East Suffolk and North Essex
NHS Foundation Trust

Maternity Report for Quality and Patient Safety Committee and Board of Directors

April 2024

CNST Update

East Suffolk and North Essex NHS Foundation Trust

On 26th March 2024, the Trust was notified by NHS Resolution that, following external verification processes, ESNEFT had been successful in meeting all ten of the safety actions required for compliance with the Maternity Incentive Scheme year 5. this information was embargoed until 10th April, to allow for any appeals to be made and at this point all results were published nationally.

Member Name	NPMRT	MSDS	Transitional Care	Medical Workforce Planning	Midwifery Workforce Planning	SBL Care Bundle	Patient Feedback	In House Training	Safety Champions	ENS	No. of Actions	Less Than or more than 10
West Suffolk NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	10 out of 10
East Suffolk North Essex NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	10 out of 10

Compliance was much improved nationally this year, in fact only 28 of the 120 member Trusts did not achieve all 10 safety actions this year details of which are below, with the biggest challenges seen in the implementation of the Saving Babies Lives Care Bundle and compliance with mandatory training requirements.

Member Name	NPMRT	MSDS	Transitional Care	Medical Workforce Planning	Midwifery Workforce Planning	SBL Care Bundle	Patient Feedback	In House Training	Safety Champions	ENS	No. of Actions	Less Than or more than 10
Northampton General Hospital NHS Trust	Y	Y	Y	Y	Y	N	Y	N	Y	Y	8	Less than 10
Royal Devon And Exeter Healthcare NHS Foundation Trust	N	Y	Y	Y	Y	Y	Y	Y	N	Y	8	Less than 10
Homerton Healthcare NHS Foundation Trust	Y	Y	N	Y	Y	N	N	N	N	Y	5	Less than 10
North Middlesex University Hospital NHS Trust	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	9	Less than 10
Kettering General Hospital NHS Foundation Trust	Y	Y	N	Y	Y	N	Y	Y	Y	Y	8	Less than 10
Plymouth Hospitals NHS Trust	Y	Y	Y	Y	Y	N	Y	N	Y	Y	8	Less than 10
York Teaching Hospital NHS Foundation Trust	Y	Y	N	N	N	N	N	N	N	Y	3	Less than 10
Dorset County Hospital NHS Foundation Trust	Y	Y	Y	Y	N	N	N	N	N	Y	5	Less than 10
Great Western Hospitals NHS Foundation Trust	Y	Y	Y	N	Y	N	Y	Y	Y	Y	8	Less than 10
Chesterfield Royal Hospital NHS Foundation Trust	Y	Y	N	N	N	Y	Y	Y	Y	Y	7	Less than 10
Hillingdon Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	9	Less than 10
Somerset NHS Foundation Trust	Y	Y	N	Y	Y	Y	N	Y	N	Y	7	Less than 10
University Hospitals Birmingham NHS Foundation Trust	Y	Y	N	N	Y	Y	N	N	N	Y	6	Less than 10
King's College Hospital NHS Foundation Trust	N	Y	Y	Y	N	N	Y	N	Y	Y	6	Less than 10
Salisbury NHS Foundation Trust	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9	Less than 10
University Hospitals of Derby and Burton NHS Foundation Trust	N	Y	N	N	N	N	N	N	N	Y	2	Less than 10
County Durham and Darlington NHS Foundation Trust	N	Y	N	Y	N	Y	Y	Y	N	Y	6	Less than 10
Surrey and Sussex Healthcare NHS Trust	Y	Y	Y	Y	N	N	Y	Y	N	Y	7	Less than 10
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	N	Y	N	Y	Y	8	Less than 10
Hull and East Yorkshire Hospitals NHS Trust	Y	Y	Y	N	Y	N	Y	N	N	N	5	Less than 10
Worcestershire Acute Hospitals NHS Trust	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	9	Less than 10
Maidstone and Tunbridge Wells NHS Trust	Y	Y	Y	Y	N	Y	Y	N	N	Y	7	Less than 10
Cumbria Partnership NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	9	Less than 10
Sheffield Teaching Hospitals NHS Foundation Trust	Y	Y	Y	Y	N	Y	Y	N	Y	Y	8	Less than 10
Blackpool Teaching Hospitals NHS Foundation Trust	Y	Y	N	N	N	Y	Y	N	N	Y	5	Less than 10
Nottingham University Hospitals NHS Trust	Y	Y	N	N	Y	N	Y	N	N	Y	5	Less than 10
Barts Health NHS Trust	N	Y	Y	Y	N	N	Y	N	N	Y	5	Less than 10
University Hospitals Dorset NHS Foundation Trust	Y	Y	Y	N	Y	N	Y	N	Y	Y	7	Less than 10

