Methodology for Maternity Safety Work:

This was a multi-staged approach, which included a collation of all College activity that contributed to enhancing safer maternity care including an analysis of themes from maternity safety reports issued from 2020-2023. The College held a number of stakeholder engagement sessions designed to inform, challenge and shape our thinking. This work contributed to the development of a maternity safety digital resource hub which signposts to all the College resources in maternity safety. This work has been overseen and supported by a Maternity Safety Working group. Membership of the working group consisted of; clinical obstetric leaders, patient and safety advocates and a safety science academic.

Using an evidenced-based framework, the Yorkshire Contributory Factors Framework (Lawton, et al., 2012) the College collated all activity related to supporting improvements in maternity safety.

This framework was developed following a systematic review of factors that contributed to errors or threats to patient safety in hospitals in the UK, USA and Australia. The framework recognises the importance of contextual factors that can create inherent weaknesses and these were separated into five domains within the framework. For example, poor team working (team factors under the domain of situational factors) or low staffing levels (management of staff and staffing levels, under the domain of local working conditions) can contribute to patient safety issues. Taking a systems approach to safety management is a way to consider all relevant factors as opposed to looking solely at an individual's performance and skill.

Using an adapted accompanying checklist to this framework all College activity and College products (e.g. guidance document, toolkit, study day, research project, training modules) were assessed against the checklist to determine whether any College activity supported our membership and maternity staff to work safer.

Each domain is broken down further into subcategories of parts. Each part, was used as a subject heading to see what activity fell under this. For example under the domain of local working conditions, are the parts of **supervision and leadership.** Looking at all the activity that fall under leadership and supervision, the College has guidance on the *Roles and Responsibilities of the Consultant.*

The framework allowed the College to methodically capture all maternity safety activity within the role and remit of the organisation.

The results from this activity were collated and shared with the Maternity Safety working group, for assurance that this was a consistent way to assess all College activity that contributed to safer maternity care.

Review of Recent Maternity Safety Reports

In parallel, a review of the actions and recommendations from maternity safety reports and inquiries published in the last 3 years was undertaken. It was important to focus on the most recent reports as they gave a sense of the current concerns while also including existing historical issues facing maternity services and the wider healthcare system.

The key findings extracted from the reports gave an initial set of themes, proposed below:

Providing personalised and compassionate care to families. This theme encompasses providing information and choices for birth options and pain relief, including outlining risks so that families can make informed decisions for themselves. This also includes treating families with kindness and respect, and supporting women and people to speak up and raise any concerns early. Listening to the needs of women and their families has to be re-established as part of routine clinical care.

Education provision includes the need for sufficient training posts to deliver safe staffing levels, devising maternity training targets, having agreed standards of professional behaviours with appropriate sanctions, training on compassionate care and a plea to re-evaluate patterns of work to allow junior doctors to have sufficient supervision at all times.

Using data in a meaningful way. This theme is multifaceted, but includes routinely collecting more comprehensive data on characteristics and demographics e.g. ethnic background, being able to make meaningful measurements that are risk adjusted and provided in a timely manner, and also developing a suite of mandated maternity outcome measures. The facility to enable calculation of complexity adjusted minimum staffing levels would also provide huge benefit for workforce planning.

A **positive reporting culture ensures** that learning can take place from errors and incidents – this should be actively promoted. Areas identified within this theme include: having regular debriefs and/or safety huddles so staff can be made aware of any immediate ongoing or upcoming issues. Standardised investigative training that views safety management from a systems approach and focusses on learning from good care as well as harmful practice. Providing psychological and therapeutic support to staff who have been involved in serious incidents. Families who have experienced harm must receive compassionate care at all times and the creation of a legal Bill to place duty on bodies not to deny or conceal information from families.

Good clinical leadership, to role model excellent professional behaviours, providing visibility on the ground and demonstration of good listening skills. Leadership that fosters an environment of psychological safety to empower all staff to speak up and raise concerns, fostering a culture of speaking to each other in a professional manner. Embedding good escalation practice with a clearly outlined process, provides constructive challenge for poor practice and decision making. Good leadership prioritises leadership development and support of colleagues, provides compassionate and inclusive leadership and encourages flexible working so that staff can be retained. Any staff that demonstrate racism, bullying or unprofessional behaviour must be addressed immediately.

A collegiate approach of good **multi-disciplinary team working** is essential. Training together as multi or inter professional teams in all aspects of practice, especially to understand the contribution

of different care pathways and how they are best offered. More opportunities for everyday joint skills and drills training not only in emergencies.

