NHS Confederation

The Role of Human Factors & Leadership approaches in Improving the Mental Health Service & Emergency Department Interface

Learning Session 3

24th Sept 2025

Mental Health Improvement Support Team

Improving mental health care through hands-on, multi-specialist support to systems

Welcome to the collaborative

House keeping

Recorded	Timing	Behaviours	Group work	Questions	Be present	Breaks
						

Our aim

To help support partnership working across acute and mental health services to *start to* improve cross system working by supporting practical, real-time testing of improvement ideas across these boundaries.

Expectations

For us

- We are facilitators supporting your learning
- Support culture, improvement & connections
- Keep teams on track & ask curious questions

For you

- You are the experts with the answers
- Listen, reflect and contribute
- What you put in is what you get out: be committed

Session 1: 21st May 2025, 10-12:30pm **Understanding the problem**	Session 2: 23rd July 2025, 1:30-4pm **Measurement, and scoping out ideas**	Session 3: 24th Sept 2025, 9:30-12:30pm **Human factors and behavioural change**	Session 4: 26th Nov 2025, 1-4pm **Testing out improvement ideas**	Session 5: 28th Jan 2026, 9:30-12:30pm **On-going testing & sustainability**	Session 6: 29th Apr 2026, 1-4pm **Recognition, spread & sharing**
• Defining your aim, purpose and "why" • Tools to use to scope out problem further • How to evidence the problem • Who needs to be involved – stakeholders • Patient first focus – not just targets, patients lives and experience • Addressing Mental Health Stigma	• Measurement for improvement • Data collection • Understanding and presenting data • Driver diagram • Tools to identify change ideas • Examples of change ideas • Understanding unintended consequences along the pathway	• Applying leadership principles to improve collaboration • Leadership & delivering successful change • Strategies for shifting mindsets and fostering adaptability • Strategies for improving the interface • Addressing mental health stigma	• Small scale testing • Improvement models • Plan-Do-Study-Act • Ongoing measurement	• Change ideas evaluation • Reflections and learning • Sustainability factors • Ongoing innovations and data for improvement	• Recognition of your progress – sharing learning • Critical reflection and analysis • Creating your spread plan • Revisit sustainability factors
Action learning period 1: Scope out your problem in your local setting ***Webinar 1: Understanding Health Inequalities 18th June 2025, 11-12:30pm***	**Action learning period 2:** Understand your data and gather as many change ideas as possible ***Buddy team check-in***	**Action learning period 3:** Discuss, share and learn about how behaviours are key to making change stick ***Webinar 2: Leading through change 22nd Oct 2025, 11-12:30pm***	**Action learning period 4:** Test out ideas in practice and experiment changes ***Buddy team check-in***	**Action learning period 5:** Continue to test and understand your assurance systems ***Webinar 3: People's Choice 25th Mar 2026, 11-12:30pm***	**Action learning period 6:** Commit to the on-going journey and how to spread wider ***Celebration event***

Team profiles

Team 1: Swindon, South West - *Great Western Hospitals NHS FoundationTrust and Avon and Wiltshire Mental Health Partnership NHS Trust*

Team 2: Bedfordshire, East of England - *Bedfordshire Hospitals NHS Foundation Trust and East London NHS FT*

Team 3: Berkshire, South East - *Royal Berkshire NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust*

Team 4: Birmingham - West Midlands - *Birmingham Women's and Children's NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust*

Team 5: Cheshire and Wirral – North West - *Arrowe Park Hospital NHS Trust and Cheshire and Wirral Partnership NHS FT*

Team 6: Dorset, South West - *University Hospitals Dorset NHS Foundation Trust and Dorset HealthCare NHS Foundation Trust*

Team 7: Essex – East of England - *East Suffolk and North Essex NHS Foundation Trust and Essex Partnership NHS Foundation Trust*

Team 8: London - *Guys and St Thomas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust*

Team 9: Coventry & Warwickshire – *Coventry and Warwickshire Partnership Trust and University Hospital Coventry and Warwickshire NHS Trust*

Team 10: Kent & Medway – South East - *Maidstone & Tonbridge Wells NHS Trust and North East London Foundation Trust*

Team 11: Surrey Heartlands – South East - *Royal Surrey County Hospital NHS Foundation Trust, Ashford and St Peters Hospitals Foundation Trust and Surrey and Borders Partnership NHS Foundation Trust*

Team 12: Yorkshire – North East - *Mid Yorkshire Teaching NHS Trust and South West Yorkshire Partnership NHS FT*

The Role of Human Factors & Behavioural Change in Improving the Mental Health Service & Emergency Department Interface - Learning Session 3

Duration	Item	Leading
0930-1000 30 mins	Welcome / Learning objectives Psychological safety contracting / Checking-in on progress - Buddy teams	EF / AS / ES
1000-1030 30 mins	**Part 1:** Introduction to Human factors at MH/ED interface - Why now? Understanding Compassionate Leadership - Maureen Banda - 'Compassionate Leadership within Mental Health'	ES MB
1030-1045 15 mins	**Speaker** - Cherry Lumley (Senior Practitioner - Critical Care / Human Factors Lead - Oxford University Hospitals NHS Trust) Real-world application of Human factors (15 mins presentation / 5 mins Q&A)	CL
1045-1050 5 mins	Discussion & Question time (Human Factors & Leadership)	ES
1050-1105	Break	
1105 -1125 20 mins	**Part 2:** Complex environments, behavioural & mindset change.	ES
1125-1200 35 mins	**Group Exercise** Behavioural leadership approaches to our challenges	ES / EF
1200-1210 10 mins	**Summary** Review of session	ES
1210-1220 10 mins	Team reflection time and change ideas exploration	EF / AS
1220 – 1230 10 mins	Close	EF / AS / ES

Some fundamentals...

Active listening

Listen to learn/understand – not to respond. Be present & make sense of the stories/experiences

Be kind

Be welcoming, make others relax and open-up. Treat each other with respect and be supportive

Be patient

Many people are struggling. Be patient with progress and engagement. It takes time

Facilitate

Don’t dictate or try to solve everything. Help people to reflect and think deeply about the issue

Build Trust

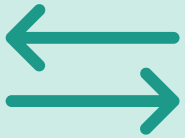
Be authentic, honest and consistent. Get to know people and be helpful

Be curious

Ask questions, think “what if,” embrace the unknown, & look in different directions

Be flexible

Be open minded, don’t be afraid to change direction, learn from mistakes



Be appreciative

Recognize good work people are doing, praise others, be positive, make others feel valued

Progress check-in: Teams Poll

On a scale of 1 – 5 (5 being high/positive):

Q1: Since the programme started, how much progress do you feel like you've made as a team?

Q2: Is the offer of the handouts and facilitator's support helpful?

Q3: How much has your confidence/belief/knowledge in carrying out improvement grown?

15 mins

Buddy team check-in

5 minutes each: share your driver diagrams/project updates with your buddy team, and allow 2-3 minutes for questions after sharing updates.

