Measuring safety culture in maternal and neonatal services: using safety culture insight to support quality improvement
We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.
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Summary

Maternal and neonatal services operate in a complex and demanding environment, and leaders at all levels should ensure the safety of both staff and the women and babies being cared for. It is everyone’s responsibility to contribute to developing and nurturing a culture that avoids harm, promotes learning when things go well and from errors, and enables staff to speak up about concerns and drive improvement in quality.

In conjunction with the Maternal and Neonatal Health Safety Collaborative, a national quality improvement programme working with maternal and neonatal services across England, 87 trusts have carried out safety culture surveys. Collectively this is the largest such survey in England and provides a snapshot of the safety culture of maternal and neonatal services, highlighting areas of strength and where improvement may be needed.

This document reports the insights and aims to:

- explain the rationale for evaluating safety culture within the work of the MNHSC and the approach used
- provide an overview of the insights from the safety culture surveys undertaken
- suggest a variety of approaches to improvement of culture and highlight interventions that create the conditions for a safety culture and sustainable quality improvement
- outline suggested behaviours that individual team members can adopt to support these changes
- link the safety culture insight interventions and behaviours outlined in this report to the planned work of the MNHSC to improve the quality and safety of care within maternal and neonatal services in England.
### Key insights

- How culture is perceived varies widely in maternal and neonatal work settings and roles, reflecting the variable nature of culture.
- Leadership is key to improving culture. Leaders need to understand the culture of their organisation to be effective in facilitating improvement.
- Culture will only improve if everybody supports the changes required.
- When quality improvement is linked to improvements in safety culture, both the quality of care and culture improve.

Across all trusts:

- Antenatal staff have the most consistently positive perception of culture.
- Neonatal unit staff perception is positive of their ability to improve but with a more negative view of leadership.
- Midwifery managers have a more positive view of culture than midwives who aren’t managers.
- Midwives who are band 6 and below have among the lowest perception of safety culture but a more positive perception of teamwork.
- There are high rates of personal burnout within all staff.
70% of midwives band 7 or above say they find it easy to speak up
65% of all respondents believe that there are communication breakdowns within their work setting

What conclusions can be drawn?

There is significant variation in the way that staff perceive culture. This variation is independent of the size and location of maternity units.

Improvements in culture are linked to improvement in the safety, quality and experience of care. Through a process of quality improvement (linked to the understanding of local culture) the quality of care improves as does the culture within the team. It is much harder to improve culture in isolation.

Where a unit’s culture is positive and supportive, our women, families and babies will experience the highest quality and safest care. Everyone must contribute changing culture where this is needed. Modelling and supporting positive behaviours and challenging poor behaviours creates a healthy, supportive and just culture in the workplace.
How does this align with work of the Maternal and Neonatal Health Safety Collaborative?

The Maternal and Neonatal Health Safety Collaborative (MNHSC) supports teams across maternity and neonatal services to undertake safety culture surveys with the aim of enabling them to develop and nurture a safety culture. We have found that focusing on safety culture and quality improvement together, enables sustainable change and improvement, with better outcomes and experience for women and families receiving care.
Introduction

Why is culture important in improvement?

Culture can be either an enabler or barrier to improvement. Elements of culture, such as teamwork and communication, can have a profound impact on clinical outcomes: things that go wrong can often be tracked back to problems inherent in the system, human relationships or behaviours, and attitudes to safety.

Improvement efforts are far more likely to be successful when team members:

- feel they are listened to and respected
- are comfortable asking questions, advocating for those they care for and interacting with their colleagues
- have the capacity and motivation to participate in improvement projects.

Our experience has shown improvement can be more difficult when team culture does not enable or support learning, communication, professional growth, and personal satisfaction. If the culture does not do this, staff can think it is futile to engage in improvement work and not worth their time. In contrast, in organisations and teams with a positive safety culture, staff feel empowered to speak up about concerns, there are formal and informal processes to address defects and staff, managers and leaders communicate and work together effectively.

Why measure safety culture?

Culture is a multi-faceted social construct comprising the behaviours, attitudes, beliefs, and values of a group of people. Culture surveys measure a variety of elements that underpin a safe culture in the healthcare setting, including perceptions of teamwork, communication, leadership, commitment to safety, psychological safety, burnout, problem resolution, and work satisfaction. The results provide insight into the dynamics within a specific group and allow the identification of overarching themes across work settings.

Culture is localised, shaped by the people within the group. In healthcare, culture is best evaluated at the work setting level - that is, on each ward, theatre, or clinic.
Culture may vary significantly from one work setting to another, even in the same hospital, and the drivers of a strong or poor culture may not be the same for every setting. Therefore, the unique challenges that staff face within their individual work setting must be understood for effective and appropriate improvement efforts.

Measuring safety culture allows managers and leaders to identify the cultural challenges and concerns of specific work areas and roles. The subsequent debriefing process – a facilitated conversation about the survey results and the factors driving the reasons for people’s responses - provides an excellent starting point for candid conversations amongst staff and management and to identify areas of most importance to be addressed.

Equally, these results reveal the highlights and bright spots within trusts, which allows for sharing of best practices.

**Method and approach**

The Maternal and Neonatal Health Safety Collaborative (MNHSC) is a national three-year quality improvement programme that was launched in February 2017 and is led by NHS Improvement’s Patient Safety team.

It covers all maternity and neonatal services across England and aims to:

- improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation
- provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England

The programme delivers these aims by developing capability for quality improvement and supporting quality improvement projects within service providers and at a system level. It is part of the national Maternity Transformation Programme and contributes to the national ambition, set out in Better Births, of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

Part of the support offer for trusts participating in the MNHSC is the opportunity to run a safety culture survey to inform and support quality improvement work. Teams carry out a detailed debrief following the survey to enable staff to identify how to
make improvements to their safety culture alongside their quality improvement work.

All trusts taking part in MNHSC used well-validated surveys to provide a baseline assessment of their safety culture, highlighting areas of strength and opportunity for improvement. All clinical and non-clinical staff members working in a relevant area across maternal and neonatal care were invited to participate.

- Seventy-six of the trusts used a process organised by the MNHSC in partnership with Safe & Reliable Healthcare, using the SCORE (Safety, Communication, Organisational Reliability and Engagement) survey, through Safe and Reliable Healthcare limited liability company (LLC).
- Ten trusts undertook their survey using the SAQ (Safety Attitudes Questionnaire) and two domains of the HSOPS (Hospital Survey on Patient Safety Culture), through Pascal Metrics LLC.
- One trust used the MaPSaF (Manchester Patient Safety Framework).

