

# Implementing Signs of Safety as the *Organisational* framework

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# Outline

- A systems view of individual performance
- Signs of Safety and organisational change
- Developing feedback loops to learn and adapt
- Implications for research methodology

# A SYSTEMS VIEW OF HUMAN PERFORMANCE

# Improving performance

“You can’t grow roses in concrete”

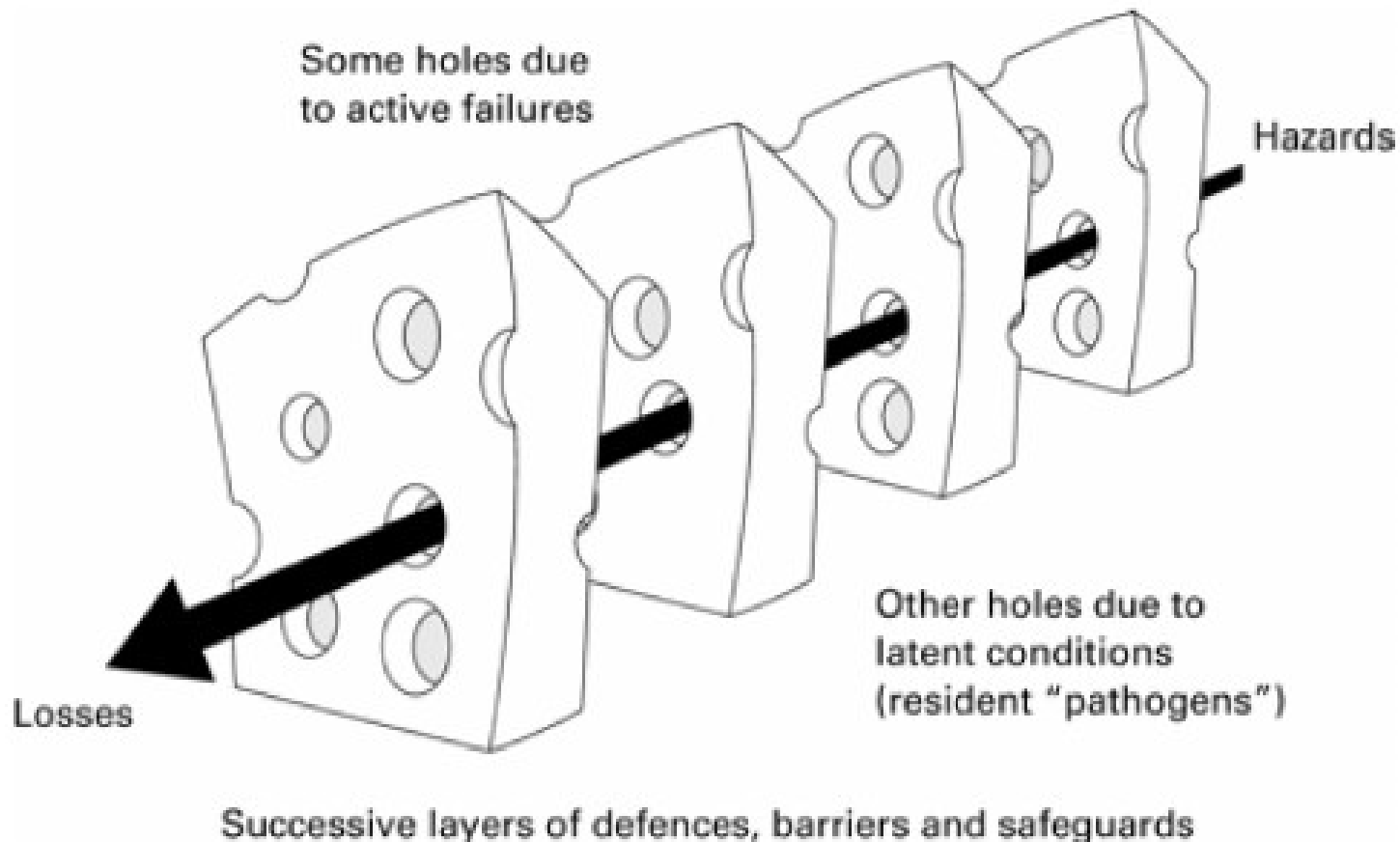
# The system-centred approach

- Individuals are not totally free to choose between good and problematic practice
- We are all part of the multi-agency systems and our behaviour is shaped by systemic influences
- The standard of performance is connected to features of
  - tasks
  - tools and
  - operating environment including culture.

