Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 15 January 2025

TB2025.04b

Title:	**Biannual Maternity Safe Staffing (Quarter 1 and Quarter 2) 2024/25**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee**

Board Lead:	**Chief Nursing Officer**
Presenter:	**Milica Redfearn, Director of Midwifery**
Author:	**Sharon Andrews, Head of Midwifery**
	Jane Upham, Legacy Midwife
Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This report is the first biannual midwifery safe staffing report for 2024/25. It provides a review of safe staffing levels in Quarter 1 and Quarter 2, along with an update and progress on workforce planning for the maternity service.
2. **Birth Rate Plus Workforce Planning**: A formal Birth Rate Plus assessment conducted in 2021 recommended a birth-to-midwife ratio of 22.9. The midwifery establishment has increased in line with this recommendation from 283.77 WTE to 332.06 WTE in 2024/25.
3. **Recruitment and Retention**: Ongoing recruitment campaigns have significantly increased staff by 15.52 wte midwives within this reporting period with a proactive workforce plan to recruit into the increased vacancy gap following the Birthrate Plus uplift, inclusive of attrition and turnover.
4. **Planned vs. Actual Staffing Levels:** The report compares planned (budgeted) midwifery staffing levels with actual staffing levels, highlighting that most inpatient areas achieved fill rates exceeding budgeted levels.
5. **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.
6. **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.
7. **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.
8. **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.
9. **Specific challenges:** The report acknowledges some challenges faced by the service around the retention of staff, the cost of living, and the flexible working requests and maternity leave.

Recommendations

10. 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 Q1 and Q2 of 2024/25 inclusive.

Contents

Biannual Maternity Safe Staffing (Quarter 1 and Quarter 2) 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 the first and second quarters 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 of midwifery staff.

1.3. Provides oversight for the Board and evidence for the NHS Resolution's Maternity and Perinatal Incentive Scheme (MPIS), this biannual midwifery safe staffing report is produced. This report provides a comprehensive overview of the measures in place to ensure safe midwifery staffing at Oxford University Hospitals (OUH) for Quarter 1 and Quarter 2 of 2024/25.

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 Birth Rate 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. Birth Rate Plus recommended that maternity services increase the midwifery staffing establishment from 283.77 wte in 2019/20 to 310.50 wte in 2023/24 and 332.06 wte in 2024/25. This review also recommended a birth-to-midwife ratio of 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 NHSR MPIS requires.

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.

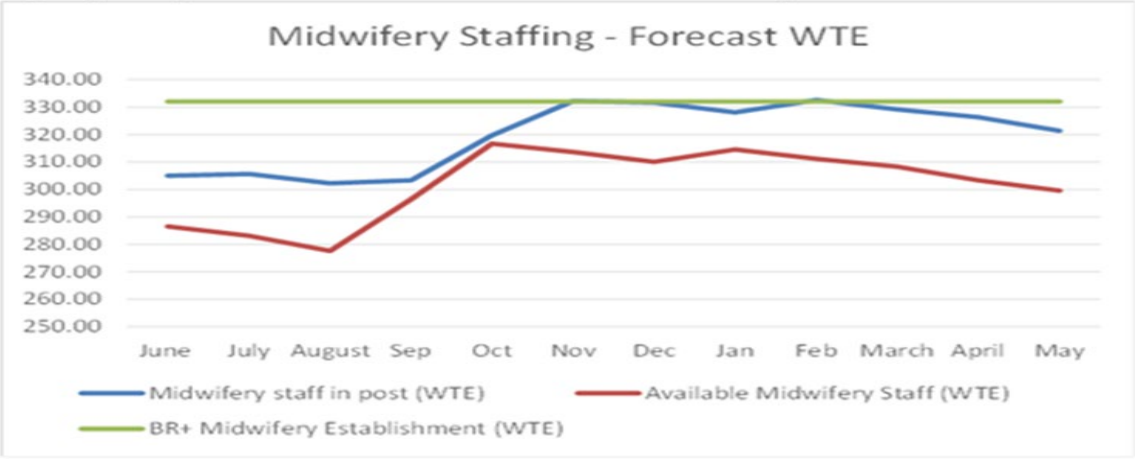
3.5. In October 2024, as part of the Trust-wide establishment review, the Chief Nurse conducted a review of the midwifery staffing establishment. This review involved collaboration with workforce leads, finance and people partners, as well as the maternity leadership team. Evidence gathered during this 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 Q1 and Q2, the Maternity Service recruited 15.52 Midwives/RNs with an additional 17 wte midwives due to start in Q 3. Ongoing recruitment campaigns for midwifery and maternity support worker positions have significantly increased staff in posts and reduced vacancies. The service employs a lead Recruitment and Retention specialist midwife, who collaborates closely with external partners and divisional and Trust workforce leaders to ensure a proactive recruitment pipeline.

