



<b>Title of Paper: <u>Maternity Services Update</u></b>		
<b>For Decision</b> <del>Requires majority decision prior to implementation or action.</del>	<b>For Discussion</b> Requires consideration and debate.	<b>For Noting</b> <del>Contains information Members should be made aware.</del>

## 1.0 Background

The Trust established a Maternity Services Oversight Group in January 2023 to oversee the recommendations and actions that had arisen from a number of external reviews and reports into Maternity services including a coroner’s report, Level 3 SAIs, an RQIA review and then subsequently the DoH-commissioned Enabling Safe Quality Midwifery Services & Care in Northern Ireland Review (the “Renfrew Report”) in October 2024.

The purpose of this paper is to provide Trust Board with an update on progress to date within Maternity Services.

A composite action plan was developed to collate all the recommendations and actions into one document, with recommendations themed into the following groups:

- Leadership and management
- Policies, Procedures and Guidelines
- Workforce
- Governance

## 2.0 Key Issues

The Maternity Services Composite Action Plan contained 94 recommendations incorporating proposed actions set out in various internal and external reports.

The Action Plan was submitted to SPPG and PHA in July 2025 highlighting 47 closed actions. The team have now moved all remaining actions to business as usual.

During June, July and August 2025, the Head of Midwifery undertook a benchmarking exercise in relation to maternity governance processes – benchmarking against the 4 other maternity units in Northern Ireland and with input from Birmingham Women’s Hospital.

The benchmarking exercise resulted in some key recommendations to take forward over the next 6 months:

- Bespoke Governance Training for Band 7 & 8 staff
- Human Factors training to be initiated
- Governance to be included in Induction for Staff
- Processes for SAIs and investigations need to be shared with frontline staff

- Higher degree of staff support during Coroners Cases
- Review processes that include Neonatal team

#### Update following the Renfrew Report: October 2024

At the Trust Board Development Day held in December 2024, the Directorate provided a detailed overview of the findings set out in Professor Renfrew's Report. By way of update, there has been no further regional direction since March 2025.

One of the recommendations from the Renfrew Report was to appoint a Non-Executive Director to act as a designate for Maternity Services. We are pleased to note Mrs Anne Quirk has been appointed by the Chairman to this role and look forward to working with her in the time ahead.

### **3.0 Resources Implications (inc Organisational, Financial, Human Resources)**

N/A

### **4.0 Impact on Safety, Quality and Experience (SQE)**

N/A

### **5.0 Key Risks and Proposals to Mitigate**

N/A

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**Date: 19 September 2025**