Then swap roles as teams and listen to the other team pitch and the other team provide feedback

Emma Spencer

MSc Emergency Medicine

Leadership Development Manager
NHS Confederation

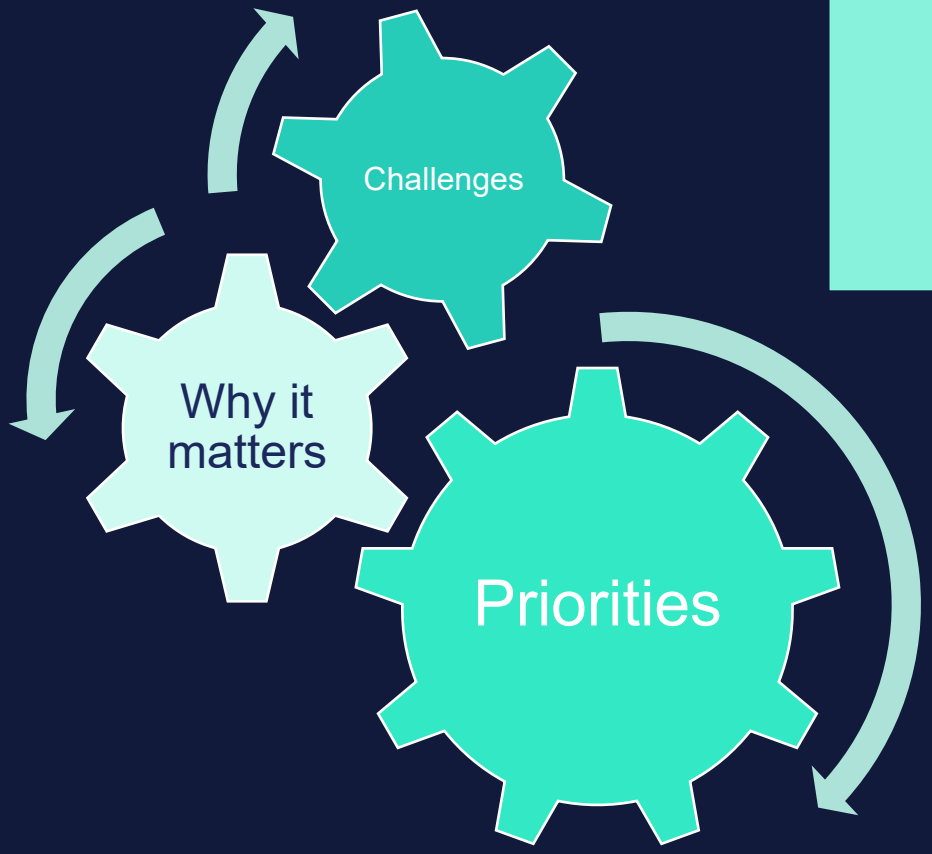
Ice breaker

(Answers in chat)

What is the most adventurous thing you have ever done?

Why now? - Collaboration at the interface

The need for improved collaboration & supporting delivery of care



Identifying the challenges

Why it matters

Priorities

Please share comments, questions, and reflections in the chat throughout.

Session 3 - Workshop Aim

To explore human factors, leadership strategies, and behavioural change tools to improve collaborative partnerships.

Objectives

1. Understand the impact of human factors on patient care and staff well-being in both Mental Health Services and Emergency Departments.

2. Explore strategies to incorporate systems thinking and human factors to improve collaboration and patient outcomes.

3. Identify challenges and opportunities in system integration, communication, and coordination between these services.

4. Share leadership insights on identifying barriers and improving team dynamics across systems.

Introduction to Human factors

Human Factors

=

People 👤 + Systems ⚙️ + Environment 🌍

=

→ Performance, Safety & Teamwork

1. Encourage teams to see the system as **people + processes + environment**.
2. Focus on **designing work for human capabilities**, reducing errors and stress.
3. Promote **shared mental models, situational awareness, and communication strategies**.

The Role of Human Factors in Leadership

Communication

- Clear, concise, and effective communication is critical in reducing errors and improving patient care.

Teamwork

- Collaborative efforts across disciplines require understanding of roles, shared decision-making, and mutual respect.

Decision-Making

- Leaders must be able to make informed, quick decisions while considering the input and well-being of their team members /patients.

Approach to understanding Human Factors

The CIEHF's *Human Factors in Health & Social Care* White Paper has a tiered system for the levels of HF understanding.

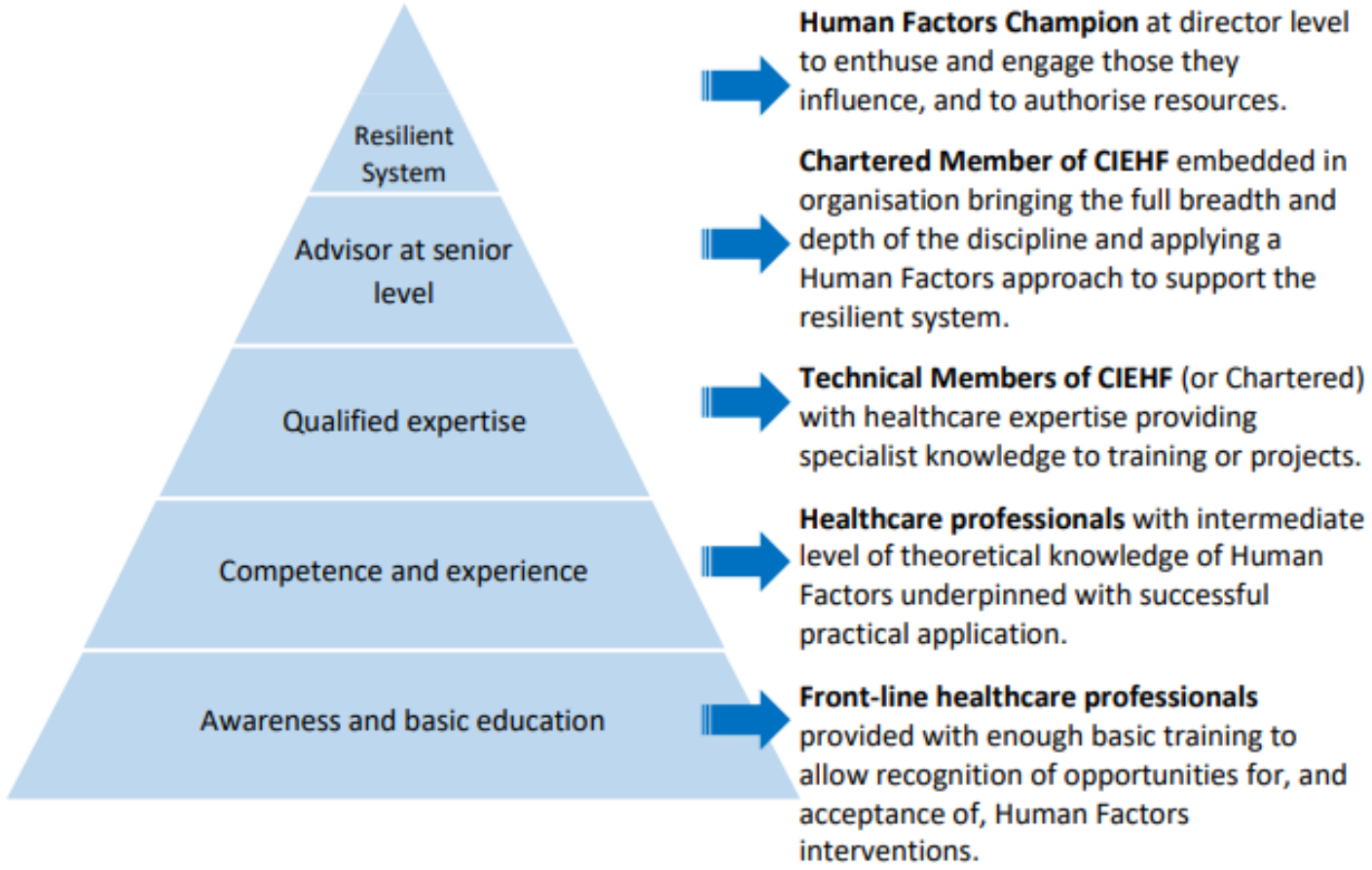
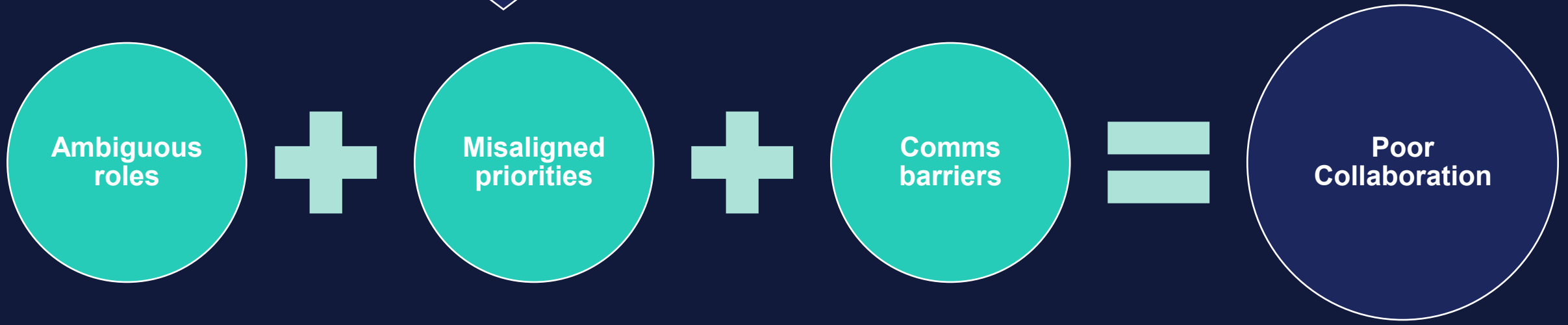


