scheme (MPIS), Birthrate Plus methodology, BAPM standards, NICE safe staffing guidance and relevant professional college standards. It provides a triangulated view of establishment, fill rates, acuity, compliance and operational risk, and assurance that key workforce risks are identified, monitored and mitigated through established governance, daily escalation processes, recruitment and workforce planning activity, and regular establishment review.

3. Birthrate Plus Workforce Planning and Establishment Assurance

3.1. A formal Birthrate Plus assessment completed in December 2022 recommended a birth to midwife ratio of 1:22.9, which remains the benchmark for workforce planning, with the funded midwifery establishment aligned to it. A further Birthrate Plus assessment commenced in November 2025, meeting the required review cycle and supported by corporate workforce and finance teams. An implementation report is due by the end of Quarter 2 2026/27 setting out any revised establishment requirements and delivery plans.

3.2. Bi-annual establishment reviews, led corporately with divisional teams, provide detailed assessment of budgeted establishments, workforce models, acuity, activity and financial alignment, and are triangulated with the Birthrate Plus review so that workforce, finance and operational data are considered together. Rostering quality assurance continues, including the Trust-wide Check and Confirm initiative, which validates staffing plans against agreed standards and key performance indicators.

3.3. The principal risks are that establishment may not keep pace with changes in acuity, activity or service configuration between review cycles, variability in workforce, finance and activity data, inconsistent rostering practice, and rising demand and complexity. These are mitigated through the ongoing reassessment, the establishment review programme, data triangulation

and continuous rostering assurance, which together enable early identification of variance and clear escalation. MPIS requirements are met.

4. Planned Versus Actual Midwifery Staffing Levels

4.1. The table below sets out monthly percentage fill rates for the inpatient areas.

	Day qualified %	Night qualified %
Oct 2025	100.0	95.8
Nov 2025	97.7	98.7
Dec 2025	96.7	97.0
Jan 2026	98.2	98.4
Feb 2026	96.8	97.3
March 2026	100.5	99.0

4.2. Fill rates measure the proportion of rostered shifts staffed by substantive, appropriately qualified midwives against the planned requirement; figures above 100% reflect staffing above planned levels in response to acuity or demand. Every month exceeded 95% for both day and night shifts against the 90% safe staffing threshold, with day rates from 96.7% to 100.5% and night rates from 95.8% to 99.0%. Occasional dips below optimal levels were managed through redeployment across clinical areas, use of on-call staff, and prioritisation of safety critical functions including one to one care in labour and supernumerary coordination.

4.3. Fill rates are reviewed at daily operational staffing meetings, triangulated with acuity, activity and clinical risk, enabling real time oversight of gaps and timely escalation. Targeted work to strengthen live rostering practice has improved the accuracy of recorded fill rates and confidence in workforce reporting.

5. Birth to Midwife Ratio

5.1. The birth to midwife ratio is calculated monthly using Birthrate Plus methodology and the actual monthly delivery rate and is monitored on the maternity dashboard alongside clinical data.

	October	November	December	January	February	March
Birth 1 to midwife ratio	1:26.49	1:23.17	1:23.86	1:23.47	1:20.98	1:24.21

5.2. The ratio ranged from 1:26.49 in October 2025 to 1:20.98 in February 2026. Five of the six months exceeded the 1:22.9 benchmark. Variation reflects the dynamic nature of maternity demand: monthly birth activity (October's higher ratio is consistent with increased birth activity in that period), fluctuations in acuity and complexity, and workforce availability and deployment, including planned and unplanned leave and responsive redeployment to maintain one to one care.

5.3. The ratio is reviewed routinely through the maternity dashboard and daily operational staffing meetings, where workforce metrics are triangulated with activity, acuity and clinical risk, ensuring variance is understood, acted upon and escalated where required, with deployment adjusted to maintain safe staffing and alignment with Birthrate Plus principles.

6. Specialist Midwives

6.1. Birthrate Plus recommends that circa 12% of the total establishment is allocated to non-clinical roles, including management and specialist midwives, to support governance, training and complex care pathways. The OUH position is 10.37%, below the recommendation. The service considers this consistent with national workforce planning assumptions for a tertiary, multi-site service. These roles are not fully supernumerary, with many specialist and leadership posts retaining a clinical component of typically at least 20%, but they cannot be counted wholly within frontline staffing without compromising their governance, training and system leadership functions.

