

Biannual Perinatal Workforce Report
(Reporting Period December 2025 to May 2026)

Public Trust Board
30 July 2026

Presented for:	Information and Assurance
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Previous Committees:	Womens Quality Assurance Group July 2026 Perinatal Quality and Assurance Committee July 2026

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Governance, Management and Sustainability
<u>Regulatory Impact</u>	Regulation 18: Staffing

Key points	Purpose
1. This report is presented to the Trust Board for information and assurance of the perinatal workforce position over the last 6 months to identify progress, escalate any concerns or emerging risks that may impact safe service delivery.	<i>Information & Assurance</i>
2. There has been a positive response to nursing and midwifery recruitment which has facilitated closure of all vacancy gaps. However staffing gaps continue to be mitigated with bank and agency to support safe staffing until the recruits join the services in Q3.	<i>Information & Assurance</i>
3. The primary impact on clinical care related to midwifery staffing is associated with delays to the induction of labour pathway with this also being the primary reason for red flags within the service.	<i>Information & Assurance</i>
4. Neonatal nursing and medical staffing are fully compliant with the British Association of Perinatal Medicine (BAPM) standards.	<i>Information & Assurance</i>
5. The budgeted establishments for the clinical and non-clinical specialist and management midwives align with the 2024 Birthrate Plus recommendations. A further birthrate Plus review is planned in Q3/4.	<i>Information & Assurance</i>

6. A business case has been reviewed and approved to support an initial expansion to the obstetric workforce. It is expected that a follow up review for further expansion will be required next year.	<i>Information & Assurance</i>
7. There are no concerns related to anaesthetic staffing.	<i>Information & Assurance</i>

Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Operating within
Operational Risk	Choose an item.	Choose an item	Operating within
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	Operating within
Financial Risk	Choose an item.	Choose an item	Choose an item.
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Operating outside

1. Summary

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been reported separately in the perinatal assurance reports and the biannual midwifery staffing reports, however, to provide evidence for NHS Resolutions Maternity Incentive Scheme, this paper now provides staffing data on other key perinatal groups including neonatal, nursing and medical, obstetricians, and anaesthetics.

This report focuses on perinatal workforce data from the 1st of December 2025 to the 31st of May 2026.

The maternity services in Leeds received a section 29A warning notice for midwifery staffing from the CQC following an inspection in 2025. There has been a positive response to recruitment, and the vacancy gaps have now been closed. However, as many recruits are early career midwives graduating in September the effect of this recruitment will not be fully realised in the service until Q3. To support safe clinical staffing in the interim, bank and agency staff are being utilised and enhanced pay offered. Nonclinical, specialist and leadership midwives are also deployed if initial mitigating actions haven't filled the gaps. However, this does create risk if this strategy is deployed regularly due to the impact on their primary portfolio and inability to meet competing demands of the additional clinical workload.

The frequency of this occurrence is anticipated to be minimal once all the new recruits have commenced in post and the service are exploring other mitigating actions in the interim.

Sickness and absence within the midwifery workforce continues to be a cause for concern which exacerbates staffing gaps with short notice sickness being particularly problematic. There hasn't been any significant improvement or deterioration with the rate remaining around 6%. The primary reason for sickness continues to be stress and anxiety.

An emerging risk was noted in relation to some of the highly specialist areas (fetal medicine and fetal assessment unit) where high levels of midwifery unavailability within small teams was posing a risk to service provision. Mitigating actions including expansion of the teams and service reviews has been initiated to reduce the associated risks.

Facilitation of homebirths continues to be monitored via the maternity services dashboard. This includes the number of women choosing homebirth as place of birth, the number of women transferred to hospital for maternal or fetal indications during either the intrapartum or postnatal elements of care and the number of women requested to attend hospital due to insufficient staffing levels to support a homebirth. During the last 6 months, the percentage of planned home births at the start of labour has ranged between 0.43% and 1.12%. Additional midwifery resource is required to support homebirth in comparison to the hospital setting and vacancy gaps and midwifery absence can negatively impact the ability to support this service. During the last 6 months, the percentage of home births that have been suspended due to insufficient staffing has ranged between 28.57% and 71.43%. Supporting choice of place of birth is a priority for the service and it is anticipated that the number of suspensions will decrease as the staffing levels increase over the coming months.

