How do they do that?

Using Appreciative Enquiry to Develop Safety Culture

22nd June 2022

NHS England and NHS Improvement

Who are we?

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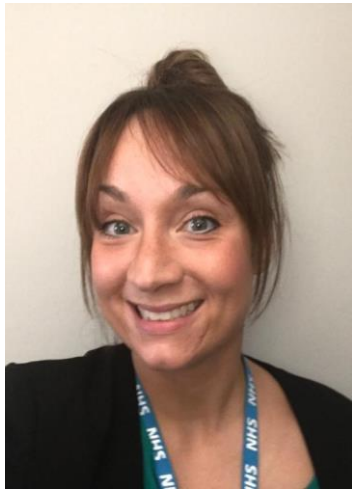
Clinical Advisor for National Maternity and Neonatal Safety Improvement Programme

NHS England & Improvement

Nicola Mackintosh

Associate Professor in Social Science applied to Health

SAPPHIRE group, University of Leicester, UK



Becky Wilson-Crellin

Clinical Lead, Culture and Leadership., Maternity Transformation Programme

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Clinical Advisor on Safety Culture for National Safety Improvement Programmes

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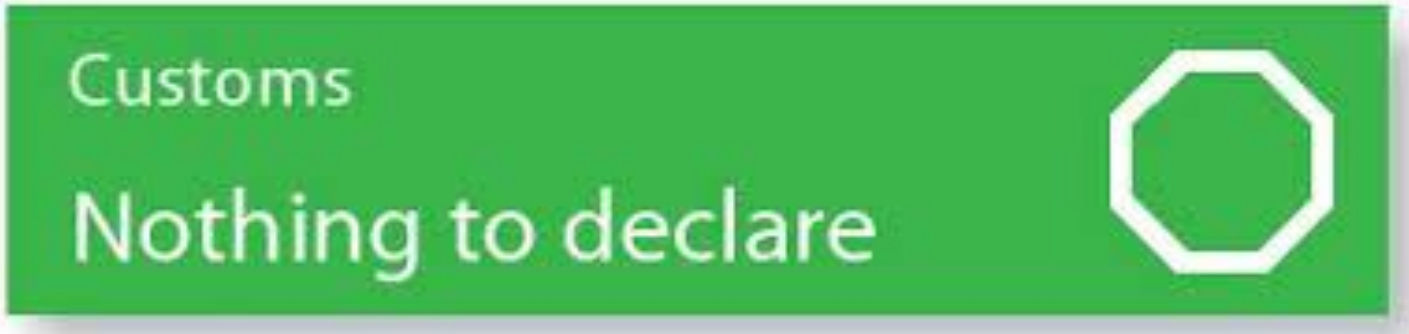
Declarations

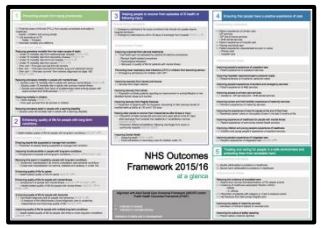


What do we want you to take away from this session?

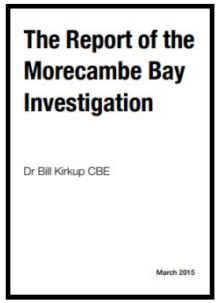
- Understand the interdependence between safety culture and safety/quality improvement
- Appreciate how the local relational aspects of effective teams can support shifts in safety culture
- How to practically provide support to teams and nurture safety culture

A national maternity safety ambition

2010 - NHS Mandate & Outcomes Framework



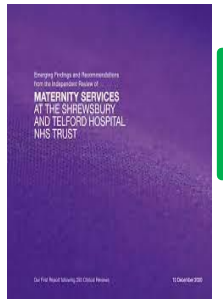
2015 – Kirkup Report



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

NHS Long Term Plan

2019

A common vision for maternity and neonatal safety

CMidO Office

Maternity Transformation Programme

MatNeoSIP

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%.