CNST Update

East Suffolk and North Essex NHS Foundation Trust

Learning from year 5 MIS

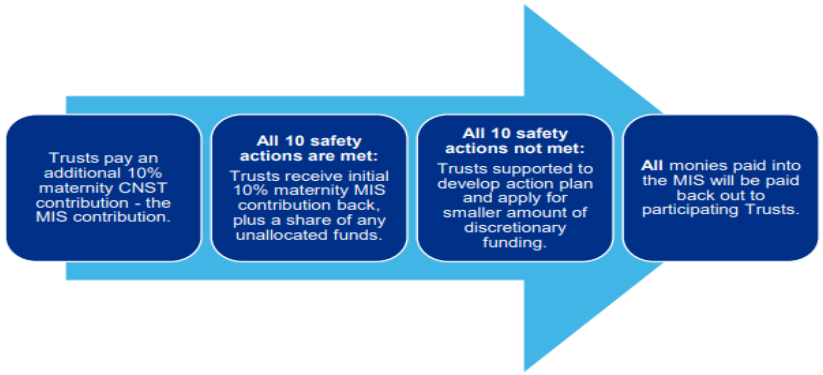
- Oversight of training
  - Annual training planner has been developed for the year with all staff allocated – some challenges with anaesthetics team due to change in ask for year 6 MIS
  - Oversight now at Divisional Board monthly
- Planning for annual reports required to go to Board
  - Huge thanks to Trust Secretary and team for supporting with this process last year. A Work plan has been developed, based on MIS 5 – some slight adjustments now required since publication of year 6 prior to submission to Board.
- Leadership and oversight of all safety actions
  - Following feedback form Trusts NHSR have realised a useful audit tool for use by Trusts if deemed valuable
  - Maternity operation post in place since Oct 2023 will continue substantively to support coordination and oversight alongside the DMT
- Workforce Planning
  - Completion of Safety Actions 4 and 5 have supported the Division around development and planning of the neonatal, obstetric and midwifery workforce. There is still work to do as this is taking time to complete

MIS year 6

On 2nd April 2024, NHSR released MIS year 6.

Maternity safety remains a critical area of focus within the NHS. The MIS was established on the instruction of the Department of Health and Social Care to incentivise Trusts to actively adopt best practices and implement essential safety measures. This not only reduces the risk of adverse outcomes, including brain injuries, but also fosters a culture of continuous improvement in maternity services.

The Division currently have a lead for CNST compliance within the Operational team, and have Leads established for each of the 10 Actions. The individual Action Leads will continue to meet with the CNST Lead on a monthly basis and within these meetings they will monitor the milestones and action needed for full compliance. Monthly progress reports are produced for Regional and Divisional meetings, so the LMNS and DMT can track progress against the plan.



CNST Update – MIS year 6

East Suffolk and North Essex NHS Foundation Trust

Notable changes to year 6 scheme

- New **rolling 12-month** PRMT reporting period
- Removed 30-day **surveillance reporting** requirement
- Removed 4-month **draft report** completion period

- Agreement of local improvement trajectory with LMNS
- Quarterly reviews to **confirm progress** with optional use of the SBL implementation tool. If not fully implemented, compliance can still be achieved

- Removed **MCoC reporting** requirements
- Two MSDS registered user minimum removed.