2. Discussion

➤ Birthrate Plus Workforce Planning

Birthrate Plus is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM). NICE (2017) recommend that an assessment is carried out every three years.

A Birthrate Plus assessment was undertaken in Q3 of 2023, with a final report received in March 2024. The report was presented to the Quality Assurance Committee in April 2024. The report highlighted that whilst there had been a small decrease in the total birth rate from the 2021 assessment, there had been a concurrent increase in acuity due to the complexity of care. Following establishment reviews, the clinical budgeted establishment was subsequently increased in line with the recommendations with approval given to commence recruitment.

The recommendations at this time were based on a 23% uplift. As per the 2022 Ockenden recommendations a review of unavailability over a three-year period was undertaken by the Head of Midwifery and a report developed and escalated detailing the findings and consideration of an increase in the uplift to 27-28% (including parental leave) requested. This has been approved by the Trust Board through the backfill of 75% of maternity leave and budgeted clinical establishments have been amended to reflect the revised uplift.

The report also highlighted that there was a deficit within the non-clinical specialist and management cohort which was based on applying a 12% requirement. A business case was written and presented to address the deficit in the non-clinical specialist and management cohort. A commitment from the Trust Board was made to support the closure of the non-clinical, specialist and management deficit of 14.5 WTE over a 3-year phased approach. A request was made to review the roles that contributed to this detailed in the business case. During 2025/26, the closure of this gap has been expedited by the Trust Board through approval of additional roles. There has been a significant increase in senior leadership roles to support capacity and visibility. The maternity service budgets are now fully aligned with the Birthrate Plus recommendations and there is active recruitment in progress to appoint to all identified roles.

In line with the recommendations and Maternity Incentive Scheme guidance and to ensure safe staffing, a further Birthrate Plus assessment will be commissioned in late Q3/Q4 2026/27. It is anticipated through regular monitoring of the casemix that this may demonstrate a further increase in the complexity of care and acuity since the 2024 report.

➤ **Planned versus actual staffing**

Within the maternity services, suboptimal fill rates are predominantly associated with vacancies and increased unavailability due to sickness, parental leave and study leave. Within the neonatal services, the increased number of patients and acuity in December 2025 & January 2026 reflects that service was OPEL Black/ 4 & Red/3 for 76% of the time. This illustrates the requirement for 100-108% qualified staff. March, April and May 2026 have reduced actual staffing percentages as these months had a reduction in activity. Bank usage was minimal; staff accessed supernumerary time for Qualified in Speciality (QIS) training and completed their mandatory training. BAPM standards were maintained throughout this period. A summary of the fill rates for registered and unregistered staff for nursing and midwifery is available in appendix 1.

➤ **Vacancy Rates**

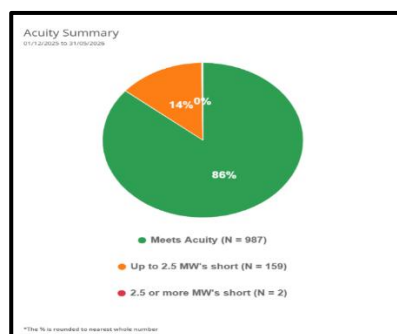
Staff Group	Vacancy	Risks Mitigations and Escalation
Midwifery	32.76 WTE as of end of May 2026 This is a 17 WTE deficit from birthrate plus recommendations. The remainder is following an increase in the uplift to 27%	There has been a positive response to midwifery recruitment, and the incoming pipeline will facilitate complete closure of the current gaps and respond to future demand by including anticipated redeployment into nonclinical, specialist and management roles and expected monthly attrition, until September 2027. The primary source of recruitment is associated with graduating midwives. Commencement of employment in the main will be in Q3 commencing in September 2026. In the interim to mitigate risks and optimise safe staffing, several controls are in place including the use of bank and agency midwives, redeployment in real time to respond to areas of pressure, enhanced payments for additional hours worked and redeployment of non-clinical specialist and management midwives.