7. Birth Rate Plus Live Acuity Tool

7.1. The Birthrate Plus Live Acuity Tool has not been used consistently across the service; therefore the service moved to an interim manual spreadsheet for acuity assessment. The spreadsheet was difficult to interpret, provided limited standardisation, and did not support reliable real time oversight. It has now been withdrawn and the tool fully reinstated across the intrapartum and inpatient areas from March 2026, with compliance with the associated KPIs on track to exceed 85% by 31 July 2026. Acuity assessment for most of this reporting period was therefore undertaken on the interim manual process.

7.2. The tool provides a real-time, four-hourly assessment of acuity, completed by the Labour Ward and inpatient ward Co-ordinator. Each woman is allocated a Birthrate Plus category on admission, and the tool recalculates the number of midwives required, aligned to the standard of one-to-one care in labour and the complexity of care. It uses the same clinical indicators as the Birthrate Plus establishment methodology, so planned

and real-time staffing are measured on a consistent basis, in line with NICE safe staffing guidance. However, the tool provides a snapshot of acuity at a point in time and should not be interpreted in isolation. Its outputs must be triangulated with wider workforce metrics, professional and clinical judgement, quality indicators and patient safety outcomes to support safe staffing decisions and escalation.

7.3. Output is reviewed at daily operational staffing meetings, triangulated with workforce availability and clinical risk, and escalated where required through the maternity and Trust-wide safe staffing processes described in this report.

7.4. The principal risk is a return to the inconsistent use that affected the initial implementation. This is mitigated by withdrawal of the interim spreadsheet, meaning there is no alternative process in place. Compliance is being strengthened through weekly mandated audits, training and competency sign-off, with oversight from the Intrapartum and Inpatient Matron and Deputy Head of Midwifery for Acute Services. Completion compliance was below 60% in March 2026 but is now on track to exceed 85%, with quarterly reporting to Board.

7.5. The Birthrate Plus Live Acuity Tool has been reinstated across intrapartum and inpatient areas, providing a standardised, real-time approach to acuity assessment. Implementation is not yet complete: compliance with the associated KPIs was below 60% in March 2026 and is being audited weekly, with a trajectory to exceed 85% by 31 July 2026. Weekly audit, training and competency sign-off support sustained use of the tool and reduce the risk of drift from agreed processes. Performance across a full reporting period will be set out in the Quarter 1 and 2 2026/27 report.

8. Supernumerary Labour Ward Co-ordinator

8.1. A supernumerary labour ward co-ordinator, typically an experienced Band 7 midwife, provides leadership, staff support and oversight of delivery suite activity, capacity and workload within the multidisciplinary team. Compliance during the period is set out below.

	Number of days per month	Number of shifts per month	Compliance
October	31	62	95.16%
November	30	60	96.77%
December	31	62	98.38%
January	31	62	100%

February	28	56	100%
March	31	62	98.38%

8.2. Compliance ranged from 95.16% in October to 100% in January and February. Where compliance fell below 100% (October, November, December and March), each occurrence was short in duration, driven by immediate clinical need such as supporting safe care during increased acuity, and mitigated through rapid redeployment to restore supernumerary status, on-call midwifery support and prioritisation of one-to-one care in labour.

8.3. Supernumerary status is monitored at twice daily Safety Huddles, with any compromise escalated immediately to the Maternity operational bleep holder. All staffing red flags are recorded in the electronic rostering system and/or the Ulysses incident reporting system and reviewed monthly by Maternity and Trust Corporate Safe Staffing leads, supported by daily operational staffing meetings, Trust-wide escalation and three daily position reports to senior leadership.

9. One to One in Established Labour

9.1. Women in established labour receive one to one care and support from a dedicated midwife, in line with national safety standards and NICE guidance; this is associated with improved outcomes including increased likelihood of normal vaginal birth, reduced intervention and shorter labour. Where one to one care cannot be achieved, immediate action follows from the Labour Ward Co-ordinator through the acuity tool and escalation processes. Compliance is set out below.

	Oct	Nov	Dec	Jan	Feb	Mar
Spires MLU	100%	100%	100%	100%	100%	100%
Labour Ward	95.16%	96.77%	100%	100%	100%	98.38%

9.2. Spires Midwifery Led Unit maintained 100% compliance in every month, reflecting stable demand and effective planning. Labour Ward compliance ranged from 95.16% to 100%, with shortfalls in October, November and March short in duration, reflecting transient acuity, activity and delays awaiting additional workforce, and mitigated through deployment of on-call staff, reallocation across clinical areas and dynamic adjustment through the Live Acuity Tool. These events are recorded and monitored as safe staffing red flags under the arrangements set out in section 8.