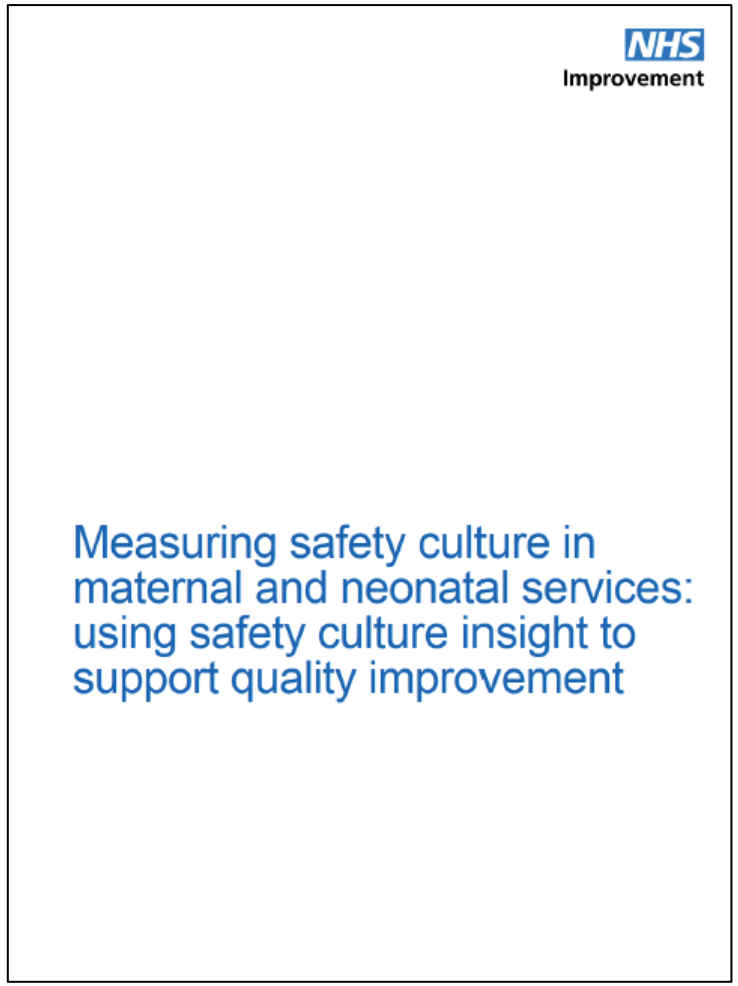
What is culture?

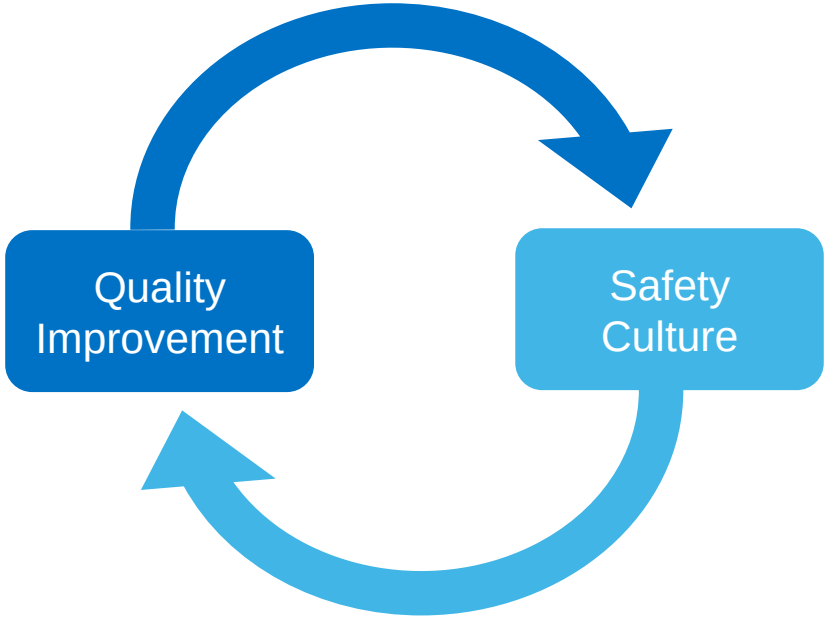
“The way things are done around here…

…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





What are we doing differently this time?