Figure 1: Attaining competence and capacity in healthcare

The need for HF in improving collaboration & supporting delivery of care

ED teams face **high-pressure, unpredictable situations.**

Mental Health Service teams navigate **complex patient health & social care needs.**



Part 1

Human Factors & Compassionate Leadership

- Introduction to *Our Leadership Way* (NHS England) and *Compassionate Leadership* (Michael West).
- The importance of psychological safety in fostering change.
- Highlight the aspects of Human factors in leadership: communication, teamwork, and decision-making.

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Understanding ‘Our Leadership Way’ & ‘Compassionate Leadership’

What is "Our Leadership Way"?

Inclusive Leadership

Ensures everyone’s voice is heard, building an environment of mutual respect and equity.

Collaborative Leadership

Encourages leaders from different teams to work together for the common goal of better patient care.

Supportive Leadership

Leaders who guide and mentor their teams, ensuring everyone has the tools and resources they need.

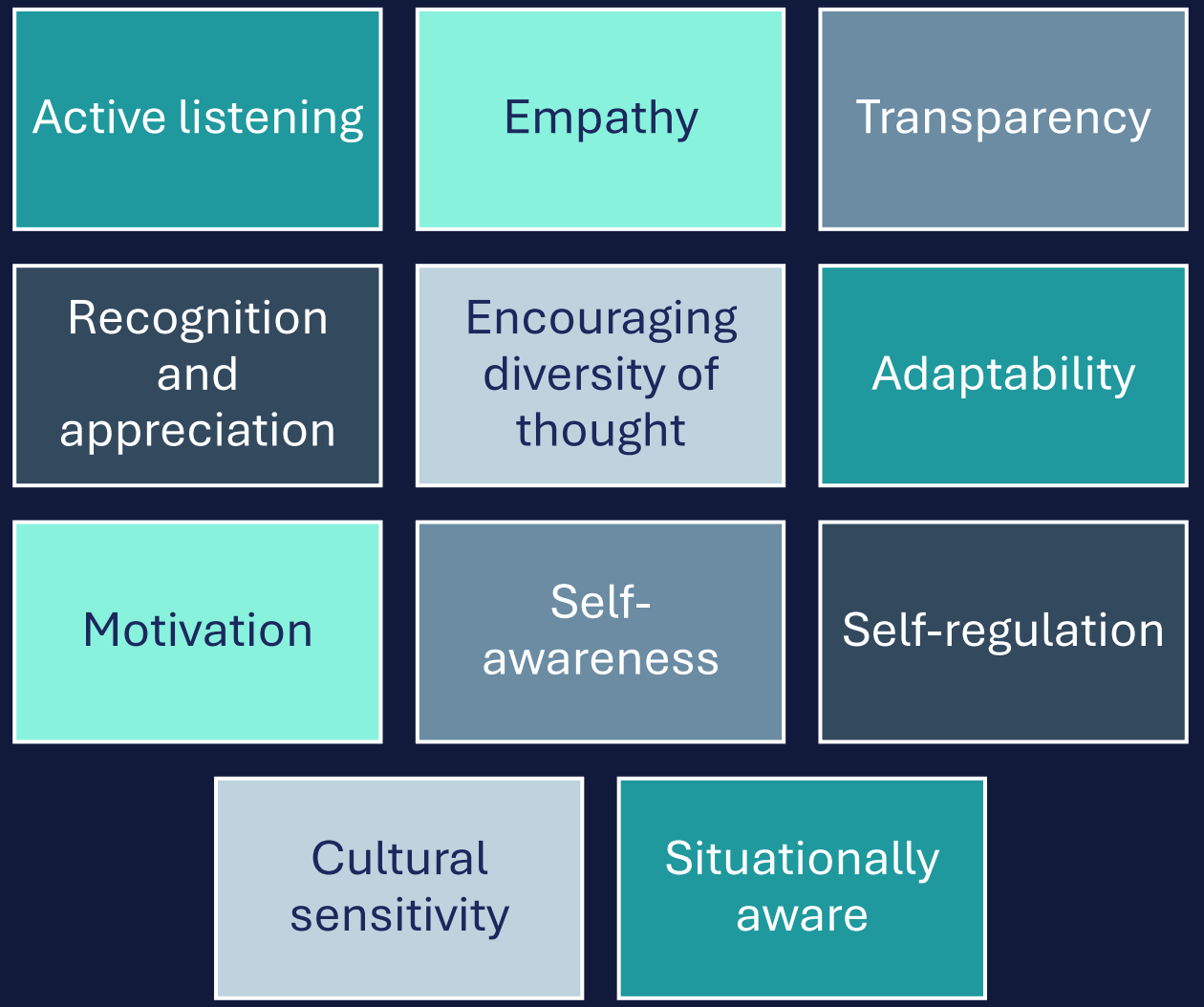
Compassionate Leadership

Prioritises empathy and emotional intelligence in leadership interactions.