		It is important to note that when the action of non-clinical redeployment is required to maintain critical clinical functions to support safe care, it negatively impacts the primary portfolio of this cohort of staff potentially creating unintended risks which then require further actions to mitigate by prioritising workload and teams working additional hours. A daily staffing meeting and a twice daily situation report are completed and unmitigated risks escalated through CSU and corporate processes. Midwifery staffing is also reported bimonthly through CSU governance processes and the Perinatal Improvement and Assurance Committee and monitored via the risk register.
MSW's	8.48 WTE as of end of May 2026	Individuals in the pipeline to close the vacancy gaps, bank and agency being used in the interim to mitigate gaps. The same processes are used to monitor staffing and escalate any risks as the registered midwives.
Obstetricians	A gap of 16 consultant posts has been identified through a workforce review. 6 posts are being recruited to this year plus conversion of 3 long term locum posts to substantive. The remaining 10 posts will require review with a view to phased recruitment over the following 2 years. 5.7 WTE gaps in tier 2 rota and 4 WTE gaps in tier 1 rota	A business case has been written and reviewed by the executive team to support expansion of the consultant and resident workforce. There is ongoing recruitment to support appointment to the approved posts within this financial year with a view to a further review of expansion anticipated next year. All job plans have been reviewed and appropriate contract changes made to reflect the additional work in risk and reviews required to meet governance requirements. Additional paid hours are being offered to support paid gaps. Gaps for the resident doctors are being mitigated through. • Enhanced pay • Actively seeking locums • Biweekly review of gaps by Clinical Director and rota leads • Development of a new rota pattern
Neonatal Nurses	There is a total of 13.45 WTE gaps across both neonatal services and transitional care.	The Neonatal nursing pipeline will facilitate closure of all Registered Nurse and Registered Nurse Associate vacancies, anticipated career progression within the service and the additional

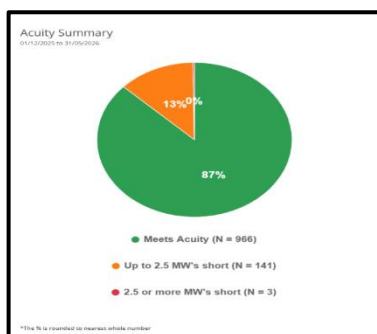
	8.94 WTE are registered workforce NA's and RN's	uplift of budgeted establishments following business case reviews. If there are any shifts which are not to British Association of Perinatal Medicine (BAPM) standards, support is requested from nurses in leadership, education and quality roles. Acute shortfalls are escalated to the Patient flow coordinator (PFC), matron for escalation and the site matron. All vacant shifts are released to bank in a timely way to optimise pick up of shifts. Vacancies, attrition and known parental leave are discussed bimonthly in the education and workforce meeting.
ACP	1 WTE	There is currently 1 WTE 8A post vacant which will be advertised in August 2026 to coincide with completion of the apprenticeship course. There are no gaps for trainee ACP's.
Neonatal Medical	0	There are no gaps within the consultant workforce
Anaesthetics	0	There are no gaps in the perinatal anaesthetic workforce

➤ **Birthrate Plus Acuity Tool, intrapartum**

L45 Delivery Suite



J03 Delivery Suite



1:1 care in Labour

	December	January	February	March	April	May
% of 1:1 care provided	100%	100%	100%	100%	100%	97%

On the 26th of May there is 1 red flag reported for J03 where there was a delay in transferring a woman from the antenatal ward to delivery suite for 1:1 care. This was mitigated by redeploying a midwife from another area. There was a further red flag raised on the 30th of May for inability to provide 1:1 care in labour, scoping had commenced to divert maternity services but didn't need to be progressed as the acuity improved and this was mitigated.

There was 1 red flag raised on BR+ acuity tool on the 4th of April for inability to provide 1:1 care, however further review has highlighted that this was mitigated through redeployment of a midwife and diversion of services.

