

Cover Sheet

Trust Board Meeting in Public: Wednesday 9 July 2025

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Title: **Biannual Maternity Safe Staffing (Quarter 3 and Quarter 4)
2024/25**

Status: **For Information**
History: **Maternity Clinical Governance Committee 09/06/2025
Safety Champions meeting 12/06/2025**

Board Lead: **Chief Nursing Officer**
Presenter: **Milica Redfearn, Director of Midwifery**
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Confidential: **No**
Key Purpose: **Assurance**

Executive Summary

1. This report presents the second biannual midwifery safe staffing report for 2024/25. It reviews midwifery staffing levels for Quarter 3 and Quarter 4, and provides an update on workforce planning for maternity services.
2. **BirthRate Plus® Workforce Planning:** A formal *BirthRate Plus®* assessment conducted in 2021 recommended a birth-to-midwife ratio of 1:22.9. The midwifery establishment has increased in line with this recommendation from 310.50 WTE to 332.06 WTE.
3. **Recruitment and Retention:** Ongoing recruitment campaigns have led to a significant increase of 24.8 Whole Time Equivalent (WTE) midwives during this reporting period. A proactive workforce plan is in place to address turnover and increased unavailability from maternity leave.
4. **Midwifery Continuity of Carer (MCoC):** The MCoC team ensure consistent care for women throughout their pregnancy, birth, and postnatal period. The current MCoC team focuses on vulnerable women and birthing people with the highest need.
5. **Red Flag Incidents:** Red flag events indicate potential issues with midwifery staffing. The report details the mitigation measures taken in response to these events, such as redeploying staff and using on-call midwives.
6. **One to one care in labour and continuity of carer:** The report confirms that the service has met the requirements of the NHSR Maternity Incentive Scheme for providing one to one care in labour and ensuring the supernumerary status of the delivery suite co-ordinator.
7. **Safe staffing and escalation process:** The report provides assurance that the service has an effective system for monitoring and maintaining safe staffing levels and responding to any staffing or capacity issues. The service uses a RAG rating system, a staffing and escalation SOP, and a safety huddle to assess and manage the staffing levels and acuity daily.

Recommendations

8. The Trust Board is asked to:
 - Note the contents of the report and formally record to the Trust Board minutes in line with the requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Perinatal Incentive Scheme (MPIS) for safety action 5.
 - Note the evidence that Midwifery staffing budget reflects establishment as calculated by BirthRate Plus®.

- Approve and take assurance from this report that there has been an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q3 and Q4 of 2024/25 inclusive.

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Biannual Maternity Safe Staffing (Quarter 3 and Quarter 4) 2024/25

1. Purpose

- 1.1. This biannual report provides a comprehensive overview of the measures in place to ensure safe midwifery staffing at Oxford University Hospitals (OUH) for quarter 3 and quarter 4 of 2024/25.
- 1.2. It addresses workforce planning, staffing levels, the birth-to-midwife ratio, specialist hours, compliance with supernumerary labour ward coordinators, one-to-one care in labour, and red flag incidents. Additionally, it highlights key workforce measures aimed at improving recruitment and retention.
- 1.3. Provides oversight for the Board and evidence for the NHS Resolution's Maternity and Perinatal Incentive Scheme (MPIS), which requires evidence of biannual midwifery safe staffing reports providing a comprehensive overview of the measures in place to ensure safe midwifery staffing at Oxford University Hospitals (OUH).

2. Background

- 2.1. It is essential for the Trust to have an adequate number of staff with the necessary skills in suitable positions at the right times to ensure safe midwifery staffing, as outlined by the National Quality Board (NQB) requirements.
- 2.2. The NICE (2017) guidelines on midwifery staffing highlight the importance of having procedures in place to systematically assess staffing levels. This approach guarantees continuity in maternity services and ensures the safety of care for women and their babies.