- LMNS member of **key Trust safety and governance meetings** on ToR (working towards quorate)
- Work with LMNS to ensure user-led MNVP funded
- **Escalate** if appropriate funding/resource not in place

- **QI initiative** to decrease admissions and/or LOS
- Removed audit requirement for all 37+ week admitted
- Focus on transitional care pathways for babies between **34+0 and 36+6**

- **Core Competency** framework not measured in MIS
- All anaesthetic doctors contributing to the obstetric anaesthetic on-call rota **in any capacity** must attend maternity emergencies training (min 70% ½ day).

- Removed option to demonstrate compliance with **engagement of locums** with an action plan.
- Removed requirement to demonstrate compliance with RCOG guidance on **compensatory rest**.

- Discussions regarding safety intelligence must take place at the Trust Board (or at an **appropriate sub-committee with delegated responsibility**) including actions relating to local improvement plan using **PSIRF**

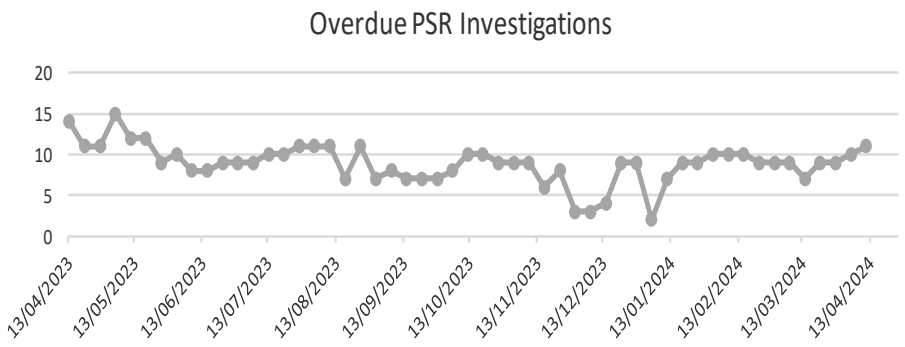
- Allocated midwifery coordinator in charge must be supernumerary at **start of every shift**.
- **Escalation plan** must initiated and must include the process for providing a substitute coordinator.

- Updated to reflect changes to **MNSI reporting criteria**

PSIRF update

East Suffolk and North Essex NHS Foundation Trust

We currently have 2 Open PSII's, and there were no PSII's completed in March. Outside of the reporting period (at the beginning of April) a new Never Event/PSII was declared. The graph below shows we have 11 Open PSR's, and none were signed off as completed in March. In the last reporting period our Governance Manager has completed a program of PSR training for our Maternity Matrons which is aimed at upskilling them and improving compliance with completing PSR investigations on time.



Incidents in March	Numbers
PPH ≥1500mls (or affecting health)	21
Term Admissions	21
Maternity Red Flag incidents	18
Inappropriate skill mix / staff shortages	15
Unsafe environment	9

Across the last 2 months we have seen a number of patients that have required admission to intensive care at Colchester hospital. A round table MDT review meeting was held on 22nd March 2024 to look at 3 cases, and further cases have occurred since this meeting. In this review we were unable to find a theme that linked all three cases and each was unique in its presentation and outcome, but staffing levels were mentioned as a factor during each review. There was a connection to the patient's social backgrounds with wider inequality impacts. Additionally it was noted that during each admission the working across specialist teams was very good with positive feedback from colleagues in the Medicine Division.

Significant near miss – declared as a never event

Incident	Learning	Actions
Missing red string from swab pack at Colchester	Audit conducted – 50% compliance;	• Exploring re-introducing sticky-pad or packs with no red string. • Never event and PSII investigation raised. • Highlight awareness to staff at safety huddles to ensure LocSSIP is used.