➤ Supernumerary Labour Ward Coordinator

	December	January	February	March	April	May
% of supernumerary	* 97%	100%	100%	100%	100%	99%

*There are 2 red flags documented on Birthrate plus for December 2025 and 1 for May 2026 for the coordinator not being supernumerary. However, the coordinator was supernumerary at the start of the shift, and these episodes were for a short period and did not involve the coordinator providing 1:1 care in labour

➤ Neonatal Capacity Pressures

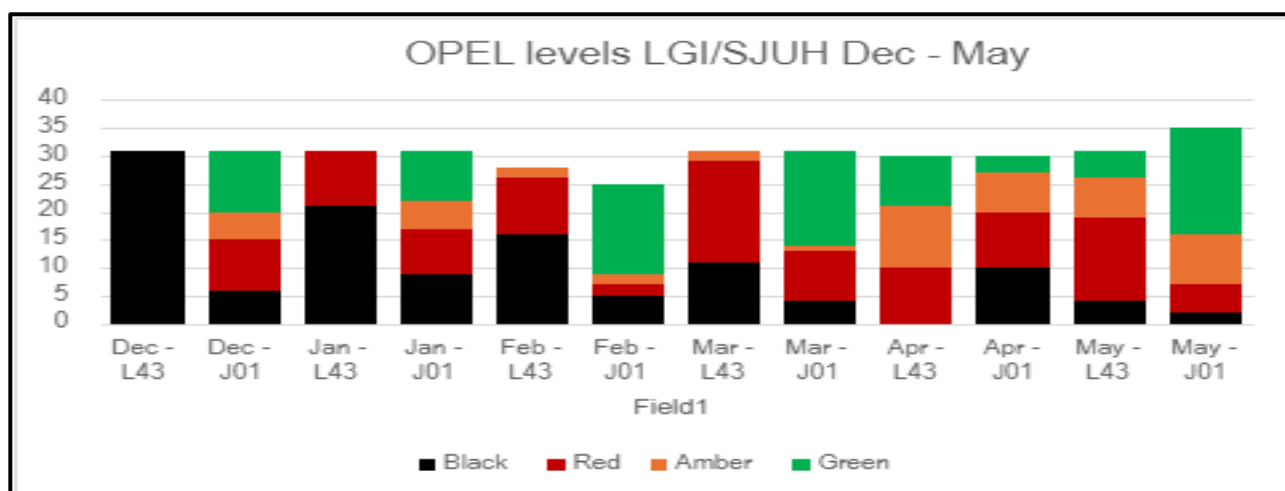
Serratia and MRSA outbreak

There was a Serratia outbreak declared on the 2nd of April, which resulted in admission criteria initially being restricted to less than 28-week babies, cardiac and surgical babies and subsequently revised due to service pressures. There was increasing capacity pressures due to source isolation impacting bed capacity and staffing numbers. There was also a concurrent MRSA outbreak that commenced in March and concluded in May which further impacted capacity and staffing due to source isolation, admission criteria was not impacted.

Business continuity incident

There was a business continuity incident caused by a flood in February which resulted in closure of the SJUH Neonatal unit for 3 days. 7 patients were transferred out into the region; emergency stabilisation areas were set up in unaffected areas of the perinatal services. Extensive estates work was required to enable the unit to open again.