Question

Answers in the chat

What leadership behaviours have you seen make a real difference to culture and collaborative working?



Compassionate Leadership in Action

Improving patient outcomes through teamwork and human-centred leadership

Compassionate leadership is about recognising and responding to the needs, challenges, and contributions of team members, while fostering psychological safety, trust, and shared purpose'.

- Michael West, 2017.

Attend	Understand	Respond	Reflect
Paying attention to people's experiences and needs.	Actively listening and showing empathy.	Taking meaningful action to support others.	Learning from experiences to improve future interactions.

Micheal West - Compassionate Leadership

Applying Compassionate Leadership to Team Collaboration

The Role of Psychological Safety in Healthcare Change

What is Psychological Safety?

An environment where team members feel safe to take risks, speak up, and make mistakes without fear of judgment or retribution.

"A belief that one will not be penalized or humiliated for speaking up with ideas, questions, concerns, or mistakes" - **Amy Edmondson (1999)**

Personal actions

Enabling Safe and Innovative Collaboration

Bass, B.M. and Riggio, R.E., 2006. *Transformational leadership.* 2nd ed. Mahwah, NJ: Lawrence Erlbaum Associates.

Heifetz, R.A., Grashow, A. and Linsky, M., 2009. *The practice of adaptive leadership: Tools and tactics for changing your organization and the world.* Boston, MA: Harvard Business Press.

Maureen Banda
Mental Health System Improvement Advisor
National Mental Health Improvement Support Team (MHIST)

Come and be well in my Presence

LABELS –Personality Disorder, Drug Addict, High Intensity User, Autism, Queer/Trans, Complex PTSD

"They don't like us. They think oh you're on drugs and you're going to die anyway so there's no point helping you. Or they think you are just going to abuse any help you're going to get".

"So just be aware of how to speak to people, always try and treat them with as much respect as you'd like back, they're still human".

"I took it as - you don't give a shit. They are saying "can't you tell us about your past history?" I told them "well haven't you read it? … And he goes "well I'd like to hear it from you"

"I was once on a ward where I was feeling suicidal. There was also another lady on the ward, and we were treated completely differently purely because of our labels. the other lady was bipolar so she was told she was a danger to herself, and she would be put on obs. Then they turned to me and said you are PD there is the door it's your choice."

The Everything Else Drawer

Its where we put:

- **Trauma we don’t want to name**
- **Neurodivergence we don’t understand**
- **Suffering that won’t conform**

Either way most professionals will be horrid to you or not deem you ‘worthy of care’ - EVEN if you’ve been incorrectly diagnosed!!!!

The Treatment Shield

A systemic defense mechanism that:

- Repeats the idea of deserving and undeserving victims
- Creates a filter where emotion is seen suspiciously
- Shuts down curiosity
- Protects staff from confronting painful realities

These aren't fringe beliefs. They show up in notes, handovers, care planning meetings, and protocols. They become scripts that justify distance and disdain.

Reframing

Myths about control and credibility

The Myth	The Reality
"They're manipulative"	People are using survival strategies from environments where direct communication was unsafe
"They're splitting the team"	The team has unresolved differences in approach and/or none of us would confide equally to everyone and/or trust has been dangerous
"They're attention-seeking"	Connection is a basic human need, not a symptom. Relational contact is the curative for relational trauma.

[Ref Wren has done excellent work amongst others on myths and BPD Aves, 2023]

Reframing

Myths about Attachment & Risk

The Myth	The Reality
"Too attached to one nurse"	Selective trust is how healing begins. cPTSD one attachment outside betrayal trauma is prognostically often the difference that makes a difference. Ditto pairing if neurodivergent.
"Never want to leave"	Fear of inadequate support post-discharge
"Don't really want to die"	8-10% of people with BPD diagnoses die by suicide. Ambivalence about suicide is near universal across diagnoses.

Reframing

Myths about Capacity & Help-Seeking

The Myth	The Reality
"They've got capacity"	Understanding ≠ safety. Nearly everyone who has to mask whether ND / traumaticised / Queer etc will have different thinking and emotional capabilities in different self-states.
"Too articulate to be unwell"	Communication masks pain; doesn't eliminate it. Hyper-rationality is a defence system that can signal elevated risk especially if ND or traumaticised.
"Just need to use therapy skills"	Skills often don’t work during nervous system overwhelm. They are not a cure-all and can be the opposite of what needed e.g. if not neuroaffirmateivly redesigned.

Narrative Humility & Dignifying

Practice small acts of validation

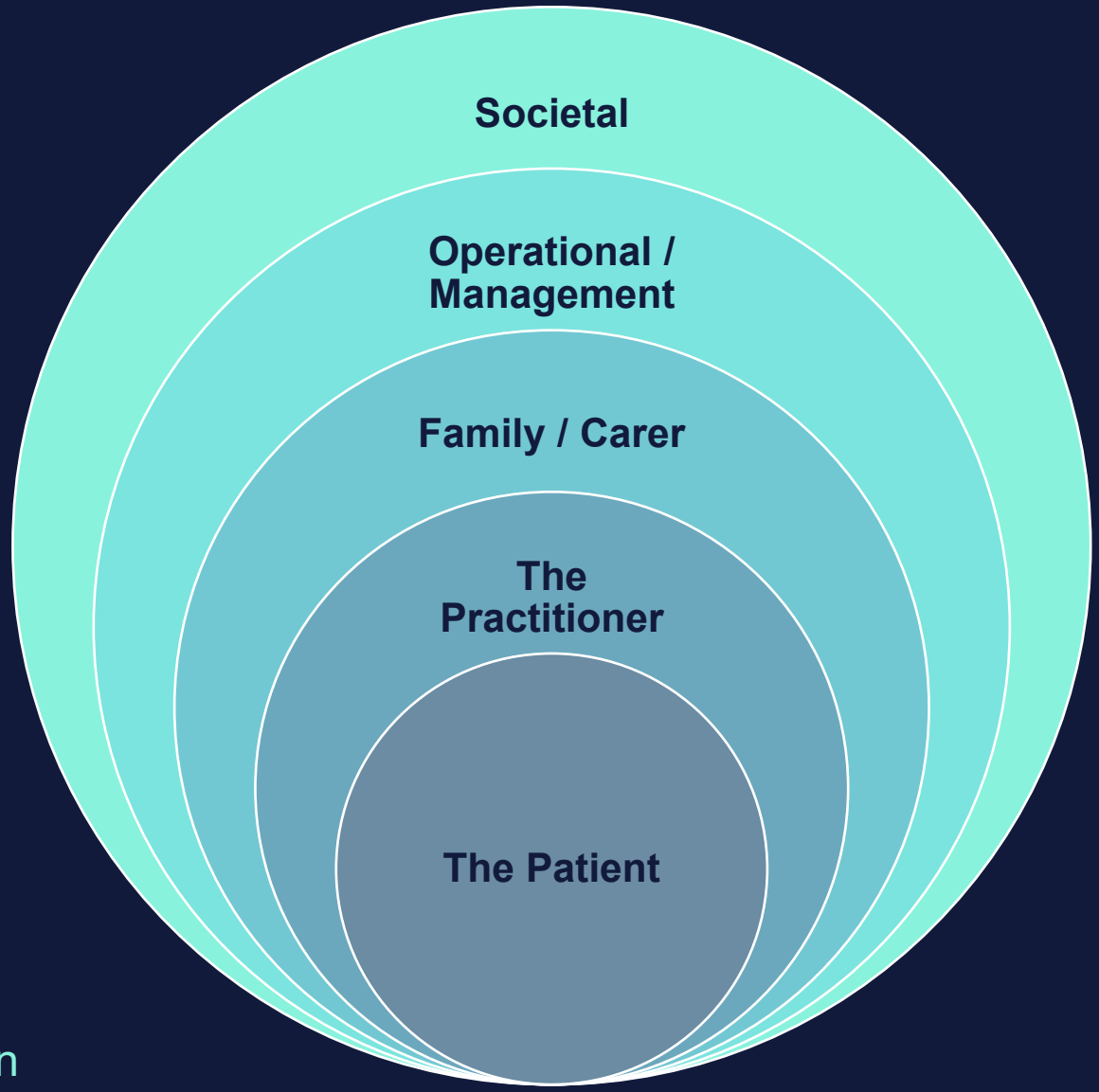
Focus on "being with" rather than "doing to"