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

-Albert Einstein

Team vs Teaming

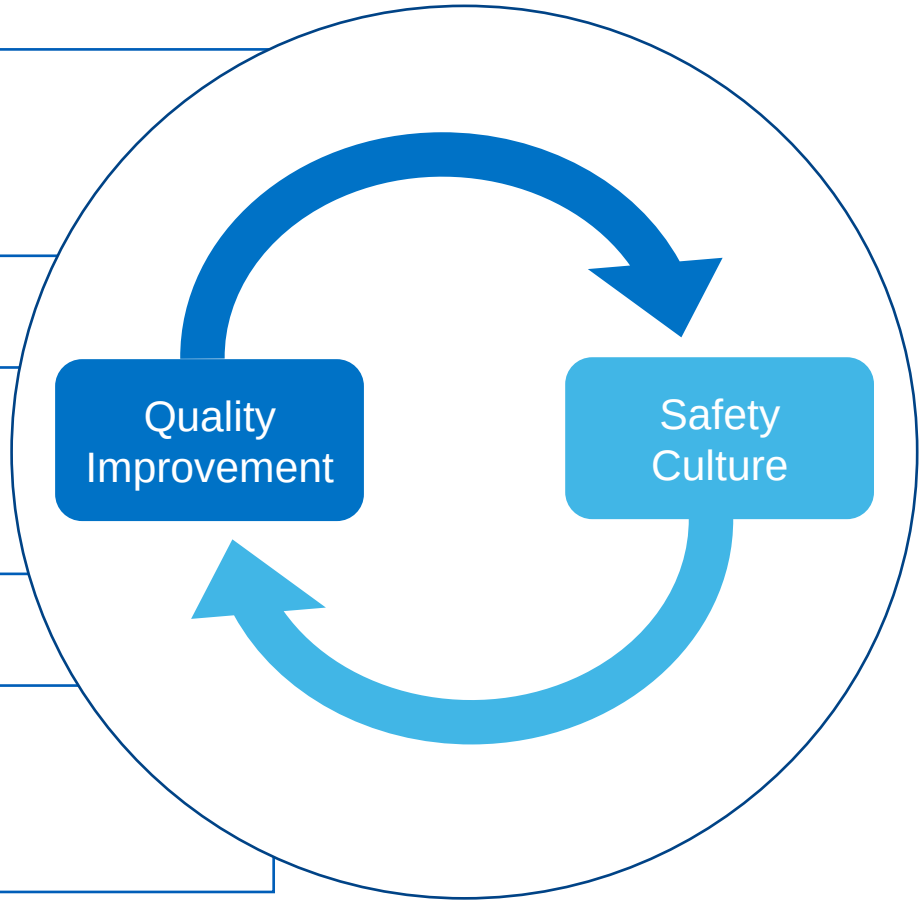
‘It isn’t team work on the fly’

Amy Edmondson. Teaming

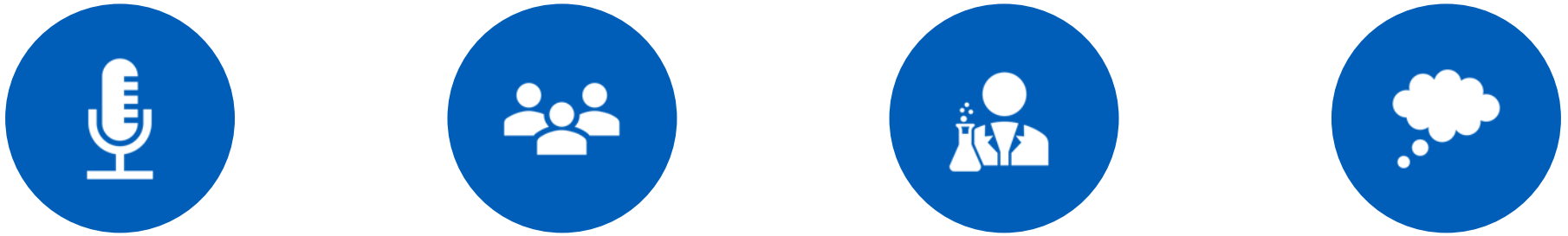
What does a positive view of safety culture look like?