OPEL Levels

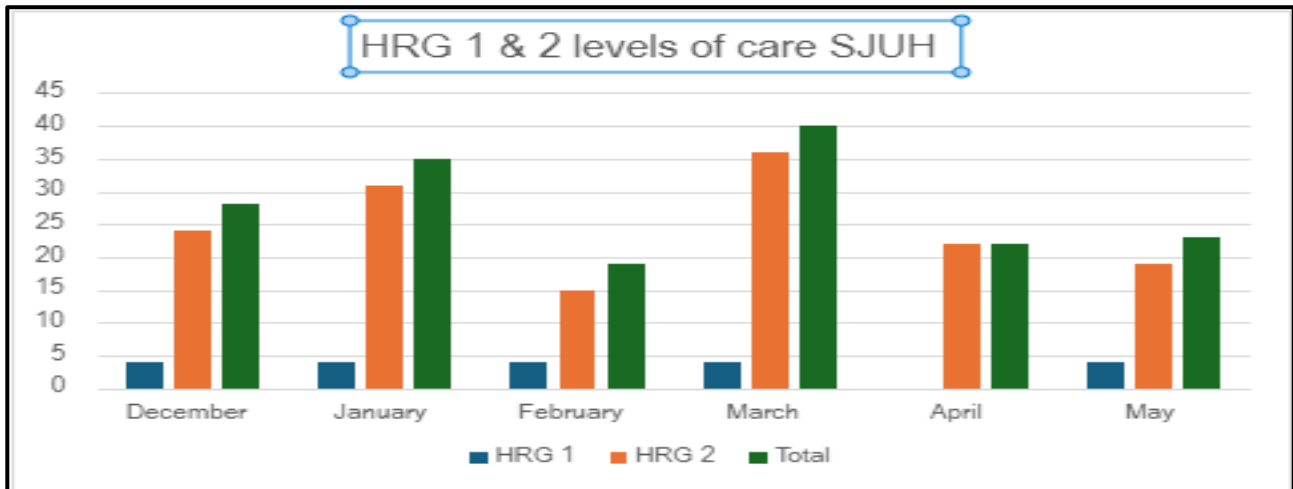


Dec, Jan & Feb saw higher days at OPEL black at LGI compared to Mar, Apr and May were LGI has spent less than half the days at OPEL black.

LGI has reported OPEL green in April and May were as the other months they had not reported OPEL green at all

Jan & Feb SJUH saw high levels of OPEL black reporting, but the other months are a consistent reporting levels between 4 and 12 days.

Healthcare Resource Group (HRG) levels



There is a continuing trajectory below 42 per month, there are similar number of HRG 1 & HRG 2 each month. Through December to May there has been 16 transfers out of SJUH to LGI and the region due to escalating care, 6 of these were due to the business continuity incident.

➤ Maternity Red Flags

Red flags 1 and 7 are primarily related to delays in the induction of labour pathway. They are recorded every four hours and therefore if an individual has a delay of greater than 6 hours, they may have multiple red flags raised. The number of red flags does not directly correlate with the number of individuals impacted. Numbers are rounded up by BR+ to the nearest whole number (%) and therefore there will be some instances that show 0%.

L45 LGI Delivery Suite

Number of Red Flags recorded

01/12/2025 to 31/05/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	529	67%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	6	1%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	3	0%
RF4	Delay in providing pain relief	14	2%
RF5	Delay between presentation and triage	2	0%
RF6	Full clinical examination not carried out when presenting in labour	3	0%
RF7	Delay between admission for induction and beginning of process	233	29%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status	2	0%
TOTAL		793	

*The % is rounded to nearest whole number

The top 4 staffing factors for L45 reported on the acuity tool were unable to fill vacant shift (44%) unexpected midwife absence and sickness (16%), second midwife required in theatre (16%) and midwife redeployed to another area (10%). Other reasons were support staff less than rostered numbers (9%), Midwife supporting homebirth (2%) and 2nd midwife supporting 2nd stage intermittent auscultation (1%). The clinical impact was primarily delays to transfers and planned procedures, this is inextricably linked with the induction of labour pathway. The key management actions taken were redeployment of staff internally (36%), staff sourced from bank and agency (21%), diversion of maternity services (20% predominantly single site) staff unable to take allocated breaks (6%) and specialist midwife working clinically (5%).