Within each work setting all staff, including non-clinical staff, were asked to participate including:

### Work Settings
- Antenatal and postnatal wards
- Antenatal clinics and assessment units
- Community midwifery clinics
- Midwifery/birthing units
- Neonatal units
- Obstetric theatres
- Obstetric (consultant-led) units

### Roles
- Consultants
- Junior doctors
- Managers (clinical and non-clinical)
- Midwives
- Nurses
- Maternity support workers
- Sonographers
- Theatre/recovery staff
- Infant feeding specialists
- Administrative and secretarial staff
- Housekeepers
The SCORE survey, the one chosen by most trusts, comprises 86 questions divided into 15 areas:

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What did we find?

We undertook surveys across 87 trusts:

87 trusts (91 sites)
16,265 people responded

1331 consultants (all specialities)
922 junior doctors (all specialities)
8149 midwives (all bands)
2021 nurses (all specialities)

61% median response rate

Common themes did emerge, but the range of responses and perceptions was wide given the localised nature of culture. This variation highlights how important it is to engage staff in improvement to ensure efforts are relevant and appropriate to local circumstances.

As expected with such a large sample size, there is a very wide range of scores across the domains and individual items in the survey. Figure 1 below shows the disparity in perceptions of a positive safety climate among all the work settings surveyed (#725), with some work settings having 100% of staff agreeing or strongly agreeing that the safety climate is positive. At the lower end, there are some work settings in which less than 10% of staff have overall positive perceptions of the safety climate.
What did we find?

Figure 1: Range of perceptions of a positive safety climate, across 91 maternity providers

The x axis indicates an overall score, an aggregate of the seven questions in that domain, as a percentage of respondents reporting a positive safety climate - higher is better. Each bar represents the responses from one organisation.

Similar ranges in perceptions were seen for all the domains, regardless of factors such as size of trust, number of babies delivered per year, or geographical location. Because culture is so local there may also be wide variations in perception within one trust.

A similar range of responses exists by roles, as shown in Figure 2. below for the overall perceptions of local leadership.
Comparing similar work settings at different sites also shows distinct variation in staff perception, with some very positive and some very negative. There is no specific work setting type that has consistently positive staff perception of safety culture across the country.

Across role types there is also a variation between the different domains, so role types are not consistently demonstrating positive or negative perceptions.
Figure 3: Perceptions of safety cultures across domains by role types

midwife (band 6)

midwife (band 7)

consultant (neonatal)

consultant (obstetrics)

manager midwifery

manager nursing

What did we find?
Common themes from across all the domains which need analysis at a local level include:

By unit type:

- antenatal clinics and assessment units and neonatal units have the most consistent positive perception of culture, and obstetric units and theatres have among the most negative perceptions
- neonatal unit perceptions are more positive overall than other units, with managers more positive than midwives or nurses
- midwifery units are more consistently positive than obstetric units
- neonatal units have a positive perception of their ability to improve, but a more negative perception of leadership, while other departments have a more consistent view of both.

By role type

- consultant neonatologists and junior doctors have the most positive perceptions in the areas of learning, teamwork and safety climate of any doctor role
- consultant anaesthetists have less positive perceptions across the domains than other doctors but better personal burnout scores and the best work-life balance of any doctor role
- managers of any type, but particularly those in midwifery, have consistently positive perceptions of improvement readiness, local leadership and safety climate compared to midwives and nurses not in a management position
- midwifery managers have much more positive perceptions across all domains than midwives at all grades
- with the exception of teamwork and work-life balance, band 7 and above grade midwives have more positive perceptions across all domains than band 6 and below midwives
- band 6 and below midwives, the largest group sampled and from whom there were more than 6000 respondents, have the lowest perceptions or second to lowest perception across all elements of culture except teamwork.
Themes, questions and actions

Some of the detailed themes are summarised below along with key actions. Detailed questions and actions are suggested in tables at the end of each section.

a. Improvement readiness and local leadership

**Improvement readiness** measures staff perceptions of the ability to identify and fix defects and concerns within their work setting. Healthy learning environments focus on identifying concerns and enable staff to address defects, either themselves or through a formal process. In an ‘improvement ready’ culture there are high degrees of trust, and staff are confident that their issues and concerns will be acted on in a visible, reliable manner.

**Local leadership** focuses on the activities of local leaders to promote psychological safety, their visibility and availability to those who report to them, and their commitment to regular and frequent feedback conversations.

The responses to two particular items in the improvement readiness and local leadership sections of the survey provide insight into the work-setting dynamics:

- ‘The learning environment in this work setting effectively fixes defects to improve the quality of what we do.’
- ‘In this work setting, local leadership regularly makes time to provide positive feedback to me about how I am doing.’

Figures 4 and 5 on responses to these two questions by role type show the below variation in response.
Managers of all types demonstrate greater confidence that problems are fixed than do the staff who report to them. In Figure 4, the top bar shows that 88% of nursing managers agree or strongly agree that they work in a learning environment that addresses defects or problems, 4% disagree or strongly disagree and 8% were neutral on the Item. It is notable that the largest group of staff (midwives, band 6 or below, n of 6039 for this item) are among the least confident that their concerns are addressed; almost a third (29%) disagree that problems are fixed. This sentiment is reflected in many comments on supplies and equipment.
Figure 5: In this work setting, local leadership regularly makes time to provide positive feedback to me about how I am doing (analysis by role type)

Again, Figure 5 shows that managers have far more confidence that leaders provide positive feedback than do other staff members. Band 7 or above midwives agreed more strongly (53%) than band 6 or below midwives (38%). Managers of all types should ensure they make time to provide ‘in the moment’ feedback to their staff members on a regular basis. It is unclear why consultant anaesthetists would have the lowest perceptions of receiving positive feedback from leadership, so further conversation is warranted.

We found:

- staff are frustrated by missing or malfunctioning equipment.
- staff across all roles and work settings do not feel that their hard work is recognised by managers.
This midwife on an antenatal/postnatal ward is positive about their manager, but recognises the frustration that comes from issues not being addressed:

“I feel that the ward manager is very approachable and kind however ... it seems issues don’t get resolved or an excuse is provided. It is very frustrating on the ward because I love the work but feel I can’t provide the best care to women… The morale on the ward is often low because the issues that affect us clinically aren’t dealt with by management and it is a constant cycle.”

Staff can clearly recognise when managers are supportive:

“We have an amazing new interim HOM [head of midwifery] who has been wonderful for our maternity unit. Strong effective leadership is vital to a healthy work place.”

