

Building psychological safety into maternity services: an educational programme to support culture change

Background

Culture, civility, and psychological safety have been highlighted by recent national enquiries in maternity as being toxic and unsafe in units that have consistently failed women, their babies, and their families (Kirkup, 2015; 2022; Ockenden, 2022). Sound, evidence-based approaches to improvement that genuinely involve all staff groups and patients are needed to move forward and learn from these repeated mistakes and painful lessons (Dixon-Woods, 2022). A civil culture with good psychological safety for staff leading to improved patient safety is in line with South Tees Hospitals NHS Trust's mission, vision, and values. In South Tees maternity, there was a recognition that the presence of psychological safety, which describes the ability to share ideas, concerns, or mistakes without fear of retribution (Edmondson, 2018) was at best, limited.

Methodology

A pilot session on psychological safety was held in December 2022, receiving overwhelmingly positive feedback. This was rolled out through ten further sessions between March-July 2023. All maternity staff were invited, participants across the full range of roles and grades attended.

The sessions included reviewing what psychological safety is, discussions around culture, tools for feedback, and reviewing what maternity does well and what could be improved. Group work and polls from the sessions were collated and shared with the department leadership.

Key Learning

176 staff attended in total. They valued time to:

- be listened to,
- learn skills to give feedback or talk to colleagues in challenging situations,
- learn about psychological safety and its importance,
- discuss culture within maternity.

When asked about psychological safety within maternity, only 24% rated it as good or better, with the remainder seeking some or significant improvement.

Reasons given for these ratings were:

- incivility,
- low staffing levels,
- hierarchy,
- disparity in communication,
- pressures of workload.

Areas where staff recognised maternity performed well were:

- peer support,
- awards/positive feedback,
- teamwork,
- obstetric emergency training,
- patient safety.

94% rated the sessions as very good or good



References

- Dixon-Woods, M. (2022) 'Learning from Maternity Service Failures at East Kent Hospitals', The British Medical Journal, 379, o2755.
 Edmondson, A. C. (2018) The fearless organization. Hoboken, New Jersey: John Wiley and Sons Inc.
 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. London: His Majesty's Stationery Office.
 Kirkup, B. (2022) Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation. London: His Majesty's Stationery Office.
 Ockenden, D. (2022) Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: His Majesty's Stationery Office.

What next?

The staff discussed ideas which could improve psychological safety in maternity, and these included:

- improving civility,
- listen to staff's ideas,
- be mindful of staff concerns,
- improve communication.

A culture group has been set up to include the Chief Nurse, Head of Midwifery, Clinical Director, and key OD and improvement partners. An action plan was produced and staff pledges for psychological safety from the sessions were collated and displayed around maternity as a visual representation of what staff are working towards.

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