J03 SJUH Delivery Suite

Number of Red Flags recorded

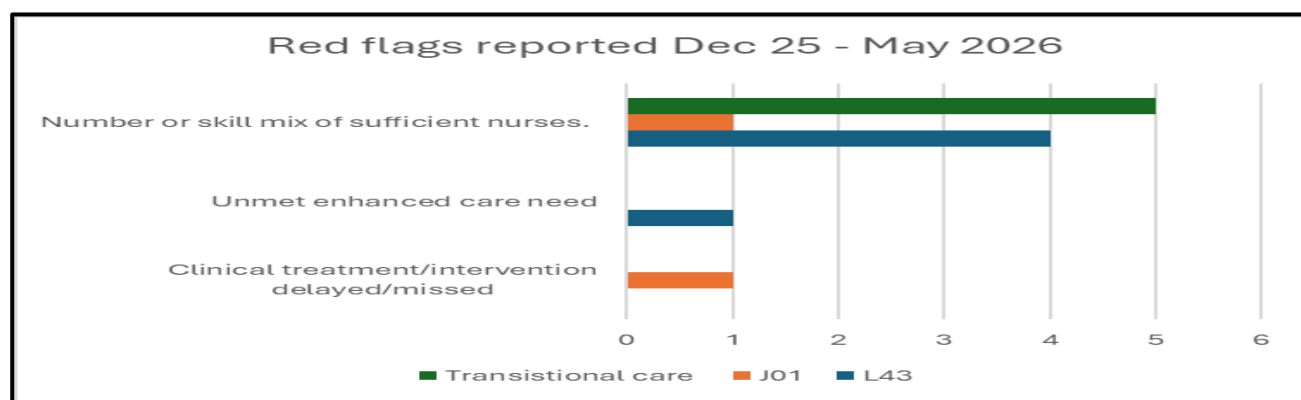
01/12/2025 to 31/05/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	314	46%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	10	1%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	9	1%
RF5	Delay between presentation and triage	2	0%
RF6	Full clinical examination not carried out when presenting in labour	9	1%
RF7	Delay between admission for induction and beginning of process	333	49%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	2	0%
RF9	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%
RF10	Coordinator not able to maintain supernumerary/supervisory status	1	0%
TOTAL		682	

*The % is rounded to nearest whole number

The top 4 staffing factors reported for J03 were unable to fill vacant shifts (53%), unexpected midwife absence and sickness (19%), 2nd midwife required in theatre (17%) support staff less than rostered numbers (8%). Other factors were midwife on transfer duties (2%) and second midwife required to support intermittent auscultation in 2nd stage of labour. Again, the primary clinical impact was delays to the induction of labour pathway. The key management actions taken were redeployment of staff internally (33%), staff sourced from bank and agency (30%) Maternity unit on divert (19% single site predominantly), staff unable to take allocated breaks (6%) specialist midwife working clinically (5%).

Neonatal Red flags



Across the Neonatal service 12 red flags have been raised between Dec 2025 and May 2026. This includes 5 on L43 (LGI NNU) 4 red flags related to number or skill mix of sufficient nurses and 1 unmet enhanced care need. 3 shifts raised for staffing were able to be mitigated as although a red flag had been raised, they had sufficient staffing to support the shift but were unable to support extra admissions. 1 staffing red flag was due to x2 inappropriate double ups, this was unable to be resolved internally or by the CSU therefore an assurance visit was performed. The remaining red flag was raised for unmet enhanced care need; the unit was over capacity at 25 babies and had no emergency space. Embrace were able to transfer 1 baby into region and 1 to SJUH NNU to create emergency admission capacity.

There were 2 red flags raised on J01 (SJUH NNU), 1 for number or skill mix of sufficient nurses and 1 for clinical intervention/treatment delayed. The staffing red flag was for 1 HRG 1 patient, 1 HRG 2 patient and 1 patient in isolation, the CSU were unable to mitigate this, and the coordinator had to provide care for a HRG 1 patient. The clinical treatment delay was due to high acuity with HRG 2 patients.

The remaining 5 red flags were attributed to the transitional care provision at SJUH. 3 shifts were due to having no registered midwife on the shift. Appropriate actions and escalations were undertaken; with 1 shift supported by the Womens CSU and on the other occasions women were moved to the maternity services to support midwifery care. 2 shifts were reported to be 1 below safe staffing, 1 shift was backfilled from the neonatal unit and the other remained red with assurance visits and support from J01.

➤ Obstetric Workforce

Consultant attendance

Consultant attendance is monitored as per the RCOG guidance which requires a minimum of 80% of attendance against the events detailed in the table below. Where compliance is less than the minimum standard all cases have been reviewed by the clinical lead to review

any missed opportunities or unmitigated risk. Compliance against preterm twins was 66% and this was due to twins <22 weeks delivering before arrival. Compliance for early warning score protocol was due to patients being pyrexial but were reviewed by other medical teams and didn't require an escalation of the level of care. All other cases also reviewed and no unmitigated risks seen.

Presentation	From 1st April 2026 to date	% Consultant Attendance
Perineal Tear 4th Degree	2 cases	100%
PPH >2litres	26 cases	80%
Preterm twins (<30 weeks)	3 cases	66%
Eclampsia		
Caesarean Section <28 weeks	5 cases	100%
Caesarean Section BMI >50	9 cases	89%
Caesarean Section Placenta Praevia	23 Cases	87%
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary	9 cases	78%

Short term locum certification (obstetric workforce)

There are 3 long term locums currently working within the maternity services. Compliance for all three against the standards is detailed below.