4.2. A large proportion of joiners are newly registered midwives. 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.

4.3. As illustrated in the chart below the services is expecting to have zero vacancies by Q3 2024/25.



Midwifery Staffing - Forecast WTE

4.4. In Q1 and Q2 there were 24 wte leavers. The table below indicates the number of new starters (in WTE) compared to the number of leavers in Q1 and Q2.

Midwives/RN's wte	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	**Total**
New Starters	0.4	3.72	1	0	1	9.4	**15.52**
Leavers	4.32	3.53	3.71	6.4	3.77	2.27	**24**

Number of new starters (in WTE) against the numbers of leavers in Q1 and Q2

4.5. The service has in place a proactive workforce plans to address attrition and turnover and are summarised below:

4.3.1 Most newly recruited midwives are in their early careers and joined the service in the autumn 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.

4.3.2 The service has also implemented a Midwifery Apprenticeship Programme, which has successfully recruited maternity support workers to start their midwifery training. Two maternity support workers have started their training, and another two will begin in January 2025.

4.3.3 The service has supported twelve Internationally Educated Midwives (IEMs). All twelve midwives have begun their roles and were fully integrated into the staffing establishment by the end of the second quarter of 2024/2025. The service is collaborating with local education providers to develop a benchmark orientation and support program that offers opportunities for internationally recruited dual-trained nurses and midwives to join the service.

4.3.4 In addition, five staff have started on the short nursing to midwifery conversion course in September 2023 and are set to become registered midwives in July 2025. The program has been well received, leading to an additional five candidates starting the course in September 2024.

4.3.5 In addition to a strong recruitment strategy, an effective retention strategy is essential. The service has faced challenges in retaining staff due to high living costs, retirement, flexible work requests, and career break applications from newly qualified employees. To address these issues, the service is enhancing staff well-being

programs, improving feedback mechanisms, and increasing efficiency in roster management.

4.6. Unavailability was a key issue for maternity services in quarter 1 and quarter 2 because of number of midwives unable to work due to medical absences, non-medical absences, and maternity leave.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Maternity Leave (wte)	15.72	15.8	15.72	17.72	20.83	19.16
Short Term Sickness (wte)	20.46	20.57	16.58	15.36	12.76	13.82
Long term sickness(wte)	6.35	9.19	5.76	4.05	6.17	5.93
Non-Medical Absence (wte)	1.72	2.4	0.61	2.18	1.53	0.78
TOTAL (wte)	44.25	47.96	38.67	39.31	41.29	39.69

Number of midwives unable to work due to medical absences, non-medical absences, and maternity leave

4.7. Maternity leave has contributed significantly to levels of unavailability and while funding is available for covering maternity leave temporarily, it has been challenging to fill temporary fixed-term positions and has been exacerbated by a national shortage in the midwifery workforce.

4.8. Despite the challenges unavailability has reduced over the 2 quarters with a significant overall reduction in short term sickness. Targeted work on sickness management support and return to work interviews has been undertaken in the service which has contributed to this decrease.

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 is available for review in Appendix 2.

5.3. As indicated in Appendix 2, all maternity areas achieved safe staffing fill rates, with actual staffing levels surpassing planned staffing levels in both the first and second quarters. This difference arises from the dynamic adjustment of midwifery staffing across inpatient areas to meet service needs, as outlined in the Maternity Staffing and Escalation Standard Operating Procedure.

5.4. The service has also identified some inaccuracies in reporting related to planned versus actual staffing. To improve accuracy, the live roster is closely monitored to ensure that the reporting on planned versus actual staffing is reliable. This process requires training to facilitate the timely

removal of shifts that are no longer needed in the planned staffing levels, as well as to ensure that all actual shifts are accurately captured in the live roster. For example, this includes situations where a worker is moved from a non-clinical shift to cover a clinical shift.

5.5. The Maternity 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.

5.5.1. Request midwifery staff undertaking specialist roles to work clinically.

5.5.2. Elective workload prioritised to maximise available staffing.

5.5.3. Managers at Band 7 level and above work clinically

5.5.4. Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.

5.5.5. Activate the on-call midwives from the community to support labour ward.

5.5.6. Request additional support from the on-call midwifery manager.

5.5.7. Liaise closely with maternity services at opposite sites to manage and move capacity as required.

5.6. All the above 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.

5.7. Safety Huddles are held twice daily to assess staffing relative to patient acuity. The maternity leadership team reviews scheduled staffing weekly, comparing it with the established requirements for each clinical area.