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



What are the behaviours that support teaming success?



SPEAKING UP

COLLABORATION

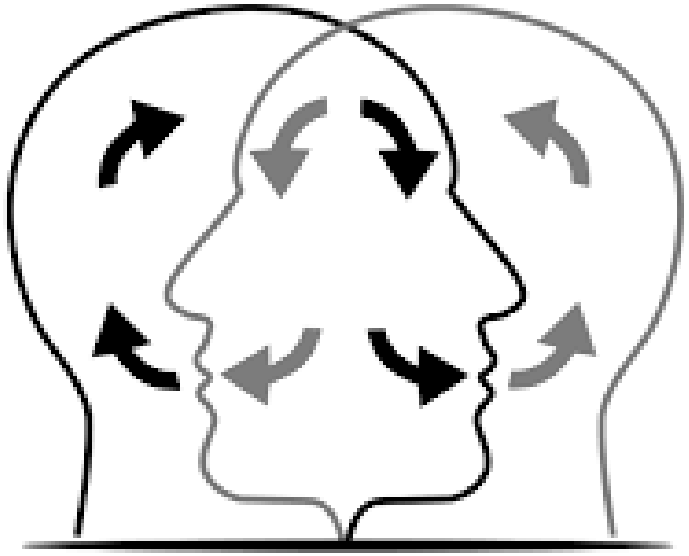
EXPERIMENTATION

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?

SAFETY CULTURE SURVEY:
QUESTIONNAIRE

Instructions:

This survey has been developed to assess the attitude towards safety within this organisation and, if necessary, what we can do to improve it. All results will be combined for analysis and no individual results will be kept. Remember – we are not looking for right or wrong answers. We want to know what your thoughts are about the safety culture of this organisation.

Please tick ONE box only for each question.

Worker?	☐
Supervisor?	☐

Training and supervision

Question 1:	We all get induction training when we start	☐
	Not everyone gets induction training when they start	☐
	We don't get induction training when we start	☐
Question 2:	We all get trained in safe work procedures* for our jobs	☐
	Some people miss out on safe work procedures* training for their jobs	☐
	We don't get trained in safe work procedures* for our jobs	☐
Question 3:	Our manager/supervisor makes sure we can do the work safely	☐
	Our manager/supervisor sometimes checks we can do the job safely	☐
	No one checks if you can do the job safely	☐
Question 4:	We are always made aware of safety issues	☐
	Mostly someone makes us aware of safety issues	☐
	We are not made aware of safety issues	☐

*A 'safe work procedure' is a list of the steps of a job or activity, the safety risks for these steps and instructions on how to remove or reduce the risks. These are also sometimes called 'safe operating procedures'.

There are other ways to document how you deal with risks in the workplace. You might use a safe work method statement (SWMS) or a job safety analysis (JSA). If appropriate, replace 'safe work procedure' with the method your company uses.

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

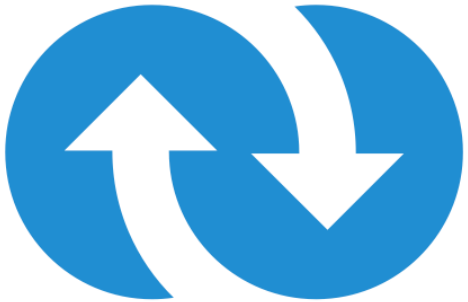
2 focus groups with doctors, midwives, allied health professionals

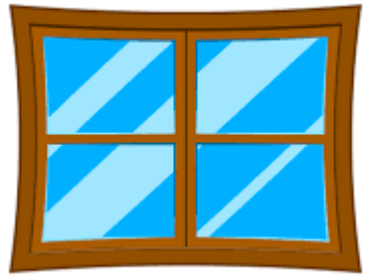
What did we find?