10. Red Flag Incidents

10.1. A midwifery red flag event is an early warning indicator that draws attention to a potential midwifery staffing risk (NICE, 2015). Where a red flag occurs, the midwife in charge determines whether staffing is a contributing factor and initiates the appropriate clinical or operational response.

10.2. During most of this reporting period, red flags were captured through the interim manual acuity process and the Ulysses incident reporting system. The Birthrate Plus Live Acuity Tool, reinstated in intrapartum areas from March 2026 (section 7), now provides real time capture, with SafeCare functionality being explored to standardise and automate reporting across all areas by 31st July 2026.

10.3. The counts below should therefore be treated as a minimum. The pattern in the data, with events recorded across six categories in October and near-zero counts in most categories from November to February, is more consistent with variable recording practice during the interim period than with a genuine step change in performance. Improving the completeness of red flag capture is itself an action arising from this report.

NICE Maternity Safe Staffing Red Flags	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Delayed or cancelled time critical activity	1	0	0	2	0	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	0	0	0	0	1
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	1	0	0	2	0	1
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0	0	0	0

Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	2	0	0	0	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	0	0	0	0	1
Delivery Suite Coordinator not able to maintain supernumerary/supervisory status	2	0	0	0	0	1

10.4. Each red flag is escalated in real time to the Labour Ward Co-ordinator and the Maternity operational bleep holder, with mitigation through redeployment, on-call midwifery staff and prioritisation of one-to-one care in labour. Red flags are reviewed at twice daily Safety Huddles and daily operational staffing meetings, escalate to the Trust-wide safe staffing meeting, and feature in the three daily workforce position reports to the Executive team.

10.5. All red flag events are recorded in the electronic rostering system and/or Ulysses, with monthly review by Maternity Safe Staffing leads. Recording compliance is confirmed through monthly Deputy Head of Midwifery oversight and will be strengthened further through the implementation of Safe Care.

10.6. Where red flags were identified, escalation and response processes operated consistently. Two limitations remain: the timeliness of induction, where a focused improvement plan is now in place, and the completeness of red flag capture prior to March 2026, which the reinstated Live Acuity Tool and planned SafeCare implementation are designed to resolve. Both will be reported on in the Quarter 1 and 2 2026/27 paper.

11. Community Midwifery workforce

11.1. The Community Midwifery Service operates nine geographically based teams covering Banbury, Bicester, Witney, Chipping Norton, Oxford City (including Florence Park, Blenheim and Ivy), Wallingford and Wantage, delivering antenatal and postnatal care and a 24/7 community birth service.

11.2. Against a Birthrate Plus endorsed budgeted establishment of 94.26 WTE, substantive staffing improved from 76.16 WTE in October 2025 to 87.69 WTE by March 2026 but remained below establishment throughout, as set out below. Staffing is monitored daily, with resilience, skill mix and on-call

availability reviewed through established operational and escalation processes.

Month	Actual establishment
Oct 2025	76.16
Nov 2025	79.7
Dec 2025	90.54
Jan 2026	83.76
Feb 2026	84.74
March 2026	87.69

11.3. Sickness absence remained above the Trust average of 3.1% throughout, improving from 7.88% in October to 4.61% in January before rising to 5.34% in March, as set out below. Absence was mainly short term with a small number of long-term cases, with no evidence that excessive working hours were a primary cause. Mitigations include targeted wellbeing support, timely occupational health referral, return to work processes, proactive long term sickness management, legacy midwife support for team lead training, recruitment, appropriate use of NHSP and Flexi midwife support, workload and wellbeing monitoring, PMA input, Matron liaison and listening events. The table below shows community service sickness absence percentage comparative to the Trust wide 3.1%.

Metric	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Sickness	7.88%	5.89%	6.26%	4.61%	5.23%	5.34%

11.4. The NICE recommended antenatal and postnatal visit schedule was maintained across the county, with continuity of care and safeguarding requirements met. Caseloads are managed against the recognised benchmark of approximately 1:96 women per WTE community midwife, with caseload trackers supporting oversight. Ivy Team caseloads are intentionally lower to provide continuity of carer for women with complex clinical, safeguarding, mental health and social care needs, particularly in the OX4 area where socioeconomic deprivation is high, in line with NHS England maternity transformation objectives and Core20PLUS5 priorities.

11.5. The 24/7 community birth service is delivered through a midwife on-call rota, whose midwives are also available to support the hospital under escalation. The proportion of on-call call outs supporting the hospital fell from 42% in Quarter 3 to 24% in Quarter 4, following expansion of the nightly on-call pool and enhanced hospital on-call cover, increasing availability to attend community births.