PSIRF update

East Suffolk and North Essex NHS Foundation Trust

Early learning and Immediate Actions from PSIRF

Harm grading	Early Learning	Immediate actions	Ethnicity & IMD rank	Investigation level
Moderate	Oxygen Sats were low – plan to repeat in 30 minutes which was not conducted. When eventually repeated; saturations were <90 and peri-arrest call was made	• MDT round table review held 23.03.2024. • Presented at MIRG. • All 3 cases to be presented at PM&M in April 2024.	White British IMD 1	Datix / PM&M +/- Joint Maternity & Anaesthetic Audit
Moderate	Delayed escalation to senior obstetric staff when saturations dropped.	• As above		As above
Moderate	Referral to MNSI however stabilising of the mother took priority.	• Referral to MNSI – awaiting consent from patient		Tbc: MNSI or External reciprocal. Datix
Moderate	Correct escalation pathways following maternal collapse, plus post-natal HDU care monitoring. Patient debriefed by consultant before discharge.	• N/A	White British IMD 7	
Moderate	Patient attended the triage at postnatal day 17 following a kiwi delivery in the room, with complaint of red string coming out of the vagina. Patient was examined and red string seen in the introitus and removed. Patient was clinically well with no signs of infection.	• Discussed at Oversight panel 04.04.2024 and Never Event and PSII raised.	White British IMD 4	Never Event / PSII

The MIRG meeting continues to be scheduled each week for early learning reviews to be presented and discussed by the group, ahead of decisions being made on incident severity and route for further investigation. The group reports into the Patient Safety Oversight Committee, and a sample from the learning gathered through our discussions at MIRG are shown below:-

- ✓ Documents on the intranet conflicting and need to be reviewed to ensure appropriate referral only.
- ✓ Learning to be shared to ensure women are not refused a visit. Additional training to be provided for staff to provide this support.
- ✓ Request to review the PN care and see if we missed the signs of sepsis evolving. Not within guidance to perform routine observations in community therefore no MEOWS performed
- ✓ Although immediate delivery was not indicated when the CTG was abnormal on Lexden prior to established labour, closer monitoring on DS was indicated which could not be accommodated due to acuity. The FH was pathological once labour was established and there was further delay in transfer to DS due to unit acuity.
- ✓ Confusion not recognised/acted on in triage, no investigations into hypoglycaemic attacks.
- ✓ ECHO was ordered in pregnancy but was still outstanding at point of admission to ICU. Anyone with comorbidity should have an echo to rule out any cardiac issues.
- ✓ Woman should have been given non rebreathe mask.
- ✓ There was no formal respiratory referral.

MNSI (Maternity and Newborn Safety Investigations)

East Suffolk and North Essex NHS Foundation Trust

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England. The programme was established in 2018 in the South East, as part of the Healthcare Safety Investigation Branch and is now hosted by the Care Quality Commission.

The data included below is from the beginning of April 2019 onwards, when the HSIB maternity programme was live across the whole of England.

Summary:-

Cases to date	
Total referrals	44
Referrals / cases rejected	19
Total investigations to date	23
Total investigations completed	22
Current active cases	1
Current cases awaiting maternal consent	2
Exception reporting	No cases currently have exceptions