3. Birth Rate Plus Workforce Planning

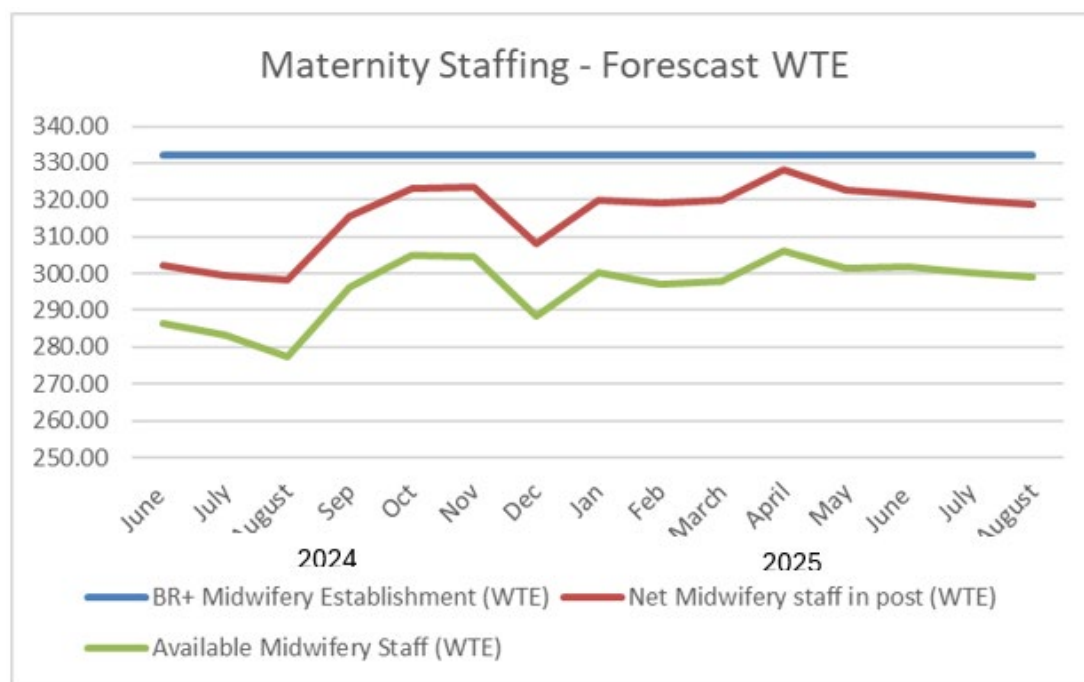
- 3.1. A formal BirthRate Plus® assessment was conducted in 2021. The assessment evaluated the number and acuity of women utilising maternity services at Oxford University Hospitals (OUH).
- 3.2. BirthRate Plus® recommended that OUH Maternity services increase the Midwifery staffing establishment from 310.50 WTE to 332.06 WTE. This review also recommended a birth-to-midwife ratio of 1:22.9 across the service.
- 3.3. The business case to support increasing the midwifery staffing establishment was agreed by the Trust Board in November 2023. Following

formal sign-off, the Trust Board communicated this approved uplift to commissioners, as per NHSR MPIS requirements.

- 3.4. Maternity services have made significant progress in recruiting to the additional posts required to increase the midwifery staffing establishment. The Birth Rate Plus Action Plan in appendix 1 provides a summary of progress.
- 3.5. In October 2024, as part of the Trust-wide establishment review, the Chief Nurse conducted a review of the midwifery staffing establishment. This review involved collaboration with workforce leads, finance and people partners, as well as the maternity leadership team. Evidence gathered during this process confirmed that the midwifery staffing budget aligned with the establishment figures as determined by Birth Rate Plus.

4. Recruitment and Retention

- 4.1. In Q3 and Q4, the Maternity Service recruited 24.8 WTE Midwives/Registered Nurses (RNs). Ongoing recruitment campaigns for midwifery and maternity support worker positions have significantly increased staff in posts and reduced vacancies. In Q3 the vacancy rate was 5.42% (18.01 WTE) and in Q4 the vacancy rate was 3.27% (10.88 WTE).
- 4.2. The chart indicates zero projected vacancies for Q4 2024/25, but actual vacancies remain due to high availability, mainly from maternity leave. Overall, the situation has improved markedly since Q1 2024/25.



Midwifery Staffing - Forecast WTE from Q2 2024/25 to Q1 2025/26

- 4.3. Unavailability of staff within maternity services remained a key issue in Q3/Q4 due to midwives' medical and non-medical absences, though there has been significant improvement from previous years. Maternity leave continues to an impact as shown in the table below:

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Maternity Leave (WTE)	18.92	20.13	19.73	21.96	22.12	21.84
Short Term Sickness (WTE)	10.59	9.62	14.11	13.58	14.92	11.02
Long Term Sickness (WTE)	4.52	2.64	1.85	2.8	3.16	1.81
Non-Medical absence (WTE)	1.2	1.66	1.37	0.61	1.89	0.25
Total (WTE)	35.23	34.05	37.06	38.95	42.09	34.92