Staff are also quick to recognise positive changes in their environment:

“I feel if I had filled the survey in a few months ago the answers would have been very different in a negative way. The leadership has changed, and I feel more positive that as a team we can go from strength to strength.”

One staff member on an antenatal/postnatal ward reported:

“Things have improved in the unit since January 2017 with improved morale and staff clearer regarding their roles and responsibilities. There is also regular acknowledgement of staff achievements, something that was previously lacking.”

In another trust, however, one delivery suite staff member stated:

“There is never really a thank you from the management but a list of complaints about what should have happened.”
Staff appreciate fairness and managers/leaders holding everyone accountable to the same level:

“Our first line manager is fantastic and ‘has our backs’ if and when we need her as long as we are following the correct protocols and procedures”

“My line manager is extremely hard working and dedicated and makes a really positive difference to the work environment. She is supportive, fair and knowledgeable”

Key actions

- Fix small issues as soon as possible.
- Discuss defects and fixes in operational huddles.
- If additional help is needed to fix a problem, get outside expertise.
- Challenge yourself to identify positive behaviours and actions and tell staff ‘in the moment’ when you recognise these.

Theme: staff ability to fix problems / have control over work environment
Item: In this work setting, the learning environment effectively fixes defects to improve the quality of what we do.

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| Employees deal with defects and ‘pebbles in their shoes’ every day. The ability to identify and fix defects not only helps reduce waste, harm and inefficiency, but gives staff a sense of control or influence in their work environment. Without this, they are more likely to burnout, detach and feel | • Fixing which common defects would make your day simpler, safer and easier?  
• Do you have examples of defects that have been successfully identified and fixed?  
• Is the process for identifying and fixing defects visible and | • Fix small issues as soon as possible - supplies, broken equipment, minor requests. Acting on them quickly shows a commitment to maintaining a safe, efficient work setting and will show staff that it is worth speaking up and suggesting improvements. Classic |
underappreciated by their organisation.

If staff continue to report defects, such as broken equipment, communication issues, patient care concerns, but perceive that nothing is then done about it, they lose confidence in management and in their own ability to effect positive change. Staff soon stop reporting defects and are more likely to develop, possibly unsafe, ‘work arounds’.

measurable? What are the annoying defects that don’t get fixed?

• If you could fix one or two things that hamper your ability to provide the quality of care that you want to, what are they?

defects include: inadequate lighting, doors that malfunction, unaddressed inappropriate behaviour, benign neglect of a work setting by senior leaders

• Include discussions of defects and fixes in operational huddles: identified defects, defects that have been fixed, defects that are big enough to become larger goals, what’s been done since the last huddle. Doing this makes fixing defects an intrinsic part of the work setting. Note that ‘defects’ can be clinical, operational or cultural.

• If the challenge is knowing how to fix a problem, get outside expertise. For example, improvement experts can help a group think through what actions to take to create workable aims or goals, and teach people how to run small tests of change to find out which action is likely to be the most successful.
Theme: Local leadership
Item: “In this work setting, local leadership regularly makes time to provide positive feedback to me about how I am doing.”

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| Although we all tend to focus on things that could have been done better, regular positive feedback is essential. This does not need to be for extraordinary or above-and-beyond sort of performance. It is often more appreciated when minor things are recognised (“Thanks for helping Sarah out when she was really busy - I appreciate that you always help your teammates”). | • What feedback is currently given?  
• What would staff like their leaders to recognise?  
• How can I, as a leader, regularly provide positive feedback?  
• Do any particular roles feel unrecognised or unappreciated? | • As a leader, challenge yourself to identify positive behaviours and actions; make a note of them and if you cannot give face-to-face feedback at the time send an email.  
• Offer coaching or online teaching modules to managers/leaders that will help them be personally more resilient, while also highlighting the attributes of good leadership and increasing their skills and focus on the social and cultural dynamics they manage.  
• Where staff feel unrecognised their direct supervisor/manager should be made aware so they can work to improve their feedback. |
b. Teamwork and safety climate

Teamwork and safety climate measure perceptions of communication, cooperation between colleagues, psychological safety, problem resolution, fairness and accountability when errors occur, and dedication to safety in the work setting. When the perception of teamwork is poor, employees may feel that colleagues are not co-operative, their voices are not heard by management, their efforts are not supported, or communication is not robust. These feelings can deeply affect employee performance and patient outcomes. Good perception of a safety culture among staff shows their belief in a genuine dedication to safety in their work setting.

The responses to four of the items in this section provide insight into several aspects of the work setting:

- “Dealing with difficult colleagues is not consistently a challenging part of my job.”
- “Communication breakdowns are not common in this work setting.”
- “The culture in this work setting makes it easy to learn from the errors of others.”
- “I would feel safe being treated here as a patient.”

Figures 6 to 9 show the responses to these four questions.
This item is one of the lower scoring and most concerning items on the survey. “Difficult colleagues” could be defined in different ways and encompass different levels of severity. To fully understand why difficult colleagues are perceived to be challenging this would need to be unpicked as part of the debriefing process. It is particularly interesting that managers – with positive perceptions of many other aspects of the workplace – score the lowest here. More than 70% of all managers are reporting that difficult colleagues are a commonplace and consistent challenge in their workplace. Junior doctors, however, have the most positive perceptions of their working relationships with colleagues.
Figure 7: Communication breakdowns are not common in this work setting (analysis by role type)

Those working in neonatology or paediatrics have a more positive perception of communication, which may be a reflection of the more controlled working environment of a neonatal unit. Doctors of all levels are also more positive about good communication than nurses or midwives.
The ability to learn from errors is a hallmark of a positive culture, and again we see that managers are confident that they are supporting these efforts. Consultant anaesthetists are far less positive than their peers in neonatology or obstetrics.
Figure 9: I would feel safe being treated here as patient (analysis by role type)

This item is a good barometer of the overall perception of safety in a work setting. There is consistency across role types and work setting types, as shown below:
Figure 9a: I would feel safe being treated here as a patient (analysis by work setting)

We found:

- almost all respondents across all work settings would feel safe being treated in their workplace

“I absolutely love working within such a fantastic team ... The ward has many challenges as a newly qualified midwife and is a steep learning curve, but I would not want to be a midwife anywhere else!”

“I feel generally there is a good working environment and staff are generally very good and work hard and cooperative.”