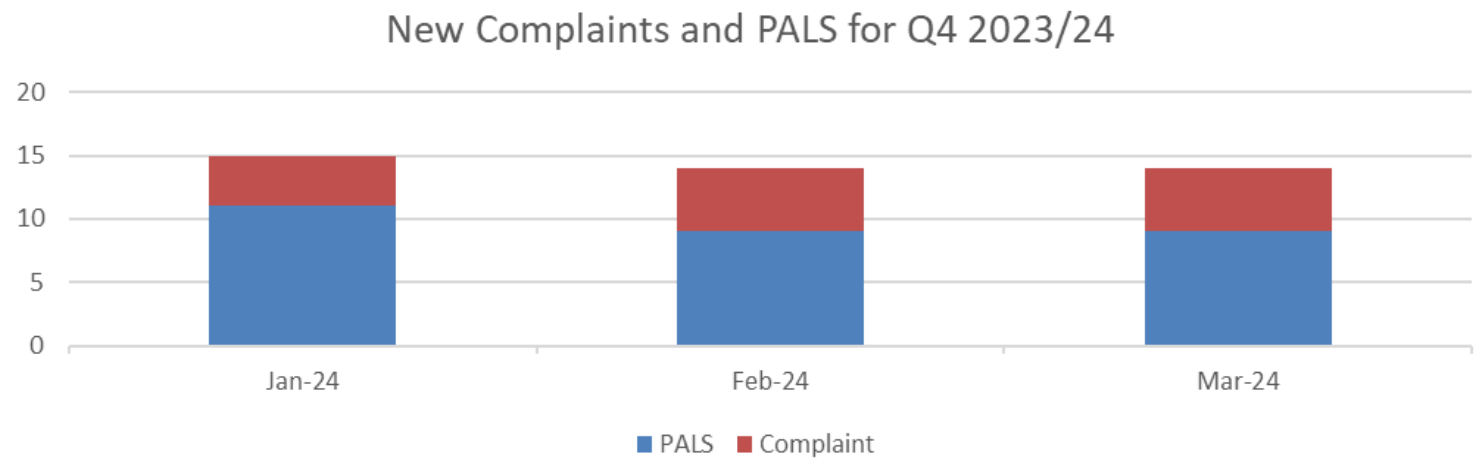
For 2023, ESNEFT had 2 safety recommendations made following 4 referrals, these were around

- Escalation
- Fetal Monitoring

Complaints and compliments update incl. scorecard

East Suffolk and North Essex NHS Foundation Trust

A recent Divisional Deep Dive into Complaints and PALS has been completed, and this looked at everything across the whole Division. The investigation found no themes from the 43 Complaints and PALS from the fourth Quarter for Maternity Services. There were only 6 themes that occurred more than once in the enquiries received, those were 'Care needs not adequately met', 'Complications during/ following treatment'. 'Difficulty contacting departments', 'Failure to give pain relief', 'Patient not listened to', which were all only recorded on two occasion, and 'communication with patient' which was raised 17 times, but for many different reason and without any clear theme.



Feedback / Concerns raised by staff	More details and Action taken so far	Timeframe for completion of actions
ITU Admissions – CGH	5 cases in a month and an additional arrest. Round table meetings held with staff and incident investigations underway.	July 2024
Obstetric Debriefs – both sites.	Concerns over backlog of debriefs needing to be completed at Colchester. Already on Risk Register – formal SOP in development	July 2024
Police investigation / MSI (or tele-medication)	2 cases from MSI have come via our services due to advanced gestations. Legal team have requested escalation and advice from LMNS/Region.	July 2024

Complaints and compliments update incl. scorecard

East Suffolk and North Essex NHS Foundation Trust

Feedback from service users	Associated improvement actions	Timeframe for completion of actions
Patient felt skin tone hindered the ease of a blood test. Patient felt her concerns were not listened to. Patient overheard staff making unprofessional and inappropriate comments about her.	• Manikins of varying skin tones are being sourced to aid better training. • Reminder to staff highlighting this type of behaviour will not be tolerated in next governance report.	June 2024

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Claims scorecard

East Suffolk and North Essex NHS Foundation Trust

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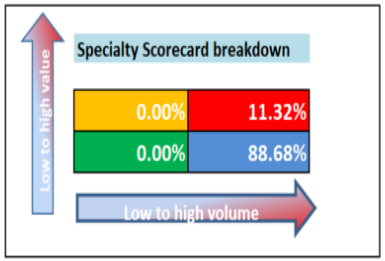
Selection Criteria: CNST claims received with an Incident Date between 01/04/2013 and 31/03/2023