- 4.4. To manage and reduce midwifery unavailability from increased maternity leave, the service has analysed past maternity leave data to predict future rates and includes these forecasts in its workforce plans.
- 4.5. A five-year review of the data indicates that maternity leave typically accounts for between 5-7% of Midwifery unavailability. It has been approved that the service over-recruit's midwives by 5–7% (25 WTE) to cover expected levels of maternity leave.
- 4.6. This will allow the service to increase staff availability and reduce turnover.
- 4.7. Despite the challenges, unavailability has reduced over Q3/Q4 with a significant overall reduction in short term sickness. Targeted work with service managers on sickness management support, return to work interviews and wellbeing signposting has been undertaken in the service. This has been well received and has contributed to the decline.
- 4.8. In Q3 and Q4 there were 14.35 wte leavers. The table below indicates the number of new starters (in WTE) compared to the number of leavers in Q3 and Q4:

Midwives/RN's wte	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
New Starters	12.16	2.32	0	3.72	6	0.6	24.8
Leavers	0.53	2.21	5.85	0.4	2.84	2.52	14.35

- 4.9. The service employs a lead Recruitment and Retention specialist midwife, who collaborates closely with external partners and divisional and Trust workforce leads to ensure a proactive recruitment pipeline. In addition, the service is focusing on retention initiatives that offer enhanced wellbeing support, flexible working options, and phased return options post-leave.
- 4.10. The service has in place a proactive workforce plans to address attrition and turnover as summarised below:
- 4.11. Most newly recruited midwives are in their early careers and joined the service in the autumn (Q2-Q3 2024/25) following completion of their midwifery degree. To ensure a smooth transition, the service has a

supernumerary period and robust training and support, including a comprehensive preceptorship programme, mentoring scheme, and ongoing professional development opportunities.

- 4.12. The service has also implemented a Midwifery Apprenticeship Programme, which has successfully recruited maternity support workers to start their midwifery training. There are a total of four maternity support workers on this programme with further plans to increase.
- 4.13. In collaboration with local education providers, the service has developed a benchmark orientation and support programme that offers opportunities for internationally recruited dual-trained nurses and midwives to join the service. With a successful bid from NHS England the service aims to recruit a further ten international educated midwives onto this programme with four starting during Q4 2024/25 and a further group planned for Q2 2025/26.
- 4.14. In addition, five staff started on the short nursing to Midwifery conversion course in September 2023 are set to become registered Midwives by Q2 2025/26. The programme has been well received, leading to an additional five candidates who started the course in Q3 2024/25.

5. Planned Versus Actual Midwifery Staffing Levels

- 5.1. The comparison of planned versus actual midwifery staffing assesses the planned number of midwives against those who actually worked during a specific timeframe.
- 5.2. All maternity inpatient areas report this data monthly in the safe staffing report presented to the Trust Board. The planned versus actual staffing for maternity for Q3/Q4 2024/25 is available for review in Appendix 1.
- 5.3. The service has identified discrepancies in reporting related to planned versus actual staffing. The Head Nurse for Workforce and Regulatory Safe Staffing has been working closely with the senior midwifery leadership teams to educate on and enhance live rostering.
- 5.4. Despite the misalignment of the rosters to ESR and the finance ledger at present, the roster can be kept live and accurate through the management of daily operational staffing requirements electronically in the roster. To enhance accuracy, the live roster is now monitored and amended more closely to ensure that the data on planned versus actual staffing is reliable. This process has involved training to facilitate the timely removal of unneeded shifts from the planned staffing levels and to ensure all actual shifts are accurately recorded in the live roster. This includes situations where a worker is reassigned from a non-clinical shift to cover a clinical shift.

The figures below should be viewed with caution while this work is in the final stages of completion.

- 5.5. Some of the differences observed month on month in the planned versus actual percentages, however, are due to the dynamic adjustment of midwifery staffing across inpatient areas to meet service needs, in accordance with the Maternity Staffing and Escalation Standard Operating Procedure. Most inpatient areas achieved fill rates exceeding budgeted levels, meaning actual staffing often met or surpassed planned levels.
- 5.6. The Maternity [Staffing and Escalation Standard Operating Procedure](#) (SOP) outlines detailed actions for managing staffing, activity, and capacity issues. Staffing levels are monitored and adjusted on a shift-by-shift basis. Reports are escalated to the Trust's central safe staffing team to identify any risks and determine mitigation strategies for staffing across all areas, ensuring both planned and urgent activities are adequately managed. Maternity have not declared unsafe staffing levels during this reporting period.
- 5.7. The outlined actions are designed to maximise staffing into critical functions to maintain safe care for the women and babies. The Maternity operational bleep holder works with the multidisciplinary team to redistribute Midwifery and support staff as needed, ensuring women in labour receive one-on-one Midwifery care while the delivery suite coordinator remains supernumerary.
- 5.8. Safety Huddles are held twice daily to assess staffing relative to patient acuity. The frequency of huddles are increased as acuity necessitates. The maternity leadership team reviews scheduled staffing daily, comparing it with the established requirements for each clinical area.
- 5.9. RAG ratings from the Safety Huddles are reported twice daily to the Central Trust Safe Staffing meeting, with action pathways in place for each rating. Additionally, bank (NHSP) hours cover maternity leave and short- and long-term sickness. As previously alluded to, ongoing recruitment campaigns have increased the number of staff in post by this reporting period (Q3/Q4).