Promoting **good organisational health** through openness, honesty and disclosure with sound governance and assurance processes. Promoting cross-site working where possible and ensuring 'staff voice' at Board level, through maternity safety champions or other mechanisms. A culture where racism, bullying, toxicity and unprofessional behaviours are not tolerated.

Addressing health inequalities to reduce disparities in maternal deaths, clinicians to have knowledge of maternal health disparities and conditions that may be specific to Black and ethnic minority women, policies to deliver care to minority groups and an awareness of culturally competent care. To have diversity in medical illustrations and assessments. To address racial stereotyping and micro-aggressions.

Enhancing technical skills and knowledge in particular in risk assessment stratification, the ability to for staff to have a review by a senior clinician, improving the quality of handovers and maintaining core competencies.

The Maternity Safety working group were asked to discuss whether they agreed or disagreed with the themes identified from the reports above and if they resonated with their perspectives of how maternity safety can be improved. This resulted in further themes with increased specificity in order to provide greater clarity as shown below:

Kindness and respect to families and staff	Organisational processes are fit for purpose	Skills to correctly assess, diagnose and treat	Multi-disciplinary teams work well together
Leaders role model compassion and are inclusive	All women are treated in a personalised way	Organisations learn from both harm and good practice	Information is collected and used in a way to improve pracice
Enough staff available at all times (at all levels)	Leaders support colleagues in a positive way	Maternity staff know how to care for disadvantaged women	Good breadth of obstetric knowledge
The O&G curriculum is fit for purpose to produce skilled doctors	The organisation promotes a safe environment to deliver good care	Clinical guidelines are up to date and used for best practice	Maternity staff know how to communicate well with families
Patient feedback is used to improve services	Staff feedback is used to improve services	Care is offered to suit each individual woman and her background	Staff are supported to look after their wellbeing

Stakeholder engagement workshops

Recognising the need for a broad range of views on maternity safety, the College consciously set out to socialise these themes with three specific groups, namely:

- RCOG Council members,
- Women and birthing people with lived experience of using maternity services, and
- Women's health charities.

The College ran three workshops with these groups, one in person and two using online video conferencing platforms. Each stakeholder group was asked to comment on whether the above themes echoed their views and insights of the current maternity safety landscape. Stakeholder groups offered their perspectives, challenged our thinking and made suggestions on what future College activity in maternity safety could look like, bearing in mind the organisation's remit and influence.

In parallel to reflecting on the themes, a key question was ***"what else should the College be doing in the Maternity safety space?"*** These comments have been considered and fed into the Maternity safety statement.

At the end of the stakeholder engagement phase a final revised set of eight headings that encompassed the twenty themes became the framework that helped to develop an innovative maternity safety digital resource hub, to accompany the maternity safety statement.

The final headings are

1. Safe Staffing:

Adequate staffing levels have been recognised as an important determinant of patient safety. Staff with the right skill set and competency are vital.

2. **Multi-disciplinary Team working-**

Effective team working enables clinicians to work together, be flexible and adaptable, communicate professionally and be able to solve any concerns together, thereby taking a collegiate approach to working towards a common goal.

3. Staff wellbeing

High levels of staff wellbeing is essential for cultivating a healthy and motivated workforce that aids the development of a positive workplace culture. This in turn reinforces the need for wellbeing support structures to be in place.

4. Leadership

Good Leadership skills are the vital components that allow for a doctor to role model excellent professional behaviour and support their colleagues to develop as good leaders themselves.

5. Personalised care

Clinicians must champion the healthcare needs of all people from all groups and provide patient centred care that is tailored to the individual's needs and choice. It also promotes non-discriminatory practice.

6. Compassionate care and listening to women

Women and their families must be treated with care and compassion at all times, be involved in informed decisions about their care and be listened to whilst taking into account any specific needs they may have.

7. Technical Skills and knowledge

Clinician's must be competent in assessing, recognising and managing their patients. Developing doctors and specialists with a wide ranging set of knowledge, professional and technical skills forms the basis of their core competency in being a doctor.

8. Addressing inequalities

Clinicians must respect the cultural diversity of women, their individual backgrounds including previous health concerns, especially in circumstances that may have an impact on engagement and care.

References:

1. Lawton, R et al., 2012. Development of an evidence-based framework of factors contributing to patient safety incidents in hospital settings: a systematic review. BMJ Quality and Safety, Volume 21 pp. 368-380

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