Specialty drop down list:	Obstetrics



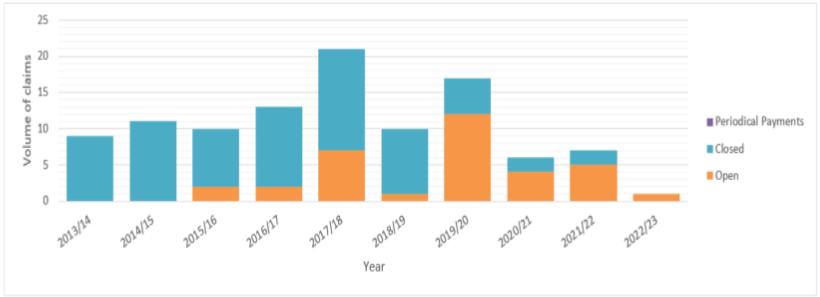
Notification Window (Years)		
Specialty	2.00	The average notification window for Obstetrics claims is 0.30 year(s) shorter than
Trust	2.30	the average notification window for all claims received by the trust.

Specialty - Volume of Claims	Specialty - Value of claims (£)	Specialty - Ave. Claim Value (£)
106	122,120,667	1,152,082

% of Trust Clinical Claims - Volume	% of Trust Clinical Claims - Value	% Trust - Ave. Clinical Claim Value
13%	49%	366%

Volume of claims by Incident Year

Year	Open	Closed	Periodical Payments
2013/14	2	12	1
2014/15	1	12	0
2015/16	3	8	0
2016/17	1	12	0
2017/18	4	9	0
2018/19	5	10	0
2019/20	7	7	0
2020/21	3	1	0
2021/22	4	0	0
2022/23	0	0	0
Total	30	71	1



Current Status

	Volume
Open	30
Closed	71
Periodical Payments	1
Total	102

Claim Outcomes

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	24	89,127	3,714	34%
Settled - Damages Paid	46	7,855,788	170,778	65%
Periodical Payments	1	11,460,000	11,460,000	1%
Total	71	19,404,915	273,309	

Claims scorecard

East Suffolk and North Essex
NHS Foundation Trust

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Psychiatric/Psychological Dmge	18	15,285,972	849,221	17%	13%
2	Fatality	14	2,333,507	166,679	13%	2%
3	Stillborn	11	1,550,697	140,972	10%	1%
4	Unnecessary Pain	9	227,963	25,329	8%	0%
5	Brain Damage	9	54,608,556	6,067,617	8%	45%
Total Top 5 injuries by Volume for Obstetrics		61	74,006,695	1,213,225	58%	61%

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Brain Damage	9	54,608,556	6,067,617	8%	45%
2	Cerebral Palsy	2	28,245,002	14,122,501	2%	23%
3	Psychiatric/Psychological Dmge	18	15,285,972	849,221	17%	13%
4	Wrongful Birth	1	10,475,000	10,475,000	1%	9%
5	Incontinence	3	3,197,795	1,065,932	3%	3%
Total Top 5 injuries by Volume for Obstetrics		33	111,812,325	3,388,252	31%	92%

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	26	2,526,005	97,154	25%	2%
2	Fail Antenatal Screening	10	25,548,593	2,554,859	9%	21%
3	Fail To Monitor 2nd Stg Labour	8	16,547,415	2,068,427	8%	14%
4	Failure/Delay Diagnosis	7	14,497,782	2,071,112	7%	12%
5	Perineal Tear-1st,2nd,3rd Deg	6	700,258	116,710	6%	1%
Total Top 5 causes by Volume for Obstetrics		57	59,820,053	1,049,475	54%	49%

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail Antenatal Screening	10	25,548,593	2,554,859	9%	21%
2	Fail To Monitor 2nd Stg Labour	8	16,547,415	2,068,427	8%	14%
3	Birth Defects	2	14,769,421	7,384,711	2%	12%
4	Fail/Delay Admitting To Hosp.	4	14,508,001	3,627,000	4%	12%
5	Failure/Delay Diagnosis	7	14,497,782	2,071,112	7%	12%
Total Top 5 causes by Volume for Obstetrics		31	85,871,212	2,770,039	29%	70%

Maternity Staffing

East Suffolk and North Essex NHS Foundation Trust

Staffing continues to flag as a challenge for both maternity units as detailed by the red flag incidents in slide 5. Red flag reports now coming to Maternity and Neonatal Safety meeting. Staffing challenges appear to be driven by sickness absence which is significantly higher than the Trust target. A deep dive into sickness within this team is currently underway with target completion date of the 31st July.