5.8. 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. A recruitment campaign has also increased the number of staff in position by Quarter 2.

6. Birth to Midwife Ratio

6.1. The birth-to-midwife ratio is calculated monthly using the Birth Rate Plus methodology and the actual monthly delivery rate. This ratio has now been

added to the maternity dashboard for monitoring alongside clinical data. The table presents the real-time monthly birth-to-midwife ratio.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Funded	01:27:43	01:28.7	01:27.8	01:26:35	01:27	01:26.1
	Quarter 1 average 1:27			Quarter 2 average 1:26		

Real time monthly birth to midwife ratio

7. Specialist Midwives

7.1. Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for the OUH is calculated to be 10.5%.

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 due to staffing challenges.

8.2. The OUH service has one current MCoC providing care to vulnerable women and birthing people with the highest need and is currently transitioning to a model of geographical based, mixed-risk caseloads. This team will be based and work from OX4 Blackbird Leys which is one of the most deprived areas in Oxford, and nationally, and also the area of greatest ethnic diversity. This model aligns with the Equity, Diversity, and Inclusion (EDI) principles which emphasises the importance of integrating diverse perspectives and experiences into all aspects of work, ensuring that these women and birthing people receive consistent and personalised care, which can lead to improved outcomes and experiences. The current MCoC team is a fully embedded resource that forms part of the current midwifery establishment.

9. Actual Maternity Staffing RAG Rating

9.1. The table below shows the RAG rating for actual midwifery staffing levels by month for Q1 and Q2 2024/25. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that day.

RAG Rating

	Red	Amber	Green
Apr-24	7	17	3
May-24	2	26	3
Jun-24	1	20	4
Jul-24	0	16	14
Aug-24	0	21	9
Sep-24	0	15	15

Maternity Staffing RAG Rating

9.2. The reported RAG rating is before any mitigation. If declared Red Level 3, the Staffing and Escalation SOP for OUH Maternity Services is used. An updated RAG rating and subsequent mitigation is sent to the Central Trust Safe Staffing Team every 2 hours until the rating drops below Level 3. Actions as per the SOP address Amber or Red ratings, including staff redistribution, using supernumerary workers, on-call staff, and sourcing additional staff from non-clinical 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 in the labour ward. This role involves an experienced Band 7 midwife who can offer advice, support, and guidance to clinical staff while managing ward activities and workload.

10.2. During this reporting period, maternity services maintained full compliance with having a supernumerary labour ward coordinator for every shift and providing one-on-one care for all women during active labour. This is supported by dashboard figures and audit results.

10.3. Twice daily Safety Huddles monitor the provision of one-to-one care in labour, ensuring all women that require 1:1 are receiving it 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 Red Flags are logged in the electronic Health Roster System and/or on the Ulysses incident reporting system. Both Maternity and Trust 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. There were 4 Red Flags regarding the supernumerary status of the second band 7 on delivery suite. On four occasions, they had to provide post-natal

care while awaiting additional midwives who were requested via the escalation process. No incidents or further Red Flags were noted during these instances. Although this is good to have oversight of, it does not affect compliance outlined within MPIS.

10.6. The table below shows the number of on-call hours required by midwives at the John Radcliffe maternity unit during this reporting period. Hospital On Call midwives are scheduled to be on call at night for 4 hour periods, while community midwives can be on call for 24 hours, mainly during the night. The hours reflect hospital team midwives and community midwives brought into the unit as part of the escalation process. Q1 and Q2 indicate an increase in on-call hours provided by hospital midwives but a decrease in those provided by community midwives. This has supported one-to-one care for all those requiring it within this reporting period:

Midwives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Total Hours
Hospital Midwife on-call hours used	226.5	230	160	201.5	225.5	161.75	1205.25
Community Midwife on-call hours used	84.5	114.8	190	85.75	97.25	76.5	648.8

Number of on-call hours required by midwives at the JR

11. Red Flag Incidents

11.1. 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.