Acknowledge limitations of our understanding

Recognize that connection itself is healing

Experiences & Perspectives
- The Patient's Perspective

There are multiple perspectives.
Let's hear the patient's experience.



Ian Callaghan
Lived Experience Programme Manager
Rethink Mental Illness

'Mental Health for All' (MH-ALL) Fellow
NIHR ARC North Thames at University College London

Key Takeaways

1. Strengthening the collaboration is crucial for improving patient care, staff satisfaction, and overall team dynamics.

2. Developing our leadership behaviours will aid in building effective teams, who feel safe to adapt and innovate new ways of working.

3. By embracing principles from "Our Leadership Way" and "Compassionate Leadership," we can break down barriers and create more effective and empathetic teams.

Break Time

Welcome back

Cherry Lumley

MSc Human Factors

Oxford Critical Care Clinical Governance Nursing Lead

Real-world application of Human Factors

Oxford University Hospitals NHS Foundation Trust

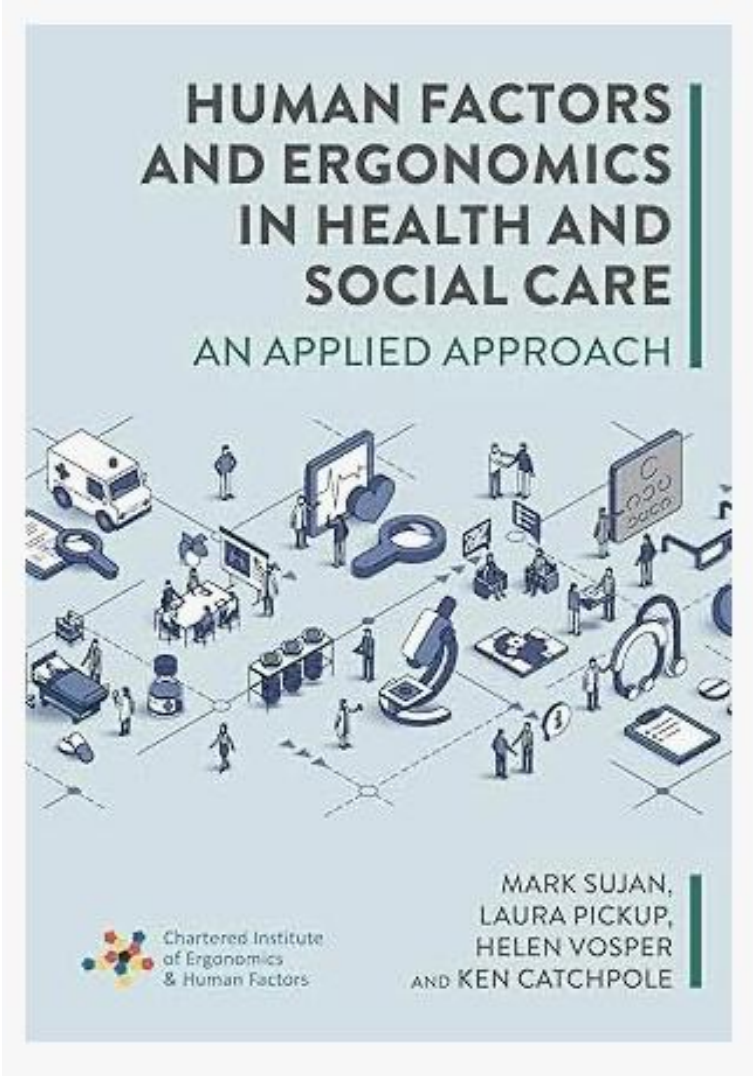
Human Factors/Ergonomics (HF/E)

"Ergonomics is the scientific discipline concerned with the **understanding of interactions** among humans and other elements of a system, and the **profession** that applies theory, principles, data, and methods to **design in order to optimise human well-being and overall system** performance."

- The International Ergonomics Association

Simply put

*HF/E applies the **principles of design** to optimise the equipment, environments, and tasks to* **make it easier for people and organisations to do the right thing efficiently**, *make it hard to do the wrong thing, and ideally, make it impossible to do anything that may cause harm.*