Below identifies the staffing information that we share as part of our regional reporting requirements – and this was our April 2024 submission which is based on February 2024 data.

	MW to birth ratio			Vacancy rate		Obstetric staffing compliant
	BR+ compliant - Full safe service offer	BR+ compliant - Delivery of CoC	Summary of gaps	Midwife no's	%age of total staff	
Colchester	Y	N	Staff shortages in community and unable to fulfil the requirements at Colchester for a CoC team	5.23	3.84%	Yes
Ipswich	Y	N	Requirement for CoC is significantly higher than establishment	3.07	2.39%	Yes

	Funded establishment (all MWs WTE)	All contracted midwifery staff in post (WTE)	Head count (all Midwives)	Current midwifery maternity leave (WTE)	Sickness midwives (%)	No of training hours allocated per head * * all mandatory trust and CCF hours
Colchester	136	130	160	7.43	5.40%	30 will move to 61
Ipswich	128.5	125.43	156	6	8.07%	30 will move to 61

	Total births (mth / ytd)	Total bookings (mth/ YTD)	BR + acuity: LW co-ordinator supernumerary status (%)	BR+ acuity: One to one care in labour (%)	PMA ratio (to meet 1: 20 headcount)	PWR joint sign off meeting in month
Colchester	280/3394	347/4179	100%	100%	01:28	Review with PWR team monthly
Ipswich	233/3031	51/3186	100%	100%		

60 Steps Update

East Suffolk and North Essex NHS Foundation Trust

The Sixty Supportive Steps to Safety' (SSSS) tool is intended to provide support to maternity services so a Trust can feel confident they are improving safety outcomes and the experiences for women and birthing people. It runs alongside the safety concerns identified in several high profile national midwifery reviews, and supports Trusts conveying their three-year delivery plan for Maternity and Neonatal services.

The tool aims to provide areas with

- ✓ An appraisal of our compliance with national reports and safety regulations.
- ✓ Identify areas of good practice to enable sharing and learning across the region and nationally.
- ✓ Any areas which require further support to improve safety.
- ✓ An insight to the Regional team to inform quality improvement projects.
- ✓

To complete the tool we welcomed a team that comprised representatives from the Regional midwifery teams, the LMNS, our MNVP and our MIA at Colchester in December 2023, and in March 2024 we had a similar visit in Ipswich.

A summary report following the Colchester visit reviewed the outcomes against the findings from the last visit in 2021/22 with clear improvements made and 1 or more positive found in 59 of the 60 steps. There were areas for improvement in 25 of the 60 steps, and 5 of those steps had multiple areas for improvement.

We agreed to wait for the outcomes of the Ipswich visit before progressing with a combined action plan for our merged services. The findings from Ipswich were shared on 4th April 2024, and we are currently compiling the necessary joint plan, and analysis of the findings against those from 2021/22, to identify similar improvements, but there were no immediate areas of concern identified.

Additional Updates

East Suffolk and North Essex NHS Foundation Trust

Standalone birthing units

Panorama aired a programme on television at the end of January 2024, reporting to have investigated the crisis in maternity care putting women and babies at risk. Whistle-blowers at a trust in Gloucestershire described specifically 3 incidents where a mother and two babies had died. They suggested that this was caused by understaffing and a culture that failed to learn from mistakes, however they did not give any clear evidence of this link. The programme suggested that maternal deaths at the Trust were almost double the national average.