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

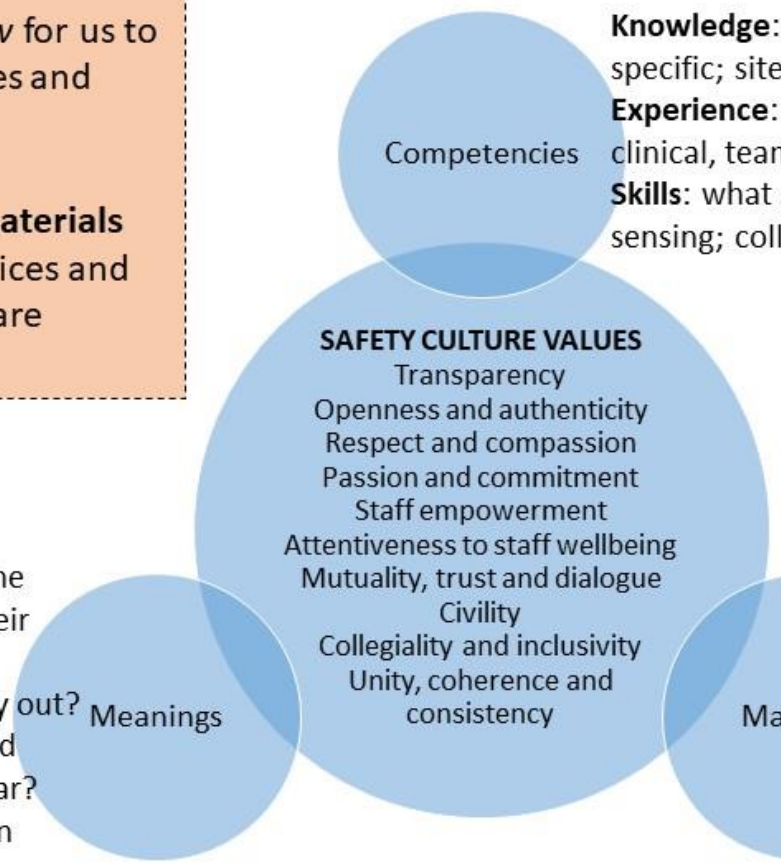
What are the implications for the work?

- 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



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?

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?

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)?

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…

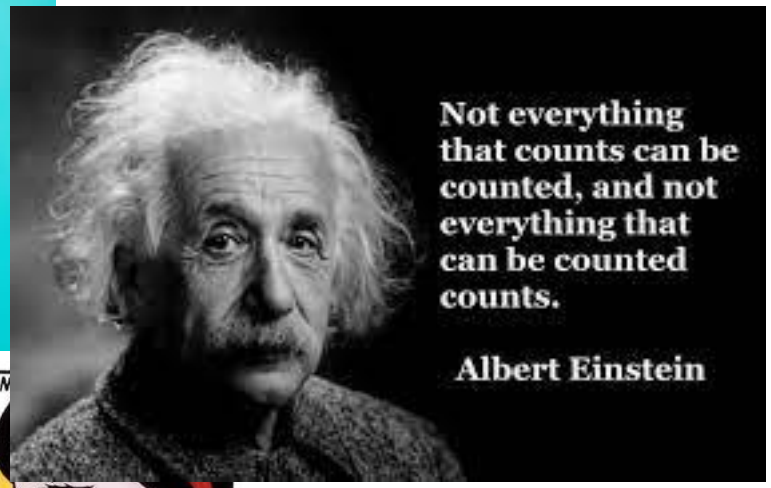
Instructions:

- 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?



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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