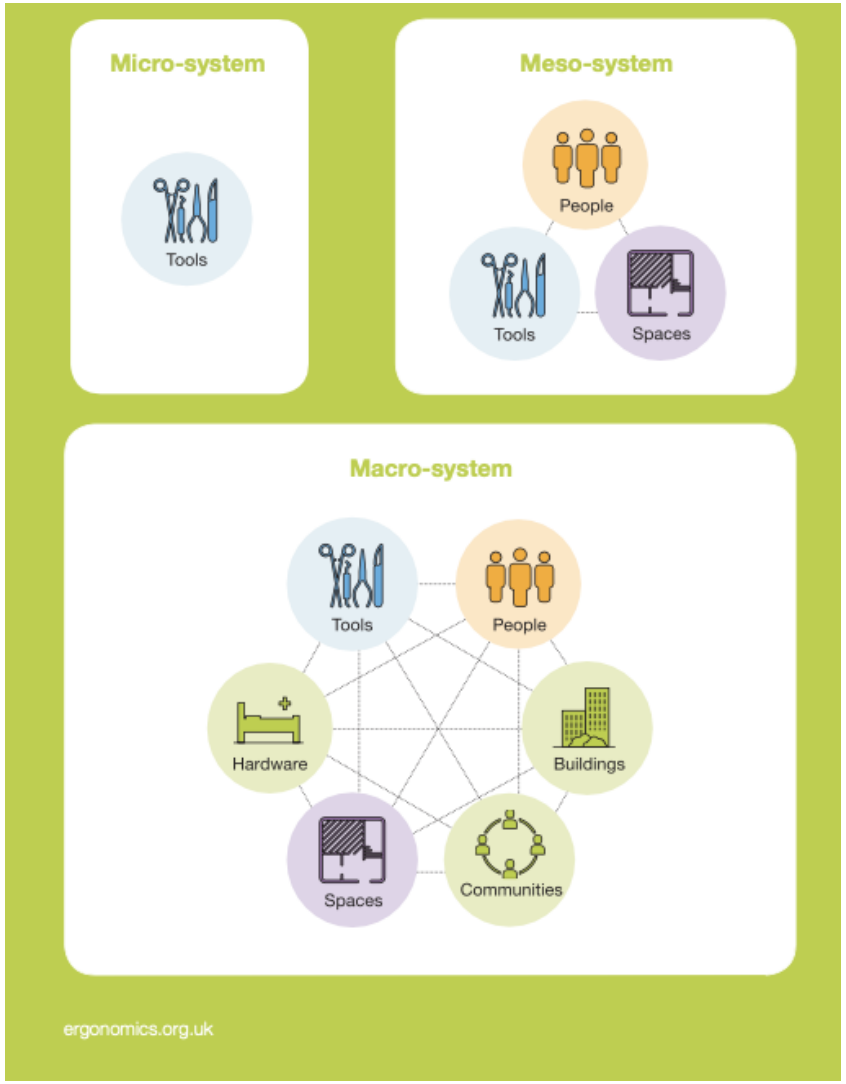


- Sujan, et. al., 2025

Systems Approach

Systems = set of inter-related activities or entities

- Links between these activities and entities =+/- change both the state and interactions in the system within a given set of circumstances and events.
- Systems will range from individuals performing single tasks or using a tool (a micro-system), through to people working as part of a team (a meso-system), and on through to complex socio- technical systems (a macro-system).



- CIEHF, 2018

SEIPS Explained

- SEIPS is the Safety Engineering Initiative for Patient Safety.
- It is based on a Human Factors systems approach to understanding care systems, processes and outcomes to inform better design and improvement.
- SEIPS can be used by anyone as a general systems analysis and problem-solving tool e.g. incident investigation; hazard identification; incident reporting & data collection; simulation design; protocol & checklist development; research design and data analysis..

Guiding Step

1. **As a team, use the worksheet as a prompt to highlight the system-wide factors that contribute to the issue at hand**
2. **Seek to understand how these factors influence processes and interact to produce outcomes (wanted or unwanted)**
3. **Link this new knowledge to making improvement recommendations**

Examples of Work System Descriptors

Person Factors

e.g. Physical, psychological capabilities, limitations and impacts (frustration, stress, fatigue, burnout, musculoskeletal, satisfaction, enjoyment, experiences, job control); personality or social issues; cognitive ; competence, skills, knowledge, attitudes; risk perception; training issues; personal needs and preferences; psychological safety; performance variability; personal goals; adaptation to work conditions.

Care team e.g. roles, support, communication, collaboration, supervision, management, leadership

Patient/client e.g. complexity of clinical condition, physical, social, psychological, relationship factors

Others e.g. families and carers, and other health and social services colleagues

Tools & Technology

e.g. design interaction and device usability issues; familiarity; positioning, accessibility; availability; access; mobility; operational /calibrated /maintained; device usability; various IT design issues.

Task Factors

Specific actions within larger work processes, includes task attributes such as:

- level of task difficulty /complexity;
- time taken;
- hazardous nature;
- variety of tasks;
- sequencing of tasks
- workload, time pressure, cognitive load,

Physical Environment

e.g. Layout; noise; lighting; vibration; temperature; humidity and air quality; design of immediate workspace or physical environment layout; location; size; clutter; cleanliness; standardisation, aesthetics; crowding

External Influences

e.g. Societal, government, cultural, accreditation and regulatory influences e.g. funding, national policies and targets, professional bodies, regulatory demands, legislation and legal influences, other risks and influences

Organisation of Work Factors

e.g. Structures external to a person (but often put in place by people) that organise time, space, resources, and activity.

Within institutions:

- Work schedules/staffing
- Workload assignment
- Management and incentive systems
- Organisational / safety culture (values, commitment, transparency)
- Training
- Policies/procedures
- Resource availability and recruitment

In other settings:

- Communication
- Infrastructure
- Living arrangements
- Family roles and responsibilities
- Work and life schedules
- Financial and health-related resources

Outcomes

Outcomes – System Performance

e.g. Safety; productivity; resilience; efficiency; effectiveness; care quality

Outcomes – Human Wellbeing

e.g. Health and safety; patient satisfaction and experience; enjoyment; staff turnover; staff welfare; job satisfaction

Areas of application of Human Factors/Ergonomics

Incident Management: Medicines Safety

QIP: Systems Approach Meeting (SAM) - Safety Huddle

Risk Assessment

Incident Management

1. HF/E – analyse the working conditions and explain how they may have influenced the **work capacity and behaviour of employees at the time the accident took place** and analyse how the work capacities and behaviour of employees might have **influenced the safety of the system**

2. Generate **safety recommendations** and not apportion blame or to obtain evidence against individuals

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- **Compassionate engagement** and involvement of those affected by patient safety incidents
- Application of a **range of system-based approached to learning** from patient safety incidents
- **Considered and proportionate responses** to patient safety incidents
- **Supportive oversight** focused on strengthening response system functioning and improvement

- Bridger, 2021; PSIRF, 2025

Incident Management: Medicines

HF/E Science
- Thematic Analysis
- SEIPS
- Hierarchical Task Analysis (HTA)
- WAI vs WAD – policy review + link analysis
- Actor Map analysis

MDT involvement in systems approach to Medication Management in OCC.

A multi-disciplinary Human Factors approach to medicines safety threats in Oxford Critical Care

Cherry Lumley, Daniele Giudici,
Elizabeth James, Lily Shaw, Laura Vincent
Oxford University Hospitals NHS Foundation Trust

Introduction

The introduction of the Patient Safety Incident Response Framework in 2022 demonstrates a significant cultural shift in the NHS acceptance of a systems approach to managing patient safety (1).
In recent years, an increase in near-miss medication-related incidents was observed within Oxford Critical Care (OCC) with potential catastrophic outcomes. This coincided with a surge in recruitment of new staff, dilution of senior nursing support due to resignation and high sickness levels. Recognising the compromise to patient and staff safety, a Human Factors (HF), systems analysis of medication incidents was initiated, to understand how the domains of the work system interact and to identify a strategy for improvement through a systematic and scientific methodology (2).

Objectives
Use HF methods and maximise on the skills and knowledge of representatives from the MDT, to analyse medication management within OCC and generate recommendations to optimise patient safety, staff well-being and overall system performance (3).