- managers have the greatest requirement to ‘deal with difficult people’
- 65% of respondents believe that there are communication breakdowns within their work settings.
Comments such as the one below, from a band 5 midwife, provide some detail about difficult interpersonal interactions in their birth centre:

“In asking questions and requesting support I have been spoken to with rudeness and contempt and made to feel very stupid in front of other colleagues.”

Staff, such as this midwife in a birthing suite, indicate bullying is an issue:

“I believe that I work in a bullying culture which includes bullying from management to junior staff of all grades but also bullying from more senior band 6 midwives to junior midwives like preceptors.”

A strong safety culture has a proactive approach to dealing with errors and adverse events and a focus on learning and improvement. Team members are accountable for their actions and behaviour and know that they will be treated fairly if they make a mistake.

One common feature of significant harm events in healthcare – regardless of specialty, role, or location – is poor communication, ranging from teams not using robust methods to exchange important information to teams minimising details because they fear speaking up. In our experience disrespectful or difficult interactions among colleagues can be the reason respondents reported communication breakdowns in their work settings.

“There is a severe lack of communication between staff. This occurs mostly between medical staff and midwifery staff - often information is not passed on, or the doctors plan between themselves and don’t communicate this to the midwifery staff. It’s so frustrating, especially when the medical staff then get annoyed at you for then not doing the ‘right’ thing.”

“Sometimes staff behave without care or compassion towards their colleagues, are disrespectful during meetings or during interactions and dismissive of concerns. It is a small number of staff who behave in these ways but it has a huge impact on your working day.”

That almost all staff would feel safe receiving care in their work setting is a good indicator of a safety culture. Managers were most likely to respond positively to this question and consultant obstetricians, gynaecologists and neonatologists also
scored more positively on this question than junior doctors. Obstetric theatres, a high-risk environment, was the lowest-scoring work setting, and consultant anaesthetists and junior doctors and theatre staff were among the lowest-scoring roles.

"Out of all the wards I would feel safest on this ward as a patient. I enjoy caring for women and the work I do with them."

Psychological safety describes the comfort with which members of a group feel free to speak up, ask questions, and raise concerns without fear of reprisal and it is a key driver of good teamwork and a safe culture.

**Key actions**

- Improving local culture requires highly visible actions and clear expectations about accountability and acceptable behaviours.
- Leaders need to clarify expectations and model these consistently.

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**Themes: Psychological safety, respectful communication, interpersonal dynamics**

**Item**: Dealing with difficult colleagues is not consistently a challenging part of my job.

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<td>In a complex clinical environment like a maternal and neonatal work setting, psychological safety is critical. Someone who feels intimidated by other team members is unlikely to raise a concern, even if they have concerns about someone in their care. Respectful, collegiate</td>
<td>• What efforts have been made on the unit to work as collaborative teams and build relationships? Is the unit an environment of respect? • What are the consequences if team members treat each other disrespectfully? Is</td>
<td>• If the culture has allowed lots of people to behave in unpleasant ways, resetting it will need to be highly visible and require very clear expectations with accountability. High performance cultures define the desired</td>
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interactions and the ability to resolve differences are the hallmarks of a high-functioning clinical team. Safety climate relates strongly to both employee safety (e.g., needlesticks, back injuries) and patient safety (e.g., bloodstream infections), so its improvement is critical to better outcomes and experience for staff, women and families.

there a clear, overarching goal that the needs of the patient come first?

- What mechanisms exist to promote professionalism? Is the ‘elephant in the room’ that specific individuals come to mind when discussing this question? Discuss the sources of difficult behaviour. Is it pervasive or limited to a few individuals?

behaviours, and don’t tolerate disrespect.

- If a few individuals are the source of this problem, leadership needs to clarify the rules of the culture, what is expected and acceptable, and what is not acceptable. Clear expectations, and especially clear consequences and ongoing monitoring are essential.

- Some dedicated time spent on setting expectations, gaining commitment and resetting the culture can be needed if unhelpful behaviours are embedded. These should be accompanied by setting clear rules, and willingness to respond when team members deviate. Senior leaders, risk personnel and physician leaders with responsibility for professionalism may need to be involved.
### Theme: Teamwork, communication
Relevant item: Communication breakdowns are common in this work setting.

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| Without agreed standardised approaches to communication teams will not be highly functioning and safety will be compromised | • Are there standardised processes for communication in the work setting – briefings, debriefings, structured language like situation, background, assessment recommendation (SBAR), so everyone knows the plan?  
• Are they consistently used?  
• What one process could we focus on to improve communication? How would we know if this is an improvement?  
• When does information commonly get lost and communication break down? | • Discuss with the team the ways information can get lost.  
• Which situations are risky and/or frequent? Pick one or two communication processes to improve and hardwire. Share the learning from this approach. |

### Theme: Safety, learning from errors
Relevant item: ‘The culture in this work setting makes it easy to learn from the errors of others’

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<td>Learning from errors has clear benefits for improving care so this is worth addressing if it is not currently happening.</td>
<td>• Do colleagues feel safe discussing errors, knowing that the goal is</td>
<td>• If the mechanisms for spreading insights are poor, test</td>
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| Underlying issues can be wide ranging including fear about reporting, operational limitations or inadequate team collection of information. | to learn and provide safer care for everyone  
- Do leaders model the values of being able to admit mistakes?  
- Is there awareness that skilled people working hard to do the right thing working in complex environments will make mistakes?  
- Does a well-understood, clear accountability model for a just culture / organisational fairness exists and is it used? | communication through safety newsletters.  
- If learning is limited because individuals fear repercussions if they discuss errors, create safe places to report and discuss events with the help of staff from safety, quality and HR departments.  
- If leaders in risk departments are averse to conversations about errors, senior leaders should show their commitment to continuous learning and the value of improving transparency when things go wrong.  
- Discuss ‘near misses’ at staff meetings and recognise any ‘great catches’ that prevented harm. |

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**Theme: Patient safety**  
**Relevant item: I would feel safe being treated here as a patient.**

| With one caveat, this item is a good indicator of a positive safety culture. In some cases, respondents will agree because they know and control their |  
- What do you see that would make you feel unsafe if you or a family member were a receiving care here? |  
- Identify locally controlled issues and eliminate or fix them – such as minimum levels of equipment, or improved |
'system' - that is they can choose who takes care of them and where they are cared for.

- Have you mentioned this? If yes, what actions were taken? Did anything change for the better?
- What is the one thing that can be done to provide better care within our resource constraints?

communication between disciplines.