6. Birth to Midwife Ratio

- 6.1. The birth-to-midwife ratio is calculated monthly using BirthRate Plus® methodology alongside the actual monthly delivery rate. This ratio has now been added to the maternity dashboard for monitoring alongside clinical data. The table below presents the real-time monthly birth-to-midwife ratio for Q3/Q4:

Funded	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	01:26.6	01:21.1	01:24.9	01:23.2	01:22.3	01:23.8

	Quarter 3 average 1:24.2	Quarter 4 average 1:23.1
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7. Specialist Midwives

- 7.1. BirthRate Plus® recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation for multi-sited Trusts, such as OUH, being 11. This includes management positions and specialist midwives. The current percentage for the OUH is calculated to be 10.5% which is in alignment of similar trusts providing tertiary level care. It is important to note that each specialist role includes at least 20% clinical component.

8. Midwifery Continuity of Carer (MCoC)

- 8.1. The Maternity Continuity of Carer (MCoC) teams were introduced to ensure that women receive consistent care from the same midwife or team of midwives throughout their pregnancy, birth, and postnatal period. However, a national directive paused the implementation of additional MCoC teams acknowledging the contemporary staffing challenges.
- 8.2. The OUH service currently has one MCoC team providing care to women and birthing people in areas with significant deprivation and ethnic diversity. This team is located in OX4 Blackbird Leys, which is one of the most deprived areas both in Oxford and nationally and also has the greatest ethnic diversity. This model is consistent with Equity, Diversity, and Inclusion (EDI) principles, emphasising the integration of diverse perspectives and experiences into all aspects of work. It ensures that these women and birthing people receive consistent and personalised care, potentially leading to improved outcomes and experiences. The current MCoC team is fully integrated into the existing midwifery establishment.

9. Actual Maternity Staffing RAG Rating

- 9.1. The table below shows the RAG rating for actual midwifery levels by month for Q3/Q4 2024/25. Green signifies that the maternity service has appropriate staffing levels and available capacity for the workload on that day:

RAG Rating			
	Red	Amber	Green
Oct-24	1	23	7
Nov-24	0	22	8
Dec-24	1	18	12
Jan-25	0	14	17

Feb-25	5	16	7
Mar-25	0	14	17

- 9.2. The reported RAG rating is before any mitigation. If Red Level 3 is declared the Staffing and Escalation Standard Operating Procedure (SOP) for OUH Maternity Services is deployed. An updated RAG rating and subsequent mitigation is sent to the Trust Corporate Safe Staffing Team every 2 hours until the rating drops below Level 3. This is alongside 2 hourly safety huddles held within the service. Actions as per the SOP address Amber or Red ratings, including staff redeployment, using supernumerary workers, on-call staff, and sourcing additional staff from non-clinical and management roles as appropriate.

10. Supernumerary Labour Ward Co-ordinator and one to one care in established labour

- 10.1. Having a supernumerary labour ward co-ordinator is recommended as best practice to ensure safety on the labour ward. This role involves an experienced Band 7 midwife who, working alongside the multidisciplinary team, can offer advice, support, and guidance to clinical staff while managing activity, capacity and workload.
- 10.2. In Q3/Q4, Maternity services fully complied with having a supernumerary labour ward coordinator for each shift and provided one-on-one care during active labour, as shown by the dashboard and audit results.
- 10.3. Twice daily Safety Huddles monitor the provision of one-to-one care in labour in real time, and the supernumerary status of the Delivery Suite Coordinator.
- 10.4. Any compromise in either the supernumerary status of the Delivery Suite Coordinator, or one to one care in labour is immediately escalated to the Maternity operational bleep holder. Mitigation actions are then executed to resolve the issue, and corresponding staffing 'Red Flags' are logged in the electronic Health Roster System and/or on the Ulysses incident reporting system. Both Maternity and Trust Corporate Safe Staffing teams review this data monthly. In this reporting period, there were no Red Flags regarding one-to-one care in labour.
- 10.5. During Q3/Q4 there was 1 Red Flag reported regarding the supernumerary status of the band 7 on delivery suite. On this occasion, provision of post-natal care was required, whilst awaiting the assistance from additional on-call midwives requested via the escalation process. No incidents or further Red Flags were recorded. This does not impact MPIS compliance but serves as a safety marker for the service.