Methodology

Human Factors methods used by the project team of nursing, pharmacy, and medical representatives, led by the lead Clinical Governance nurse, to understand medication management within OCC:
1) Thematic Analysis of medication-related incidents on OCC.
2) Implementation of Systems Engineering Initiative for Patient Safety (SEIPS) protocol to study the interaction of the entire system (2).
3) High-level Hierarchical Task Analysis (HTA), a structured approach to understanding the steps a user must complete to achieve a task (4).
4) A comparison of how Work-as-Imagined vs Work-as-Done through review of policies and link analysis.
5) Actor Map analysis (Swimlane diagram) to identify communication gaps within the work system.

Results

Comparison of Work-as-Imagined vs Work-as-Done, evaluated the effectiveness of mitigations/controls such as policies and procedures that the unit has in place.

The Actor Map analysis of communication within OCC identified gaps in communication and informed areas for improvement, emphasising the role of communication across the MDT and system hierarchy. The novel introduction of Systems Approach Meetings (SAM) to the working day highlighted the value of risk identification and communication at the bedside (5).

Through evidence-based Human Factors methods, the MDT project group provided recommendations that are sustainable and replicable. In collaboration with the education team, the project group have implemented 20 actions points, to mitigate risks in medication management.

Conclusion

The systems methodologies employed by the multi-disciplinary medication safety project group to tackle medication management within OCC has demonstrated how our department can learn from the interaction of the whole work system (NHS England, 2022). An MDT, HF grounded approach to medication safety can yield far reaching improvements not only to patient safety but to the wellbeing of patients and staff.

References

1. NHS England (2022). *Patient Safety Incident Response Framework* [online]. https://www.england.nhs.uk/publication/patient-safety-incident-response- framework-and-supporting-guidance/ [Accessed 18 October 2022].

2. Carayon, P., Xie, A., Kianfar, S. (2013). *Human factors and ergonomics as a patient safety practice* [online]. https://qualitysafety.bmj.com/content/qhc/23/3/196.full.pdf. [Accessed 21 November 2022].

3. International Ergonomics Association (2023). *What is ergonomics?* [online]. https://iea.cc/what-is-ergonomics/ . [Accessed 15 February 2023].

4. Hornsby, P. (2022). Hierarchical Task Analysis [online]. https://www.usmatters.com/mt/archives/2010/02/hierarchical-task-analysis.php [Accessed 22 March 2022].

5. Lumley, C. (2022). *Systems Approach Meeting: A SEIPS 2.0 approach to safety huddle*. Oxford Critical Care, Oxford University Hospitals NHS FT.

Care System Interactions and Outcomes Medication Management in OCC v 0.2

Safety, Skills & Improvement Research Collaborative

Technology and Tools

EPR that can scan PPID, use of Care Vue (manual PPID process, readability of Rx, automation)
Bedside medication drawer design – digital lock, layout of drawers
Availability and accessibility of medication
Availability of disposables (at bedside and near CD cupboard)
CD cupboard design (height, manual lock)
Green CD book usability – not compatible with day-to-day use
Medication Room layout
No phone, No computer in medication room, no Computer next to CD cupboard

Tasks

Increased workload: care of HDU/Level 3 patients

Fast patient turnover

Independent checking unit policy, CD management policy

Interruptions during medication management

Multiple trips to medication room/levels due to limited supply at bedside

Competing priorities and ability to prioritise work

Bank/Agency Shifts

External Influences

NMC, GMC, CQC, GPhC, ICS, BACCN, RCN, WHO, DOH, UKCPA, HEE, HSE, SPS, NICE, Safety II, Human Factors Science: CIEHF, NHS England: PSIRF/PSS/Patient Safety,, **SSSM Economic uncertainties, family emergencies**

Person

Highly complex patients
MDT
Staff Fatigue
Cognitive and physical load

High reliance on NHSP/Agency worker: lack of knowledge on unit process

Economic challenges (resulting to less selfcare time)

Shift pattern: working days and nights at a stretch

Multi-cultural staff with varying work experience (UK and abroad) in OCC

Professional accountability

Organisation of Work

FCP, ICC
Historical change – pandemic nursing
Work Culture – association of high-risk tasks

Allocation of work (when working with SN staff/students/ICU Course/FC/Agency staff – side rooms)

Variability in medication management process
Guidelines regarding meds mgt.(Rx, Independent Checking, Ordering of Medication, Discharge process, Admission process, SSSM)

Staff availability to complete task, float
Skill mix
Shift pattern, lack of flexibility in working

Organisation of bedspace, discharging patients
Variability in Safety Huddle

Physical Environment

Allocated bedside medication storage, workspace station,
Location of medication and fluids cupboard
Location of storage of disposables
COVID ward lack of easy access to storage due to isolation
Side Rooms can be quite isolating and difficult to get independent checker**s**
Lack of lighting during night shifts
Noise that can interfere with communication at bedside/hub room
Limited storage at bedside (SSSM requires taking whole box from medicine room)

Desired/Undesirable Outcomes

System Performance:

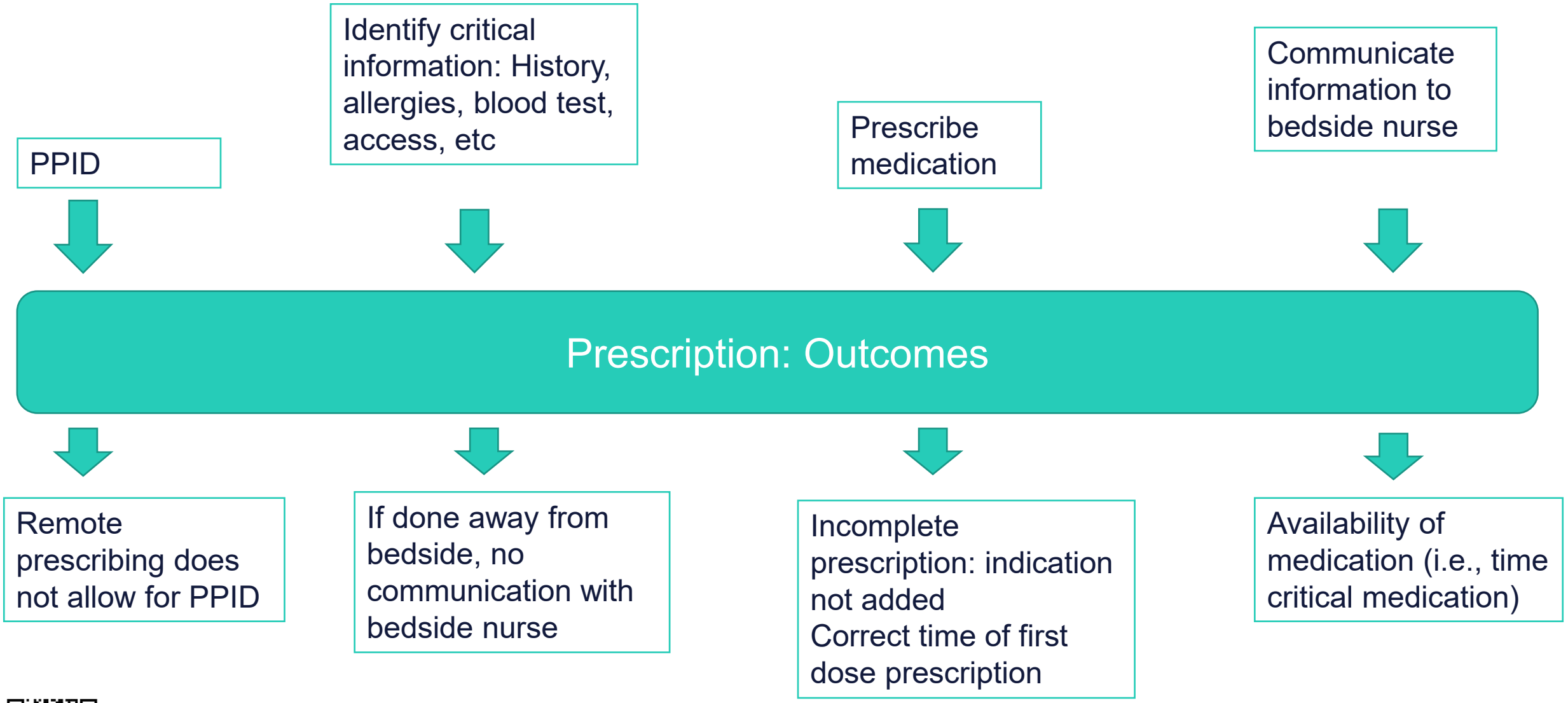
30 est. medication/ patient/day = 30 pts a day
vs
Number of reported medication incidents/SIRI
Increased reports on Near misses that could have led to serious harm
Budgetary control
Business continuity planning (MDT)