- If the findings raise more significant issues such as poor behaviours, professionalism or communication across work settings that cannot be immediately resolved these should be escalated for action plans - with guarantees of feedback

c. Burnout and work-life balance

Burnout in those working in healthcare is increasingly common. High levels of burnout undermine patient care and diminish organisational capacity to improve. The results from these surveys provide important feedback about the readiness and ability of staff to engage in improvement work.

High burnout scores indicate strain and that staff are likely to focus more on personal issues than on organisational priorities.

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**Burnout climate** elicits assessments of the level of emotional exhaustion among staff in a given work setting. The questions were about how respondents perceive others around them, and responses will be influenced by what someone observes in their colleagues.

**Personal burnout** elicits self-assessment of emotional exhaustion. Items in this domain reflect feeling depleted: “I feel frustrated by my job,” or “I feel burnt out from my work”.

**Work-life balance** describes the ability to split time and energy between work and other aspects of your life important to you. When staff experience burnout
or regularly have to cancel plans due to working late or exhaustion, their work-life balance is badly affected.

Items that provide significant insight to the readiness and ability of staff to engage in improvement work include:

- “I feel frustrated by my job,” or “I feel burnt out from my work.”
- “During the past week, how often did you skip a meal, work through a day shift without breaks, arrive home late from work, slept less than five hours per night?”

When we analysed the responses to these four questions we found the below results.
Figure 10: I feel burned out by my work (analysis by work setting)

Staff in community clinics reported the most frustration (59%) and those working in neonatal units the least (35%). When that same item is analysed by role type, it is clear most midwives are experiencing frustration in their work lives. Doctors of all ranks express the least frustration in their jobs.
Figure 11: I feel frustrated by my job (analysis by work setting)

(Colours indicate the percentage of respondents who were positive - blue, neutral - orange, negative – grey.)
Figure 12: In the past week worked through a day/shift without any breaks, (analysis by work setting)

(Colours indicate the percentage of respondents who were positive - blue, neutral - orange, negative – grey.)

People working in community clinics – who expressed the most frustration – are the most likely to get a break during the day. In contrast, those working on neonatal units feel the least frustration but are also the least likely to get a break during their shift. The concept of ‘cognitive scarcity’ suggests that our mental resources are limited and the stress of making numerous important and impactful decisions, as a clinician must, can deplete these resources. Without a break to relieve this stress, the clinician may experience some degree of cognitive exhaustion, in which their decision-making skills are significantly impaired. Built in ‘buffers’, such as regular breaks, can relieve this stress and allow them to approach their next patients with a refreshed mind and ability to think critically.

We found:

• staff working on antenatal and postnatal wards report the most burnout and the least amount of emotional thriving
• midwives of all types on antenatal and postnatal wards, but particularly managers and those at band 6 or below, report that they feel burnt out.

This midwife who seems otherwise positive about her work environment nonetheless recognises the importance of avoiding burnout by maintaining wellbeing:

“I think the world of the unit, my colleagues and support and feel privileged to help people at such a time of their lives. We all work hard and need to look after each other. I do feel that breaks are being overlooked and that needs to be supported as it won’t help staff wellbeing.”

Even staff members who love their role can experience a worrying amount of burnout, as expressed by this midwife:

“Every day I drive to work I dread it. I sit in the car park before each shift preparing myself to open the door and walk in. I don’t sleep enough, I don’t eat enough of the right thing. If I didn’t need money to literally live I don’t think I would be here! Which is so sad. I love my role as a midwife and I love what I do but yet I often hate it!”

Key actions

• Check if team members are getting breaks or meals and provide food in the work setting.
• Formally block time for breaks and meals.
• Re-allocate responsibilities where one individual is overwhelmed while another has capacity.
<table>
<thead>
<tr>
<th>Why address this?</th>
<th>Questions to ask</th>
<th>Actions</th>
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| Work-life balance reflects the balance between professional, job-related demands and a healthy personal lifestyle. A good work-life balance is important both for the health of employees and to prevent burnout. Working through the day without breaks, arriving home late from work and needing to change personal plans will all negatively affect work-life balance. Leaders who talk to their staff about work-life balance and burnout are effectively showing their concern for them. Leaders who do not run the risk of disenchanted and disconnected employees will set the tone in their work setting. When demands consistently exceed the resources of a given work setting, burnout indicates severe disengagement and | • How often do workers get breaks and the opportunity to decompress during their shift?  
• Are some shifts worse than others for missing breaks? Do staff in certain roles miss breaks more often than others?  
• Is the manager aware and what have they done to try and improve this? | • Survey the work setting to assess if team members are getting breaks and meals and provide food in the work setting.  
• Formally block time for breaks and meals by scheduling time on the calendar.  
• Design the day with re-briefs including a component to re-allocate responsibilities where one individual is overwhelmed while another has capacity.  
• Set a goal to improve the level of breaks and meals taken by X%, or to 100%, as deemed feasible by the work setting. Hold everyone accountable for achieving the goal and then routinely measure progress and make the results visible. Periodically brainstorm on ways to improve, and then test the ideas. |
emotional exhaustion at work. Built-in buffers, such as regular breaks, can relieve this stress and allow clinicians to refresh their mind and their ability to think critically.
What behaviours can we adopt to support changes in safety culture?

Managers and leaders need to ensure that the safety culture survey is seen as the beginning of a conversation about what action and improvement are needed.

Leaders may want to investigate possible interventions to set an expectation around behaviours and enhance communication, team working, positive reporting and learning from excellence.

All members of a multidisciplinary team have a responsibility to support, develop and improve the safety culture in their workplace.

The following examples of positive behaviours can be demonstrated by clinical leaders of all professions, managers, executive leaders and all other members of the multidisciplinary team. By modelling these types of behaviours leaders at all levels can set an expectation that can contribute positively to the safety culture within teams.

1. **Clinical leaders**

**Improvement readiness**

- Invite and encourage all members of the team to join in conversations about the safety and quality of care, share care plans, and raise questions or concerns.
- Learn the names and roles of all team members and include everyone in conversations and procedures.
- Finish a case/delivery/procedure with a quick debrief – cover what did and did not go well, what could be improved and what you can learn?
- Encourage each team member to engage in problem-solving and to share their ideas.
- Follow up quickly on any identified issues and feedback outcomes.
• Model improvement behaviour and escalation if the improvement cannot be made in real time or requires support from outside the department.
• Ensure you maintain the momentum for continuous improvement and be sensitive to the slowing of progress.
• Be curious and open to different kinds of safety thinking, behaviours and attitudes.
• Acknowledge when any team member models behaviour that supports patient safety or quality improvement.
• When staff disagree or raise a concern, thank them for raising the issue and make sure their concerns are taken seriously and investigated. Make sure they know that they were right to raise a concern even if no one came to harm or no change to care is needed and let them know what action if any has been taken.
• Model making time to pause and reflect, and encourage team members to ask for this time when needed.
• Share learning from other work settings with your teams; accompany colleagues to look at other ways of working.