Issue	Completed
Locum doctor CV reviewed by consultant lead prior to appointment	Yes
Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	Yes
Departmental induction by consultant on commencement date	Yes
Access to all IT systems and guidelines and training completed on commencement date	Yes
Named consultant supervisor to support locum	Yes
Supernumerary clinical duties undertaken with appropriate direct supervision	Yes
Review of suitability for post and OOH working based on MDT feedback	Yes
Feedback to locum doctor and agency on performance	Yes

➤ **Anaesthetic Workforce**

Compliance for immediately available duty anaesthetist for the obstetric unit 24 hours a day

	December	January	February	March	April	May
% Compliance	100%	100%	100%	100%	100%	100%

Compliance for immediately available duty anaesthetic assistants 24 hours a day

	December	January	February	March	April	May
% Compliance	100%	100%	100%	100%	100%	100%

➤ **Neonatal Medical Staffing**

Neonatal medical funded posts

There are 18 funded consultant posts

Gap to achieve BAPM standard

The rotas for both neonatal units are fully compliant with BAPM standards. There are 1.6 WTE LST gaps due to a shortage from the deanery/doctor leaving. This is mitigated by running either a 1:15 or a 1:16 rota both of which are BAPM compliant. The SJUH NNU is due to be redesignated which will require an increase in HST, and this will be scoped and enacted as part of the redesignation plans.

Mitigation and Plan

There is 1 consultant on long term sickness absence, and a locum has been appointed and commenced in post. Work is in progress to secure further LST's, and surge funding is being explored.

➤ **Neonatal Nursing Staff**

Neonatal Nursing Funded posts

There are 180.16 currently funded. This will be amended to reflect the further uplift across neonatal services following the approved business case reviews.

Gap to achieve workforce identified in neonatal nursing workforce calculator

There is a total of 13.45 WTE gaps across both neonatal services and transitional care. 8.94 WTE are registered workforce Nursing Associates and Registered Nurses.

Mitigation

In addition to the current vacancies, there has been development and approval of business cases, known promotions and backfill of these individuals culminating in an increased pipeline of Neonatal Nurses and Nurse Associates. Staff will commence in post by December 2026 with the majority commencing in September and October. There will be

further recruitment for the remaining staff identified through the business cases in early 2027.

Plan

As there is a significant number of new starters, consideration has been given to the induction process. All new starters have been divided into 4 groups (ICU/HDU, Surgical newborns, SJUH NNU and Transitional care). They will commence in allocated areas for 6 months and then rotate in all other areas for 4 months each. There will be a total of 8 weeks supernumerary with 2 weeks in each area.

A quarterly workforce tool is developed and submitted to the ODN. The workforce tool measures the neonatal nurse staffing, AHP's and quality roles. The ODN Lead Workforce Nurse reviews the information submitted. A face-to-face review with the ODN and NHSE Neonatal Improvement Advisors in February 2026 to review the Neonatal Nurse establishment. With the changes to the ICB function, clarity has been sought and a response awaited regarding future steps in reporting workforce metrics to the ICB.

3. Financial Implications

There are no new financial implications from this report.

4. Risk

Midwifery vacancy gaps continue to be mitigated using bank and agency, and redeployment of non-clinical specialist and management teams. Redeployment creates risks to the primary portfolio if enacted frequently and further mitigating actions need to be enacted to support wider governance and quality and safety metrics.

The obstetric workforce will require further review and expansion to meet service demands.

5. Communication and Involvement

There are ongoing communication and engagement strategies with the perinatal teams.

6. Impact on Equality & Health Inequalities

There is no specific health inequality impact from this report, however equality and health equity are inextricably linked with safe perinatal services.

7. Publication Under Freedom of Information Act

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

8. Recommendation

For the Trust Board to be assured of the recruitment and processes in place to support a safe perinatal workforce and note that there are gaps in the nursing and midwifery workforce that will be resolved by the end of Q3/early Q4, ongoing current mitigation will be required until this point. To note that further review of the obstetric workforce will be required in 2027 to support further expansion to meet service needs.