# People's behaviour is shaped by systemic factors



# Reason's Swiss cheese model of latent conditions



# Example: why is the child invisible?

We have told staff to pay attention to the child so why don't they?



# Understanding performance in context requires

1. Appreciating the cognitive and emotional complexity of the work
2. in-depth appreciation of the pressures and dilemmas practitioners face and the resources and adaptations practitioners bring to bear to accomplish their goals
3. Tools, manuals, QA system are active shapers of performance
4. Organisational culture is very influential

# Aspects of a safety culture 1

- *Teamwork climate*: the level of satisfaction with the quality of teamwork and cooperation experienced with colleagues.
- *Safety climate*: the extent to which individuals perceive a genuine and proactive commitment to safety in their organization.
- *Perceptions of management*: the extent to which the wider system supports the work.

# Aspects of a safety culture 2

- *Job satisfaction*: the level of satisfaction with the organization, the individual's morale.
- *Stress recognition*: the extent to which individuals recognize personal vulnerability to stressors and their impact on performance.
- *Work conditions*: the extent to which the organization gives priority to key aspects of their work, such as having time with families and critical reflection.
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# SIGNS OF SAFETY

# Signs of Safety as an example

- ‘What’ worker does with family
- methods
  
- ‘How’ worker does it
  - Expertise
  - Role of organisation in facilitating good practice
  
- Turnell A. & Murphy, T. 2015 *Signs of Safety Comprehensive briefing Paper*, 4<sup>th</sup> Edition.

# Signs of Safety principles underpinning practice:

*Working relationships - to enable honest and respectful discussions of concerns and worries*

*Critical thinking – to minimize error a culture of shared reflective practice and a willingness to admit you may be wrong is needed*

*Based on everyday experience: assessment and safety planning is grounded in the everyday lived experience of the child*

# Methods

- To cover the process of case management
  - Assessment of harm, risk, complicating factors, strengths and protective factors
  - Involving child
  - Involving naturally occurring network
  - Safety plan with specific safety goals
  - Monitoring

# Implementing in England required:

- Reforming managerial oversight and quality assurance
- Development of tailored software to facilitate aligning documentation with SofS
- Developing feedback mechanisms from staff and families
- Embedding culture of on-going learning, sharing practice to enhance expertise
- Explicitly tackling the blame, defensive culture



# DEVELOPING FEEDBACK LOOPS TO LEARN AND ADAPT

# Quality Assurance

- Case audit reflecting Signs of Safety theory of change - collaborative
  - Family feedback on practice and staff feedback on organizational culture and leadership
  - Case trend monitoring with a small set of KPIs already collected
- Measurement sets practice whether intended or not - what counts is what we count