Leadership

• Give positive and constructive feedback to team members: highlight their strengths and encourage them to consider if they would do anything differently in future.
• Encourage teams to give you positive and constructive feedback and suggestions of how you could improve.
• Challenge any disrespectful behaviours or breaches of the behavioural standards immediately or seek support to do this as soon as possible.

Teamwork

• Encourage those who are usually quiet to share their opinion.
• Thank those who don’t usually contribute when they do.
• Ensure that everyone who offers an opinion is listened to respectfully.
• Encourage and model respectful disagreement and highlight that disagreement can be in the best interest of a patient safety.
• Be seen to look for and accept alternative ideas others than those you have.
• Work with team members to identify the day’s procedures or shared goals and ask everyone to agree and contribute to achieving these goals.

• Ask to be told if a situation changes and plans need to be adapted.

• Set a positive tone, display thinking out loud and invite enquiry.

• Look for opportunities to test improvement suggestions in real time.

• Tackle problems head on and with a view to exploring the best way forward.

• Model good communication with colleagues, don’t over use emails, face to face is often the best way to communicate.

Safety climate

• Identify when you have made an error and tell others you have done so.

• Share your error with team members and explore together what you have learnt and what you will do differently next time.

• Model appreciative inquiry approaches in yourself and colleagues by highlighting good catches of near misses and good examples of sharing learning.

• Simulate high risk procedures that you are involved with, error and near miss and also practise applying a just culture guide.

• Model safety behaviours through respectful teamworking and communication, prioritising attendance at safety activities and procedures, and displaying a safety attitude and prioritising safety.

Burnout and work-life balance

• Identify systems, processes, frustrations and experiences that impact on the development of burn out and work life balance.

• Model the importance of continuous improvement and support others to identify and test change ideas.

• Be mindful of workloads and model reallocation of work to others with less to do or who have finished their tasks.

• Manage how you externalise frustrations; understand the potential negative impact on your colleagues.

• Discuss with team members how to reduce burnout and improve work-life balance.
• Identify and highlight how not taking breaks can risk safety; before starting procedures check in with staff to check they have had adequate breaks.
• Cover for colleagues so they can take breaks, test out ideas for ensuring that missed breaks are identified and workarounds found.

2. Managers

Improvement readiness

• When defects are reported act swiftly to find a solution, thank team members for reporting the defect and keep the team aware of progress.
• Use a range of ways to communicate to your teams: feed back personally in huddles and individually to the reporter, via the team newsletter and on the improvement board.
• Know which other work settings can be learned from and arrange for staff to go and visit them. Do this regularly across a range of work settings and with other specialties.
• Build in time each day to ‘pause, reflect and learn’, attend these sessions or follow up later to find out how they went and what actions have been set.
• Support and empower staff to try improvement in real time and model how to access wider help if solutions can’t be found internally. Ensure measures are collected to inform change ideas and whether an improvement has been achieved.
• Look for opportunities to coach others in real time to pause, reflect and extract learning.
• Design monthly 10-minute coaching sessions on what individuals and the team have learned, encouraging staff to reflect on their own contribution and the team’s contribution.
• Seek and highlight when examples of real time and reflective learning has occurred. Raise the status of learning by celebrating, promoting and sharing.
• Spread your learning to other work settings and other specialties in a range of ways - displayed on improvement and notice boards, in newsletters, meeting agendas, at briefings - and seek to learn from other teams.
Leadership

- Be present on the floor/unit through daily rounds. Review and address what keeps you from having a good presence.
- Keep your office door open whenever possible, encourage people to pop in and shape the behaviours of others by initiating conversations.
- Be interested in all team members, initiate conversations with those who do not normally talk to you.
- Model interpersonal respect and kindness.
- Model a strong interest in developing a safety culture in the work setting.
- Protect, nurture and develop opportunities and practices in the work settings that create a safety culture by promoting them and celebrating successes.
- Show your support for and commitment to prioritising safety.
- Do regular rounds on night or weekend shifts and hold staff meetings on off shifts as well as day shifts.
- Do not rely on email, as face to face can often be the most effective way to communicate.
- If you haven’t received a reply from an email, find the person and speak to them directly; this will help them know that their response matters to you.
- When you are with your team ask them if they have any needs or questions; do not wait for team members to come to you.
- Offer to relieve staff members for quick breaks during the day.
- Make time to attend briefings and meetings and show your team that you value this time with them. In briefings, role model a positive tone and safety attitudes, thinking and behaviours.
- Work with your teams to review and agree the expected behaviours and actively promote and model these behaviours.
- Agree how any breaches of behaviours should be raised and managed. Ensure that all unacceptable behaviours are addressed as soon as possible.
- Ask for support from HR, executive colleagues or professional leads if you are unable to address any unacceptable behaviours alone.
Teamwork

- Have a process for dealing with disputes and make sure that all team members know what this is, that it is consistently applied and that decisions being made as a result are always in the best interest of the patient. Display this process where team members can see it.
- Ensure that all team members understand that what is right for the people in your care is always the priority. Disagreements should be dealt with professionally and should not impact on safety or care.
- If needed, seek help from professional leads if disputes cannot be resolved by staff adhering to the agreed process.
- If necessary, escalate unresolved issues to an executive member to ensure disputes are resolved in the best interest those receiving care or services.
- Ensure that all team members show the team’s expected and acceptable behaviours.
- Look for common sources, themes or patterns that lead to conflict and look to make improvements.
- Have a tested mechanism that allows people to report lack of psychological safety, and work with staff to understand what this mechanism should be.
- Teach staff how to disagree and communicate respectfully, seek help from HR and professional leads and executives to support this if needed.
- Model strongly that disrespect amongst colleagues is not tolerated.
- Identify all handoff opportunities, knowing that each staff member can carry out a process and understands why it is safety critical.
- Support and, where possible, join briefings, ensuring that these are multidisciplinary and frequent.

Safety climate

- Ask each day: “How is everything today? Is anything broken? Do we have any ‘pebbles in our shoes’ today? Is there anything preventing us from being able to deliver quality safe care today?” If problems are identified, model dealing with them immediately.
- Work with the team to develop different ways for team members to feel comfortable enough to raise safety concerns and safe places for them to do so.
• Display the safety concerns raised in public areas, and the outcomes from raising them.
• Make the sharing of ‘Greatex’ and errors raised routine as well as the learning and changes made from this. Test that this communication is effective.
• Frequently lead, take part and observe simulations of errors and near misses in the work settings.