9. Supporting Information

None

Appendix 1

Midwifery Workforce Planned Versus Actual Staffing December 2025 to May 2026**LGI Maternity Services**

Month/ Year	Ward name	Day		Night	
		Average fill rate - registered midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered midwives (%)	Average fill rate - care staff (%)
May 2026	L36 Postnatal Ward	86%	98%	96%	97%
	L44 Antenatal Ward	97%	93%	95%	106%
	L45 Delivery Suite	86%	94%	82%	92%
April 2026	L36 Postnatal Ward	90%	94%	92%	95%
	L44 Antenatal Ward	97%	98%	91%	93%
	L45 Delivery Suite	85%	92%	83%	96%
March 2026	L36 Postnatal Ward	87%	94%	95%	95%
	L44 Antenatal Ward	96%	93%	94%	100%

	L45 Delivery Suite	89%	91%	87%	86%
February 2026	L36 Postnatal Ward	93%	90%	102%	100%
	L44 Antenatal Ward	100%	97%	104%	96%
	L45 Delivery Suite	92%	93%	88%	82%
January 2026	L36 Postnatal Ward	91%	85%	91%	97%
	L44 Antenatal Ward	101%	103%	99%	82%
	L45 Delivery Suite	86%	89%	89%	87%
December 2025	L36 Postnatal Ward	89%	86%	99%	88%
	L44 Antenatal Ward	99%	94%	99%	93%
	L45 Delivery Suite	90%	92%	88%	85%

SJUH Maternity Services

Month/ Year	Ward name	Day		Night	
		Average fill rate - registered midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered midwives (%)	Average fill rate - care staff (%)
May 2026	J03 Delivery Suite	91%	101%	87%	85%
	J04 Antenatal Ward	102%	101%	100%	87%
	J05 Postnatal Ward	80%	100%	95%	103%
April 2026	J03 Delivery Suite	93%	98%	88%	92%
	J04 Antenatal Ward	100%	94%	100%	95%
	J05 Postnatal Ward	88%	100%	89%	95%
March 2026	J03 Delivery Suite	93%	100%	92%	87%
	J04 Antenatal Ward	100%	105%	100%	93%

	J05 Postnatal Ward	86%	95%	94%	92%
February 2026	J03 Delivery Suite	89%	111%	88%	81%
	J04 Antenatal Ward	103%	89%	100%	100%
	J05 Postnatal Ward	87%	100%	94%	94%
January 2026	J03 Delivery Suite	92%	88%	91%	92%
	J04 Antenatal Ward	101%	101%	100%	97%
	J05 Postnatal Ward	92%	96%	98%	95%
December 2025	J03 Delivery Suite	93%	111%	94%	95%
	J04 Antenatal Ward	101%	85%	100%	90%
	J05 Postnatal Ward	90%	101%	102%	97%

Nursing Workforce Planned Versus Actual staffing December 2025 -May 2026

Month/ Year	Ward name	Day		Night	
		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
May 2026	J01 Neonatal Unit	89%		91%	
	Transitional Care - SJH	92%	100%	98%	100%
	L43 Neonatal Unit	95%		98%	
April 2026	J01 Neonatal Unit	103%		108%	
	Transitional Care - SJH	94%	100%	95%	95%
	L43 Neonatal Unit	91%		95%	
March 2026	J01 Neonatal Unit	96%		97%	
	Transitional Care - SJH	94%	95%	95%	88%

	L43 Neonatal Unit	94%		94%	
February 2026	J01 Neonatal Unit	103%		101%	
	Transitional Care - SJH	86%	104%	89%	100%
	L43 Neonatal Unit	96%		98%	
January 2026	J01 Neonatal Unit	106%	121%	107%	102%
	Transitional Care - SJH	90%	109%	97%	100%
	L43 Neonatal Unit	99%	100%	100%	100%
December 2025	J01 Neonatal Unit	108%	114%	106%	113%
	Transitional Care - SJH	95%	103%	101%	90%
	L43 Neonatal Unit	100%	100%	100%	100%