11.6. On a small number of occasions the service was unable to support a woman's first choice of place of birth. Each occasion was escalated in real time to the Manager on Call and reported through the incident system for review under established governance. In Quarters 3 and 4 these occasions arose when all community midwives were already attending other births. This is now most likely to occur at times of peak demand. It is expected to reduce further as the community establishment recovers towards 94.26 WTE.

12. Obstetric Medical Workforce

12.1. The obstetric workforce comprises a 1:16 consultant on-call rota, a two-tier 1:9 Specialist Registrar (SpR) rota and a 1:18 Senior House Officer (SHO) rota, with resident doctor staffing shared across maternity, gynaecology and urology.

12.2. A shortfall in resident doctors, most notably at SpR level, affected the ability to consistently fulfil on-call activity and senior decision-making. Six WTE SpR posts were approved and recruitment commenced, though full recruitment was not achieved within the period. Mitigations included internal patchwork rostering, maximised deployment of existing resident doctors, and consultant obstetricians acting down to provide registrar level cover, which had not previously been required; Medirota data shows over 50 additional consultant sessions between October 2025 and March 2026, with time off in lieu supporting consultant cover. Temporary staffing and external locum use was limited, in line with MPIS requirements and the need for robust induction to maintain safe practice.

12.3. Consultant provision remained balanced overall, with weekend activity delivered to demand, and all planned and emergency activity maintained during national industrial action through enhanced consultant presence and rota flexibility. Medical staffing is reviewed through the day at Safety Huddles against clinical risk and NICE red flag indicators, with escalation through maternity and Trust-wide safe staffing processes. A draft Medical Obstetric Staffing Escalation SOP incorporating operational leadership, clinical governance oversight and structured escalation is pending formal ratification, with Divisional decisions required on the balance of maternity

and gynaecology activity. The service aligns with RCOG guidance on consultant attendance in high risk clinical situations.

12.4. Ongoing actions comprise: a planned SHO staffing increase from August 2026 supporting RCOG/BSOTS compliance, particularly in the maternity assessment unit; a business case for additional SpR capacity to strengthen overnight senior decision-making; leadership and structural review aligned to the developing Perinatal Directorate; implementation of team based job planning; and alignment with the RCOG Workforce Planning Tool once published.

13. Obstetric Anaesthetic Workforce

13.1. The service maintained full compliance with the availability of a duty anaesthetist 24 hours a day (ASCA standard 1.7.2.1) and a trained anaesthetic assistant available 24/7 (ASCA standard 1.3.1.2), at 100% in every month from October 2025 to March 2026, including periods of increased activity, as set out below.

	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026
% compliance	100	100	100	100	100	100

14. Perioperative Workforce

14.1. The perioperative workforce, including anaesthetic and recovery teams and scrub staff, ensures safe, continuous provision of emergency and elective obstetric theatre services. Day staffing for anaesthetic and recovery areas comprises five registered practitioners, supporting elective activity, two emergency theatres and recovery; night staffing comprises four registered practitioners. Scrub staffing combines registered and non-registered staff across elective and emergency activity.

14.2. Across October 2025 to March 2026, compliance with the requirement for appropriately qualified staff remained at 100% on both day and night shifts for all perioperative roles, including anaesthetic, recovery and scrub teams, ensuring emergency obstetric procedures could be supported without delay.

	Day qualified %	Night qualified %
October 2025	100%	100%

November 2025	100%	100%
December 2025	100%	100%
January 2026	100%	100%
February 2026	100%	100%
March 2026	100%	100%

14.3. Perioperative staffing is monitored through safety huddles and daily staffing reviews aligned to clinical demand, supported by Trust-wide safe staffing governance.

15. Neonatal Medical Workforce

15.1. In line with MPIS, the Trust maintains a fully funded neonatal medical establishment aligned to BAPM standards and the Neonatal Workforce Calculator (2020), comprising 13.5 WTE consultants and 39.5 WTE resident doctors. The consultant establishment is filled by 10.5 WTE substantive and 3 WTE locum consultants, and the consultant rota is fully BAPM compliant. A business case to convert the locum posts to substantive roles is scheduled for Trust approval in July 2026, securing the long-term stability of the consultant workforce.

15.2. The resident medical workforce carried a 3 WTE shortfall at the end of the reporting period, and the resident rota is not yet BAPM compliant. Short term gaps were mitigated through rota management and escalation, overseen through divisional governance with regular review of performance, risks and mitigations. Newly appointed locally employed doctors are expected to commence by October 2026, restoring full establishment and delivering BAPM compliance of the resident rota by October 2026.