**Burnout and work-life balance**

• Take time to assess the level of burnout and work life balance among staff in your work settings.
• Engage in conversations with staff to understand what contributes to burnout and poor work-life balance.
• Acknowledge that you and the organisation are obliged to support team members and ask them to share their feelings, experiences and ideas for improving burn out and work life balance in the team.
• Frequently raise and address burnout and work-life balance issues and ask team members to report daily if they have been able to take breaks and leave work on time. Use feedback as a baseline to track future improvement.
• Work with team members to test ideas that could improve burnout and work life balance in the team.
• Celebrate milestones and success in improving the number of meal breaks taken, or the number of shifts that people report went well, remembering to share what contributed to the improvement.
3. Executive leaders

**Improvement readiness**

- Be aware of what might make people in the organisation unlikely to approach you and work to counteract this.
- Identify which groups of people in the organisation you never hear from and go and talk to them.
- Consider how easy it is for staff to find time to talk to you, and provide a range of ways for them to contact you. Test these, make changes and share your findings with colleagues.
- Make sure that staff know what kinds of issues or concerns they can contact you about, and make it clear that you are interested and want to understand their point of view.
- Regularly visit the floor/unit. Review and address what stops you from having a good presence in the work setting.
- When visiting work settings make sure you are visible, stop and speak to all team members not just the manager, get to know staff names and roles.
- Ask staff how defects in the work setting are reported and ask if the process is easy to use, or if they have any ideas to improve it.
- Ask if there are any unresolved defects that are not getting mended.
- Ask to see the process and check if there is a clear loop from the reporting of a defect to resolution and communication back to the team.
- Connect the team to other work settings that have managed a similar problem, show interest in the process and outcome of sharing learning between teams.
- Identify any themes among common defects and seek to address these.
- Ask team members when they last took time to pause, reflect and learn.
- Find time to take part in team briefings.
- Ask managers and work setting staff, to test whether your organisation’s values and expectations of improvement readiness in relation to safety culture is being effectively communicated and received.
- Communicate the importance of the work setting being improvement ready, to supports the aims of the wider organisations.
- Share with teams what the board is doing to be improvement ready, and how this impacts on the decisions made.
• Feed back to executive colleagues the improvement readiness of the work settings; share success, local challenges and barriers; work together to identify how executive members can enable Improvement readiness in the work settings; test and measure the impact of ideas.

**Leadership**

• Ask department leaders to describe how they make themselves visible and accessible, and how they seek out staff in the work setting to engage with them and give and receive feedback. Ask staff in the work setting to take part in this.

• Ask team members how do they know they are doing well both as an individual and as a team. Ask whether they receive positive and constructive feedback and how are they are supported to reflect on their performance, strengths and weakness.

• Ask individuals what they have gained and learned from conversations with their leaders.

• Ask members of the work setting if their leaders support the behavioural standards for the team.

• Ask department managers and clinical leads if expected behaviours are followed, if they address unacceptable behaviours and if they have the skills and support to do so. Offer to support them with coaching or training if required.

• Ensure you convey that unacceptable behaviour is not tolerated by the organisation and that staff will receive the right support to challenge others.

• Convey that individuals will be supported to manage and change their own behaviour to meet expected behaviours, personally support individuals, and clearly define what behaviours are not expected or acceptable.

• Asking managers and work setting staff, to test if the organisation’s values and expectations of local leadership in relation to safety culture are being effectively communicated to the work settings. Do people in the work setting hear the organisations messages about the role of local leadership in improving safety culture?

• Feed back your local leadership findings to executive colleagues; share success, local challenges and barriers; work together to identify how the
executive members can enable local leadership in the work settings; test and measure the impact of ideas.

Teamwork

- Support teams to access teamwork development opportunities.
- Share knowledge of other teams that exemplify good team working.
- Ask each team member how they contribute to the team, what their role is, and how the way the team works impact positively and negatively on the safety culture.
- Ask whether individuals feel supported to work as a team. How do they manage disagreements or conflict?
- Ask how individuals work with other teams across work settings. Do disagreements occur and, if so, how are these resolved?
- Ask managers, leaders, and work setting staff, to test if the organisation’s values and expectations of how teams should work in relation to safety culture is being effectively communicated. Do team members hear and understand the organisation’s messages about the negative impact poor team working has on improving and achieving a safety culture?
- Ask staff if changes to improve teamwork are effective. Ask for further suggestions.
- Feed back your findings on teamwork to executive colleagues; share success, local challenges, and barriers; work together to identify how the executive members can enable teamwork in work settings; test and measure the impact of ideas.

Safety climate

- Ask managers, leaders, and staff what the most common errors are.
- Thank people personally for reporting errors and near misses.
- Ask what the main contributors are to errors in each work setting area.
- Acknowledge error will happen in complex areas, and emphasise how important it is to report errors to learn for the future.
- Find out how many incidents happen in each area and talk to team members to understand why they happened and if any themes can be identified.
• Ask staff how they deal with error. Do they feel that a just culture is applied, and are they confident that a just culture would be applied every time?
• Ask managers, leaders and work setting staff, to test if the organisation’s values and expectations of having a safety climate in relation to developing a safety culture is being effectively communicated. Do staff hear the organisation’s messages about the impact of developing the safety climate to improve safety culture?
• Ask staff if changes to improve the safety climate are effective. Ask staff for further suggestions.
• Feed back your findings to executive colleagues about the safety climate; share successes, local challenges and barriers; work together to identify how the executive members can enable the safety climate in the work settings to develop; test and measure the impact of and ideas.