11.2. The following tables demonstrate red flag events across the maternity service for Q1 and Q2 2024/25:

Red Flags for In-Patient areas	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Staff moved between speciality areas	57	57	51	50	56	45
Supernumerary workers within the numbers	58	32	48	11	27	29
Administrative or Support staff unavailable	8	12	15	16	10	8
Staff unable to take recommended meal breaks	118	100	89	107	129	133
Staff working over their scheduled finish time	43	32	41	52	123	100
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	0	0	1	1	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
Delay of 2 hours or more between admission for induction and beginning of process (Days)	25	28	26	15	22	15
Any occasion when 1 midwife is not able to provide continuous one to one care during established labour	1	0	0	1	0	0
Woman not getting location of choice for birth	3	0	2	2	0	0
Delivery suite coordinator not SN at start of shift	0	0	0	0	0	0
Delivery suite coordinator not SN After shift started	1	1	1	0	0	1
Number of women delayed during IOL process more than 24 hours.	87	98	73	29	70	37

Red flag events across the maternity service for Q1 and Q2 2024/25

11.3. Mitigation measures to respond to Red Flags included redistributing staff, consolidating inpatient beds, and deploying on-call midwives to assist services. When staffing levels are inadequate, missed breaks and extended shifts increase – to address and mitigate these issues, multiple strategies are being adopted. Enhancing staffing levels through proactive recruitment and optimised workforce planning is ongoing as is evidenced in this report. Additionally, ensuring staff well-being by guaranteeing rest periods and providing mental health support is vital. Alongside this, the ongoing work targeting efficient rostering and real-time acuity monitoring, coupled with

ongoing review and staff feedback, is helping to manage and decrease the occurrence of Red Flags and sustain excellent care and a supportive working environment.

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 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 safety.

12.3. The service has also implemented a comprehensive recruitment and retention plan, making significant progress in addressing vacancies and is on track to achieve zero midwifery vacancies by the third quarter. 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 Q1 and Q2 of 2024/25 inclusive.

Appendix 1: Birth Rate Plus Action Plan that the service continues to work towards:

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Monitor the midwifery establishment in line with BirthRate Plus	2022 Re-fresh of BirthRate Plus	Director of Midwifery	Nov-22	Evidence collated and submitted for analysis by BirthRate Plus Team in Oct 2022	Completed 2022
	To submit staffing paper with recommendations from BirthRate Plus	Director of Midwifery	Dec-22	Agreed Uplift to a midwifery establishment of 332.06 wte from 2022	Completed March 2024
	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus	Deputy HOM and Matrons	Mar-24	Completed for in-patient areas, AN Services, Governance, Education and Public Health and Community teams	Completed September 2024
	To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting.	Leadership Team	Ongoing	MCGC Minutes	Completed March 2024

Appendix 2: Planned vs Actual Midwifery Staffing

Apr-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	76	18.88	17.3	8.64	14.4	27.52		31.7
MW Delivery Suite	510	12.9	17	2.24	2.1	19.1		19.1
MW Level 5	990	4.57	3.09	2.1	1	4.5		4.5
MW Level 6	492	3.09	4.24	1.39	2	6		6

May-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	66	18.88	18.4	8.63	16.3	27.51		34.7
MW Delivery Suite	519	12.91	17.2	2.3	2.6	19.8		19.8
MW Level 5	1023	4.56	3,35	2.1	1	4.8		4.8
MW Level 6	486	3.1	4.5	1.39	2	6.3		6.3

Jun-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	57	18.86	17.7	8.63	18.8	27.49		36.4
MW Delivery Suite	482	12.89	18.2	2.28	2.5	15.18		20.7
MW Level 5	990	4.56	3.28	2.11	2	6.66		4.8
MW Level 6	510	3.09	3.92	1.39	2	4.48		5.7

Jul-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	28	7.7	36.1	7.72	26.2	15.42		62.3
MW Delivery Suite	437	12.9	20.7	2.29	3	15.19		23.6
MW Level 5	1007	4.56	3.55	2.1	2	6.66		5.1
MW Level 6	409	3.1	5.41	1.4	2	4.5		7.7

Aug-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	109	18.85	11	8.64	10	27.49		20.9
MW Delivery Suite	493	12.89	16.7	2.29	2.6	15.18		19.3
MW Level 5	957	4.56	3.17	2.11	1	6.67		4.6
MW Level 6	506	3.09	3.9	1.39	2	4.48		5.7

Sept-24	Planned vs Actual							
Ward Name	Cumulative count over the month of patients at 23:59 each day	Budgeted Registered nurses and midwives	Actual Registered nurses and midwives	Budgeted Care Staff	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall
MW The Spires	73	18.87	16.8	8.63	15.7	27.5		32.5
MW Delivery Suite	527	12.91	17	2.27	2.6	15.18		19.6
MW Level 5	1023	4.56	3.17	2.1	1	6.66		4.6
MW Level 6	534	3.09	3.64	1.36	2	4.48		