The programme focused on a failure of midwives to escalate concerns. In the case of the two babies that had died, this occurred at a standalone birth centre within the Trust. The whistle-blowers suggested there was a culture to try to keep birth low risk and that there was a reluctance by some to escalate to medical teams.

There is clear guidance (which has been shared with the CQC at our July inspection) that directs teams on when is appropriate to seek assistance if birthing in the stand alone centre at Clacton or indeed at a homebirth. It is also key to note that the Birth Place study (2011) demonstrated significantly improved outcomes for multiparous women (have birthed previously) birthing in midwifery led settings such as birth centres or at home, when they have ben appropriately risk assessed and it showed no statistical difference for nulliparous women. The study hasn't been repeated since so this is the most current place of birth data that we have. This information wasn't discussed as part of the programme.

We had only 17 births at Clacton maternity unit last year and our homebirth and co-located birth centre rates are also declining. With the implementation of the Saving Babies Lives Care Bundle, we are seeing a significant increase in medical interventions such as Induction of labour, in an effort to reduce our still birth rates. This is national challenge as strains current resources, such as our infrastructure. Infrastructures that were designed at a time when we had many more community/midwifery led births. Currently births in our low risk areas, such as our stand alone and alongside birthing units and at home, are only totalling around 10% of all our births.

A recent estates survey has been collated and submitted to the national team as per the request, which is looking to review what resources there are nationally.

Additional Updates

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Projects underway to tackle EDI challenges in maternity

Funding was awarded by ESNEFT to both Angelia Ruskin University and University of Suffolk to undertake research projects to explore equality an diversity and the impact on maternal health to inform service developments in maternity services.

ARU

A Consultant Midwife has been appointed by ARU to explore an area of service delivery where there was a need for development in maternity services. This involved varying discussions with different members of staff, and it was agreed that there was a need to explore mental health challenges with Black African Women in the perinatal period. The purpose of this research is to explore Black African women's views on mental health challenges around the time of childbirth and any experiences they might have of mental health support services at that time. It will also explore their views on how they might be helped to access such services if needed them. This project has just received its ethical approvals.

UOS

University of Suffolk has also employed a Consultant Midwife/ Doctoral Researcher, she is undertaking a research project to develop a better understanding of obstetricians' and midwives' views of the introduction of Maternity Continuity of Carer (MCoC) and Personalised Care and Support Plans (PCSP) in maternity services across ESNEFT and to share recommendations for how to safely implement and sustain the roll out of these initiatives.

The initiative lead held two 'Choice and Personalisation' events in 2023 as part of her commitment to co-production. We know from these events that some women have a positive birth experience of maternity and neonatal services at ESNEFT, but also through these events, we must acknowledge that there are times when the care we provide is not as good as we want it to be. We are therefore working with women/birthing people and those representing users of our service, to ensure all groups are heard, including those most at risk of experiencing health inequalities. The initiative lead Co-Chairs the 'Equity, Choice and Personalisation' workstream within the Local Maternity and neonatal System (LMNS); to support her research and to influence service design.

Work has progressed and is now looking at the implementation of the BSS-R (Birth Satisfaction Rate Revised (BSS-R)):
BSS-R is the lead international measure of birth satisfaction and is used to assess women's perception of care provided and experiences of care provided during labour and birth.
The initiative lead is currently working towards trialling this validated tool in maternity services across ESNEFT to evaluate the experiences of women, placing women at the centre of birth experience. It will mean that staff from "boards to wards" have access to up-to-date patient feedback and thus will be informed and empowered to take immediate action to tackle areas of weak performance and build on success.
Further details and approval form Board will be sought once clearer plans in place. The aim is that the BSS-R will replace the Friends and Family Test (FFT) during the trial. The BSS-R is recommended as the method of choice for assessing women's experience by the International Consortium for health Outcomes Measurement (ICHOM). It is anticipated that this will be a more comprehensive method for measuring patient satisfaction.