Belfast Health and Social Care Trust

caring supporting improving together

TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Belfast HSC Trust Board Meeting (Public Session)**	**Ref No. P62-2024**
DIRECTOR	**Paula Cahalan** **Director Child Health & NISTAR / Maternity, Dental, Gynae and Sexual & Reproductive Health**	**Date 07 November 2024**
• ***Renfrew Report – Enabling Safe Quality Midwifery Services and Care in Northern Ireland, October 2024***		
Purpose	**To provide an update to Trust Board on the recently published report**	
Corporate Objective	• *Safety, Quality, Experience* • *Service Delivery* • *Resources*	
Key areas for consideration	This report was an examination of midwifery and the wider maternity care and services across Northern Ireland. It arose firstly from a Coroner's inquest into a baby's death, with concerns about safety in a Freestanding Midwifery Led Unit. The report contains 32 detailed recommendations that are aligned to seven interrelated key conditions. Those conditions are themed under five areas: • safe quality care in midwifery units and at home for home births • regional strategic developments • safe quality care and services in all settings • monitoring and review of information and data • building for the future • In summary, the report advocates and recommends the following: • A reconfigured relationship with women, families and communities	

	• Improving clinical, psychological, and cultural safety and equity for women, babies and families across the whole continuum of care and in all settings • Changing the prevailing work culture to implement an enabling environment for all staff and managers • Strengthening midwifery care and services across the whole continuum of maternal and newborn care • Investment in community as well as hospital services and increasing midwives' influence over the safety and quality of care and services • Better oversight through improved accountability, monitoring, evaluation, and research • A unified approach to education and training of all staff, including leadership development - especially for midwives - and capacity building for the future The report identifies three issues as critical priorities. • Improving postnatal care both in hospital and at home - ensuring that women receive adequate pain relief and essential care for themselves and their babies. • Improving interdisciplinary working for women requesting care 'outside of guidance', and improved safety for the midwives who care for them • Psychological safety for all staff The Department has outlined their position as follows: Regarding the need for alternatives to hospital based care, Professor Renfrew states that at least one community midwifery hub should be available in all HSC Trusts and that the sites of the free-standing midwifery-led units (*to note these are Mater, Lagan Valley and Causeway*) should be developed and reconfigured as community midwifery hubs in a phased programme to ensure safe, quality care for all. Before any community midwifery hubs offer facilities for labour and birth, all essential requirements outlined in the report must be met. The immediate focus must be on the stability of maternity and neonatal services. The future configuration will need to consider the key requirements outlined by Professor Renfrew, the wider health and social care population needs, demographic trends and system capacity. The Department will establish an interdisciplinary maternity and neonatal partnership with a programme board governance structure to lead the development, implementation and oversight of evidence-based, safe and quality maternity and newborn care and services in order to maximise the contribution of those services to maternal and

	newborn health. That will also include the implementation of a consolidated regional action plan. The Trust received correspondence from the DoH on 14 October 2024, ahead of the publication of the report, indicating the following immediate actions that HSC Trusts should now take forward and which will require a response to SPPG by 12 November 2024 as follows: • Each HSC Trust needs to review the current staffing establishment allocated to their maternity ward to ensure that, over the 24/7 period, women and babies receive essential care and that appropriate analgesia can be accessed by women in a timely manner. • Each HSC Trust should ensure that this letter is shared with the maternity team and that a local mechanism is in place at Maternity Ward level to gather feedback from women on a regular basis, providing assurances that essential care is being delivered and timely access to analgesia is occurring. • Each HSC Trust should review their current framework of accountability from Head of Midwifery to Senior Executive Team and Trust Board to ensure that these are clearly defined and understood, with a clear process for the escalation of any safety concerns. • Each HSC Trust should review their escalation plans for all maternity settings and ensure accessibility and understanding by their maternity teams to encourage timely and appropriate escalation of any safety concern, ensuring there is psychological safety for all staff to enable them to speak out and escalate concerns without fear. • Each HSC Trust should ensure that there are improvements to interdisciplinary working for women requesting care 'outside of guidance', and that there is improved support and safety for the midwives who care for them.
Recommendations	• *For noting and questions*