How do they do that?
*Using Appreciative Enquiry to Develop Safety Culture*

22\textsuperscript{nd} June 2022

NHS England and NHS Improvement
Who are we?

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Declarations

Customs
Nothing to declare
What do we want you to take away from this session?

• Understand the interdependence between safety culture and safety/quality improvement
• Appreciate how the local relational aspects of effective teams can support shifts in safety culture
• How to practically provide support to teams and nurture safety culture
A national maternity safety ambition

2010 - NHS Mandate & Outcomes Framework

2015 – Kirkup Report

2016 – Better Births

2017 – Progress and next steps

2022– Final Ockenden Report

East Kent Report
Nottingham Review

2014 – Five Year Forward View

2015 – National Ambition

2016 – Safer Maternity Care Action Plan

2019

NHS Long Term Plan
A common vision for maternity and neonatal safety

Our collective aim is to make measurable improvements in safety outcomes for women, their babies and families in maternity in neonatal services, as set out in Better Births.

This includes halving the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025 (2010 baseline), with a 20% reduction by 2020.

Also, reducing pre-term births by 25% (2015 baseline) by 2025 by reducing the pre-term birth rate from 8% to 6%.
What is culture?

“The way things are done around here…

…when nobody is watching”
What have we done previously to understand culture?

2017-2019
- 87 organisations
- 16,265 respondents
- 1331 consultants
- 922 junior doctors
- 8149 midwives
- 2021 nurses
- 61% response rate

Measuring safety culture in maternal and neonatal services: using safety culture insight to support quality improvement
What are we doing differently this time?

Insanity: doing the same thing over and over again and expecting different results
- Albert Einstein

FAILRE
SUCCESS
‘It isn’t team work on the fly’

Amy Edmondson. Teaming
What does a positive view of safety culture look like?

Craft, create and nurture the conditions where individuals and teams flourish in the delivery of brilliant care.
How are safety culture and quality improvement related?

- The doing matters, but isn’t everything, how we do things matters
- Culture as a dynamic social construct
- Complex responsive processes of relating

Quality Improvement

Safety Culture
What are the behaviours that support teaming success?

- SPEAKING UP
- COLLABORATION
- EXPERIMENTATION
- REFLECTION

Amy Edmonson. Teaming
What is the role of reflection & team reflexivity?

- When do we reflect on the task and the relational aspects of the work?
- How can we create the space?
  - Structured
  - informal
- What do we talk about?
- How do we talk about it?
- What is the role of leadership?
Now over to you…

Instructions:
• For 7 minutes
• Discuss at your table
• In groups of 2-3

Tasks:
• How does it feel for you to work in your own teams?
• Focus on the relationships and how they feel
Enabling safety culture: development practices across maternity and neonatal services
Who were the research team?

**SAPPHIRE**: Social Science APPlied to Healthcare Improvement REsearch

Principal investigator

Co- investigators

Researchers
What was the background to the research?

Opportunity to understand *how* these scores came into being, *what* these scores represented
What was the aim of the research?

• To explore qualitatively relationships between safety culture, interventions and context

• Research questions:
  – What enabling factors relate to leadership actions attending to safety that provide the basis for safety culture to take root?
  – How does enactment of safety practices reflect and reinforce local safety culture?
  – How do elaborating practices (‘soft’ and formal measures) reinforce safety norms, values and assumptions?
How was the research designed?

14 organisations with high safety scores invited to participate

10 interviews with 13 service leads (3 shared)

Purposively selected 4 organisations for further follow-up; (labour wards (4); antenatal clinic (1); neonatal unit (3))

14 interviews with clinical/safety leads

2 focus groups with doctors, midwives, allied health professionals
What did we find?

Cultural Values

shaping how strategies and interventions work in practice.
What did we find?

• Safety culture represents a dynamic, shifting state of balance
• Rather than thinking about interventions e.g. safety huddles/walk-rounds as solutions, they can be seen as ‘a window on practice’ to see how things are working
• Fidelity of function is as much linked to the supporting social structures as the form of the intervention itself
What did we find?

• In terms of interventions ‘one size does not fit all’ – scope to tailor to own unit

• History (key cultural shifts), organisational identity and team/structural reflexivity all significant (‘slow intervention’)

• Practical toolbox of competencies, materials and meanings
What are the implications for the work?

- Safety culture surveys can be used as a diagnostic entry point
- Use of the identified cultural domains ‘map’ as an interpretive aid
- Ongoing work to develop practical toolbox
How can we apply this in practice? Safety Huddles

**Safety huddles** provide a *window* for us to explore local safety culture values and practices.

**Competencies, meanings and materials** are linked to safety huddle practices and *cultural values shape how they are implemented*.

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**Competencies**

- Knowledge: who brings historic; experiential; subject specific; site specific knowledge to the huddle?
- Experience: who brings leadership; management; clinical, team working; QI experience to the huddle?
- Skills: what skills are needed i.e. reflexivity; problem sensing; collaboration; coordination; translation?

**SAFETY CULTURE VALUES**

- Transparency
- Openness and authenticity
- Respect and compassion
- Passion and commitment
- Staff empowerment
- Attentiveness to staff wellbeing
- Mutuality, trust and dialogue
- Civility
- Collegiality and inclusivity
- Unity, coherence and consistency

**People** – are the right people there in the huddle?

**Protocols, policies, toolkits, guidelines** – how do these shape huddle practices?

**Data** – what data gets shared?

**Communication networks** – what networks are utilised?

**Geography:** what role does unit proximity take? Shared physical spaces?

**Training:** role of multi-disciplinary team training, human factors, leadership?)

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Are there *rules* about the huddle? If so what is their impact?

How do *hierarchies* play out?

What’s *talked about* and what lies under the radar?

What’s *valued* and given social approval?
How can we apply this in practice? **Safety Huddles**

**Importance of social cohesion**

‘that’s what I notice a kind of inclusive atmosphere. If I’m at a huddle where there’s a really good turnout and people are joining in, and even there’s little bit of banter, you know, that friendly kind of chit-chat. That feels like a safer ward than one where everyone’s kind of on-edge, standing nervously by the person that’s in charge’  
[Scoping interview 2]
Now over to you…

Instructions:
• For 10 minutes
• Discuss at your table
• In groups of 2-3

Tasks:
• Do you use safety huddles in your teams and organisations?
• Why did you implement them?
• Reflect on how this window lets you see how your teams are working?
How can we ensure sustainability?

Not everything that counts can be counted, and not everything that can be counted counts.

Albert Einstein

THE ART OF CONVERSATION
Did we manage to fulfil our ambition for the session?

- Understand the interdependence between safety culture and safety/quality improvement
- Appreciate how the local relational aspects of effective teams can support shifts in safety culture
- How to practically provide support to teams and nurture safety culture
Thank you

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