Burnout and work-life balance

• Ask individuals what frustrates in their working day. Ask if improvements are being tested to resolve this.
• Ask what the main contributor is to staff people feeling frustrated.
• Ask staff if they are able to take breaks and finish work on time regularly, and if they have needed to change plans outside work due to work.
• Ask department managers what challenges they face in trying to resolve frustrations, and what could be changed to remove or reduce these frustrations.
• Acknowledge to staff and leaders that the organisation wants to know about levels and causes of burnout in teams, and any issues with or concerns about work-life balance. Share the organisation’s plans to help improve this.
• Ask managers and work setting staff, to test if the organisation’s values and expectations of improving burnout and work-life balance in relation to safety culture are being effectively communicated to the work settings.
• Ask staff, to check whether ideas to improve burnout and work-life balance are effective and ask for further suggestions.
• Feed back your findings to executive colleagues in relation to burnout and work-life balance; share success, local challenges and barriers; work together to identify how the executive members can enable improvements, test and measure the impact of ideas.
4. All other team members

Improvement readiness

- When you notice that something is broken or failing, report it as soon as possible by following your team defect reporting process. Do not wait for a huddle to report.
- If a defect is not resolved as per work setting policy, inform the department manager and ask them to let you know the outcome.
- Find other work settings that are good at managing things your work setting needs to improve and learn from them, share your findings with the team and agree what could be tested.
- Develop the habit of reflecting, and telling others about your reflections with a view to learning. Take time to, pause, reflect and learn. Practice and take part in debriefs and after clinical interventions.
- Develop your own reflection rules, “At work, I will take one minute of every hour to reflect. I will ask myself what went well, what could have been better and what will I do in future?”
- Offer to lead improvements where you are best placed to do so. Generating and testing change ideas is best done by those who use the processes.
- When raising a concern, always propose a solution if possible.
- Understand the aim of improvement work in your work setting and know how you will contribute to it, such as generating and testing ideas or collecting measures. If you are testing a tool you should be aiming for 95% reliability in the use of the tool or process.
- If you are treated with disrespect or witness unacceptable behaviour, follow the agreed process for addressing this. Never let unacceptable behaviours go unreported. Work as a team to shape the behaviours you want to work with.
- Ask colleagues or leaders for feedback and suggestions on how you can improve how you communicate.
- Tell leaders and managers if you don’t understand their communications or if they could be delivered in a more effective way.
- Know how to handover within and across work settings, and understand why this is needed to ensure safety.
• Practice using communication tools such as SBAR (Situation, Background, Assessment, Recommendation).

• When a defect process or intervention is not working as planned make the clinical lead aware immediately and inform the wider team if needed.

• If the day is not working as planned in the shift brief, inform the clinical lead and don’t assume that other people will have noticed.

Leadership

• Regardless of your job title or position within the organisation, you can be a leader too. You can take responsibility for your personal development and for contributing to the functioning and development of the team, to deliver safe and quality care and to make improvements.

• Develop your leadership skills by leading in and actively contributing to briefs, reflection and planning conversations.

• Request a ‘pause, reflect and learn’ session if you need to.

• Talk to leaders of all levels, and develop a rapport with them.

• Be a leader of safety, advocate, practice and take part in safety behaviours, activities. Help others to build a positive attitude to safety.

• Promote and explain to women and team members when safety behaviours are being implemented.

Teamwork

• Believe your view is valid and deserves to be heard.

• Be aware of and raise with managers or leaders, hierarchy, routine practices or individuals that compromise your psychological safety.

• Aim to develop a rapport with everyone in the work setting regardless of their role.

• Make decisions based on what is in the best interest of the women and babies in your care.

• When working in a team, work towards the agreed common goal. Goals should be shared and not individual.

• If you do not feel safe to speak up, raise this with a leader or colleague and ask to be supported to resolve this.

• If you do not understand, ask questions.

• Disagree with respect and without emotion.
• Inform team members if a plan or goal is off target.

Safety climate

• Speak up and report when you know, suspect or have concerns about safety or quality. If you do not think your concerns are being listened to or acted on raise them with another leader or manager.
• Report any errors you have made by yourself and if you observe an error tell the person involved what you saw.
• Share your experience in team meetings of making, reporting and learning from errors. Was there a just culture and what process was followed?
• Ask leaders or managers to support you to understand how an error occurred.
• Speak up and report if you managed or witnessed a near miss.
• Speak up and congratulate others if you see a ‘good catch’.
• Ask leaders and managers what their values are, and how these align to yours and the aims of the work setting.
• Contribute to the development of agreed values for the work setting and strive to achieve these.
• When senior leaders visit the team, ask about the values of the organisation and how these relate to the work setting.

Burnout and work-life balance

• Work with colleagues in your work setting to identify effective positive psychology tools and offer to test them.
• Contribute to measuring burnout and work-life balance.
• Report frustrations through the agreed work setting route.
• Understand the impact of externalising frustrations to colleagues; it can make you look as if you are unable to cope, make people less likely to look to you for advice or support and even prevent them from reporting key safety information.
• Support colleagues who do externalise frustrations to do so appropriately. Remind them of the agreed behavioural standards and the process put in place for reporting.
• Ask team members who regularly externalise their frustrations to stop if this is impacts on you. In a respectful manner explain the effect of hearing the frustrations.
• Understand the impact of burnout and work-life balance on the work setting.
• Speak up if you have any ideas to reduce levels of burnout and work-life balance.
• Identify at the start of the shift workarounds for missed breaks and meals or for finishing late.
Using safety culture insight to support and inform improvement work

Following the safety culture survey, it is important that managers and leaders ensure that there are debrief sessions and survey results are seen as the beginning of a conversation about what action and improvement should follow.

It is not possible to drive changes in culture unless there is collective will and shared responsibility. It is imperative to create the right conditions for safety culture to flourish. Improvements in the safety and quality of care and improvements in safety culture are linked.

It is important that when examining any change in process within a care setting that the results of any local culture survey are incorporated into improvement planning. For example, if improvement work focuses on escalation of deterioration in a labour ward, it is important that any issues expressed by staff, such as poor communication or lack of psychological safety, are also addressed. It is not uncommon for midwifery staff to struggle to take breaks, yet tired and hungry staff are less able to make timely and effective decisions. Focusing on testing a new process of escalation without addressing cultural elements such as burnout, communication and teamwork, will reduce the chance of success.

The MNHSC will continue to support maternal and neonatal teams in trusts to consider cultural elements to inform and support their ongoing improvement work by:

- developing understanding of the different components of safety culture such as teamwork, communication, leadership, burnout, resilience and work-life balance
- helping teams to understand how safety culture can both impact on and support quality improvement projects
- providing support and coaching through debriefing and encouraging teams to start conversations around how to improve their safety culture
• developing safety culture capability within trusts through the MNHSC learning sets and local learning systems, an improvement forum sharing good practice and supporting improvement across local maternity systems

• supporting teams to use findings from safety culture survey to inform and support their improvement plans

• sharing good practice in safety culture improvement through the MNHSC change packages and support teams to test change ideas and interventions

• developing capability around engaging others to feel ownership and motivation to make cultural improvements

• working with senior leaders to understand what their role is in shaping, improving culture and modelling acceptable behaviours.

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