16. Neonatal Nursing Workforce

16.1. The neonatal service demonstrated full compliance with MPIS Safety Action 4 for 2025, supported by a structured workforce plan monitored through divisional governance. BAPM nurse to baby ratios were maintained throughout the reporting period (ICU 1:1, HDU 1:2, LDU 1:4), with the Neonatal Unit at 100% SafeCare compliance in every month.

16.2. A key priority remains achievement of 70% Qualified in Specialty (QIS) compliance in line with BAPM standards. Compliance during the reporting period was 49% (82 of 166 WTE). The internal training programme delivered 15 QIS qualifiers in 2025, supplemented by recruitment of

externally qualified staff where available, although the national specialist pool is limited.

16.3. The table below sets out sickness absence, vacancy and turnover for the reporting period. Vacancy rates of circa 14 to 15% reflect the establishment correction completed earlier in 2025/26. Turnover improved from 6.6% in October to 4.6% in March, supporting workforce stability. Sickness absence remained between 5.2% and 5.7% and is managed through early intervention, wellbeing support and workforce planning.

Metric	Oct	Nov	Dec	Jan	Feb	Mar
Sickness	5.2%	5.4%	5.3%	5.5%	5.7%	5.7%
Vacancy	14.6%	14.1%	14.4%	15.4%	15.1%	15.1%
Turnover	6.6%	6.5%	6.6%	5.2%	4.3%	4.6%

16.4. Registered nursing fill rates were 97% to 100% in every month, as set out below. Unregistered staffing dipped to 83% on day shifts in November but reached 100% from January onwards, reflecting stronger deployment and improved roster management. Staffing is managed through dynamic rostering and daily SafeCare review, reviewed three times daily by Matrons under the Trust Rostering and Safe Staffing Policy, with three times daily reporting to the central safe staffing meeting

	Day RN	Day Unregistered	Night RN	Night Unregistered
Oct 25	97%	93%	100%	95%
Nov 25	97%	83%	99%	96%
Dec 25	98%	93%	99%	98%
Jan 26	99%	100%	99%	100%
Feb 26	100%	100%	100%	100%
Mar 26	100%	100%	100%	100%

16.5. Strategic oversight comprises bi-annual establishment reviews aligned to BAPM standards, triangulated with workforce metrics and service demand.

17. Triangulation with quality and safety outcomes

17.1. Workforce indicators are triangulated with quality, safety and experience data within the wider governance framework. Pressures, including

induction delays, are identified in real time through the Live Acuity Tool and red flag reporting, escalated and mitigated through safety huddles, daily operational meetings and Trust-wide safe staffing processes, captured in incident reporting systems, and reviewed monthly at corporate level in line with PSIRF learning. Workforce data are considered alongside complaints, PALS and patient experience feedback, particularly on flow and timeliness of care, so that areas of sensitivity are understood and addressed. This integrated approach links workforce governance to patient safety, experience and outcomes through a closed loop of escalation, oversight and learning.

18. Conclusion

18.1. Staffing across maternity, obstetric, anaesthetic, perioperative and neonatal services was actively monitored and managed during Quarter 3 and Quarter 4 2025/26, with gaps escalated and mitigated in real time through established safe staffing processes. Midwifery fill rates remained strong, one to one care in labour and supernumerary coordination were sustained, and the reinstated Live Acuity Tool has strengthened real-time oversight of acuity and red flags. The midwifery establishment remains set by Birthrate Plus methodology, with a reassessment underway to confirm it reflects current demand. Anaesthetic and perioperative staffing were fully compliant throughout. Pressures in obstetric and neonatal medical staffing and neonatal nursing QIS compliance were managed through senior clinical oversight, dynamic rostering, recruitment and daily escalation, with workforce data triangulated against quality, safety and patient experience outcomes. Workforce risks are understood, monitored and managed, and resilience and compliance continue to be strengthened.

19. Recommendations

The Trust Board is asked to:

- note the staffing position across maternity, obstetric, anaesthetic, perioperative and neonatal services for Quarter 3 and Quarter 4 2025/26;
- note the progress made in strengthening workforce oversight, including reinstatement of the Birthrate Plus Live Acuity Tool, continued SafeCare monitoring, and ongoing establishment and recruitment review; and
- support continuation of the actions set out in this report to maintain safe, sustainable staffing and further strengthen resilience and compliance across the perinatal service.