- 10.6. The table below shows the number of on-call hours required by 'hospital on call' midwives at the John Radcliffe maternity unit during Q3/Q4. Hospital on call midwives are scheduled to be on call for 4-hour periods overnight, whilst community midwives can be on call for a 24-hour period. A consultation process is currently underway to ensure equity in the on-call requirement across the whole Maternity service. The hours support the requirement for one-on-one care provision, along with other types of care. The table below reflects the hours provided by hospital on-call midwives and community midwives brought into the unit as per the escalation process. Q3 and Q4 indicate a decrease in on-call hours provided by both:

Midwives	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total Hours
Hospital Midwife on-call hours used	221.75	119.3	135	103.5	171.8	118.5	869.85
Community Midwife on-call hours used	177.25	142	77.75	54.5	170	83.5	705

11. Red Flag Incidents

- 11.1. A midwifery red flag event signals potential issues with staffing. Upon occurrence, the midwife in charge assesses the situation and decides on necessary actions. Red flags are tracked using various methods including the Local Risk Management System (Ulysses) and the Birth Rate Plus acuity tool.
- 11.2. The following tables demonstrate red flag events across the maternity service for Q3/Q4 2024/25. Mitigating midwifery red flags is a key part of ensuring safe, responsive, and high-quality maternity care.
- 11.1. When a red flag is raised mitigation measures are put in place to address and respond to the red flag. These include redeployment of staff, consolidating and cohorting inpatient beds, and deploying on-call midwives to assist services. The table below provides a summary of the red flags raised and mitigated during the reporting period.

Red Flags for In-Patient areas	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Staff moved between speciality areas	60	45	37	24	57	32
Supernumerary workers within the numbers	50	40	39	20	44	33
Administrative or Support staff unavailable	7	6	13	11	8	6

Staff unable to take recommended meal breaks	156	79	125	92	102	100
Staff working over their scheduled finish time	114	139	129	132	76	NA
Delays in answering call bells	0	0	0	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0	0	0	0
Delay or omission of regular checks on patients.	0	0	0	0	0	0
Beds not open to fully funded number - state number not staffed and reason	0	0	0	0	0	0
Elective activity or tertiary emergency referrals declined	0	1	0	0	0	0
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
No of Days with a Delay of 24 hours or more during IOL process	26	20	23	10	22	15
Number of women delayed more than 24 hours during IOL process	53	41	70	22	71	23
Any occasion when 1 midwife is not able to provide 1:1 care during established labour	0	0	0	0	0	0
Woman not getting location of choice for birth	1	2	2	0	0	2
Delivery suite coordinator not SN at start of shift	0	0	0	0	0	0
Delivery suite coordinator not SN After shift started	0	1	0	0	0	0

12. Conclusion

- 12.1. Midwifery staffing is a complex issue, as patient needs and case complexities can lead to rapid changes in acuity levels. Therefore, maintaining safe staffing levels is an ongoing and dynamic process.
- 12.2. This paper provides an overview of the methods used to monitor staffing levels and ensure that clear and robust escalation plans are in place. It includes a minimum of twice-daily assessments of the maternity unit's acuity in relation to staffing levels. By conducting these assessments, early interventions can be initiated to maintain both safety and quality of care. Additionally, assurance around how on-call Consultant cover on labour ward is achieved is provided.
- 12.3. The service has also continued with a comprehensive recruitment and retention strategy, making significant progress in addressing vacancies and pro-actively managing consistent high unavailability levels. The workforce plan has enabled the service to be more proactive in planning for, and addressing, turnover and attrition rates.

13. Recommendations

- 13.1. The Trust Board is asked to:
 - Note the contents of the report and formally record to the Trust Board minutes in line with the requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Perinatal Incentive Scheme (MPIS) for safety action 6.
 - Note the evidence that midwifery staffing budget reflects establishment as calculated by BirthRate Plus®.
 - Approve and take assurance from this report that there has been an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q3 and Q4 of 2024/25 inclusive.

Planned versus actual staffing for maternity for Q3/Q4 2024/25

	Oct-25			Nov-25			Dec-25			Jan-25			Feb-25			Mar-25		
	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate	Overall Average	Average Reg Fill Rate	Average Unreg Fill Rate
Maternity Services Average	80%	79%	81%	79%	78%	81%	78%	78%	77%	78%	78%	79%	77%	78%	77%	82%	82%	83%