# IMPLICATIONS FOR RESEARCH METHODOLOGY

# Defining the 'it' to study

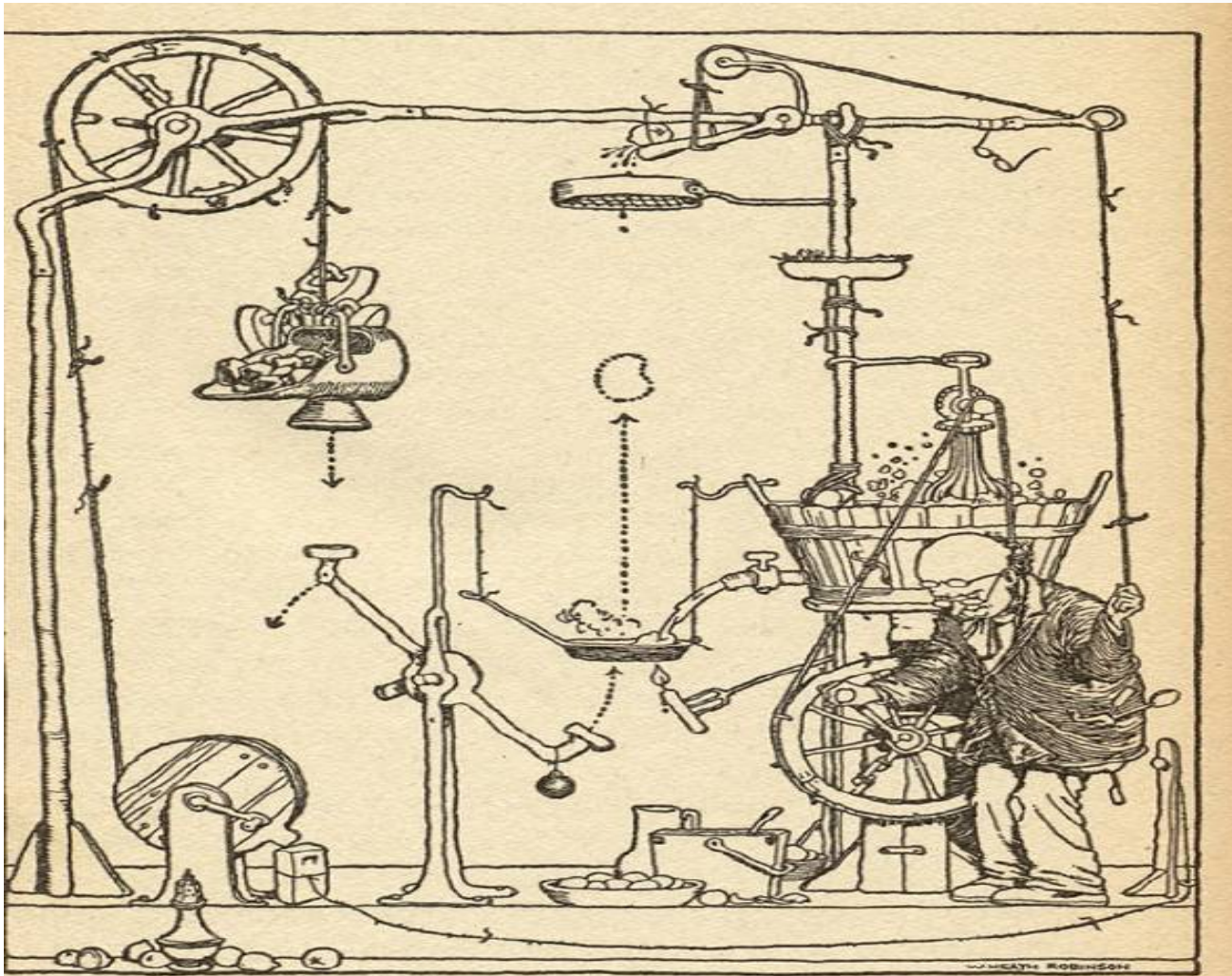
- Measuring whether service users receive the intervention being evaluated
- Enabling others to use the findings
  - external validity
  - what do they need to copy?
  - how can they achieve the same practice?

# The complexity of the causal process

Top down control over-estimates how much you can control the interactions.

Complicated versus complex

Implications for logic models



*The pancake-making machine*



# Difficulty of running an RCT

- What variable do you randomise?
- How long does it take to implement an experimental approach?
- How useful is a 'black box' approach? What can a logic model cover?
- How transferable are findings?



# Alternative ways of making causal claims

- Comparative case analysis
- Comparative dynamic pattern analysis
- Need to ask: ‘for whom, under what work conditions does this intervention have an impact both positive and negative?’
- Having a causal model of how it works and testing it