Human Wellbeing:

Open, honest, and transparent culture
No blame culture
Just culture
Professional accountability
Staff resilience
Teamwork
Health and safety; patient satisfaction and experience; enjoyment; staff turnover; staff welfare; job satisfaction

Cherry.Lumley@ouh.nhs.uk

Example Analysis



Workspace station

Before

AICU/HDU WORKSPACE STATION
Design Methodology using Human Factors Tools

HIERARCHICAL TASK ANALYSIS – WE IDENTIFIED THE HIGH-VOLUME TASKS WITHIN AICU. IDENTIFICATION OF EQUIPMENT REQUIRED PER STEP.

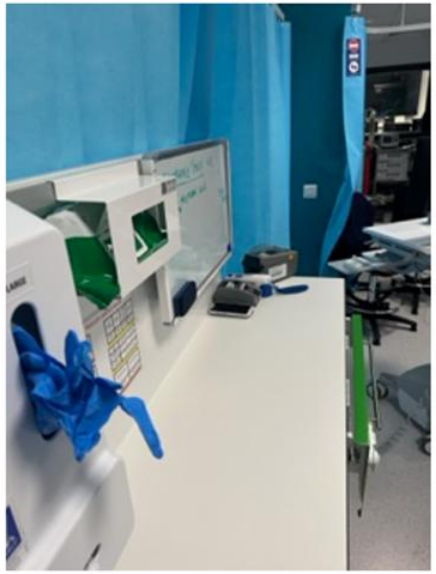
PROCESS MAPPING AND LINK ANALYSIS – WE LOOKED AT HOW THE STEPS OF EACH HIGH-VOLUME ACTIVITY IS COMPLETED AS STAFF USE THE DRAWERS AND MOVE AROUND THE BEDSPACE.

DECISION MADE FOR CONTENT OF EACH DRAWER TO HELP LESSEN STAFF WORKLOAD AND INCREASE PRODUCTIVITY.

STAKEHOLDER INPUT.

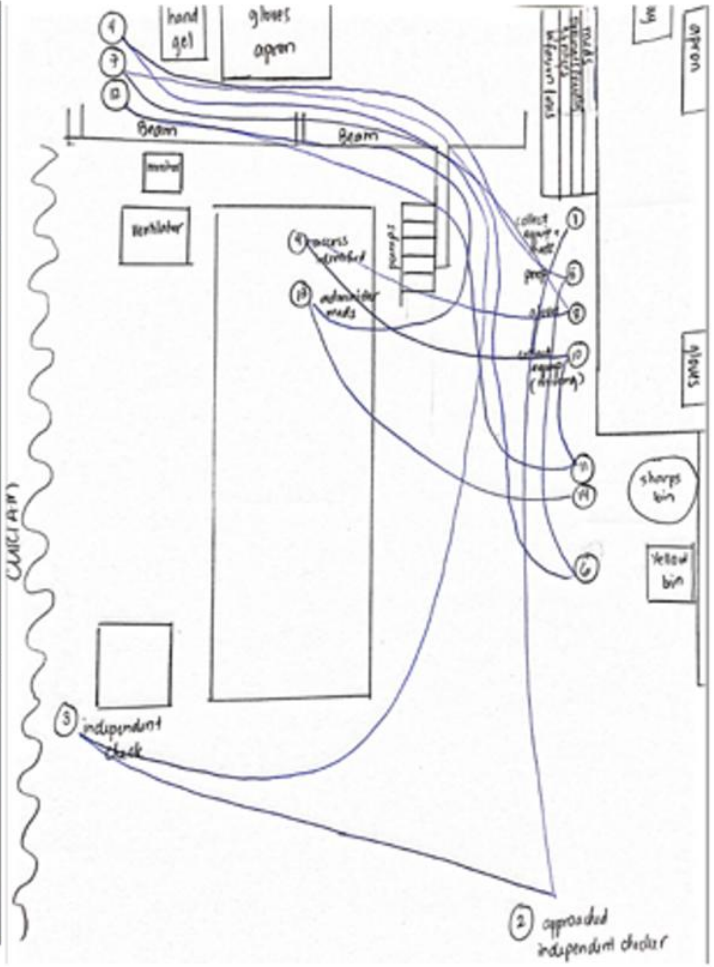
TO CONTINUOUSLY REVIEW UNIT REQUIREMENT AND STORAGE SUPPLIES WITH STAKEHOLDER.

New Layout



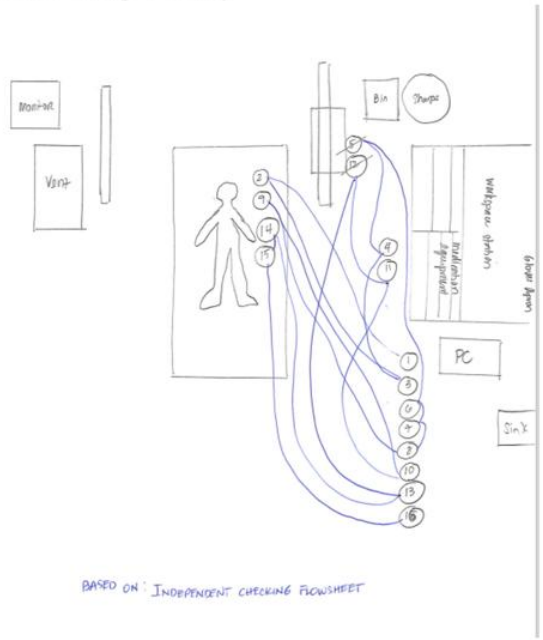
Nurse movement at bedspace
- Prior to applying an HF lens

Mapping of staff movement in ICU bedspace (B4): Administration of IV Metoclopramide

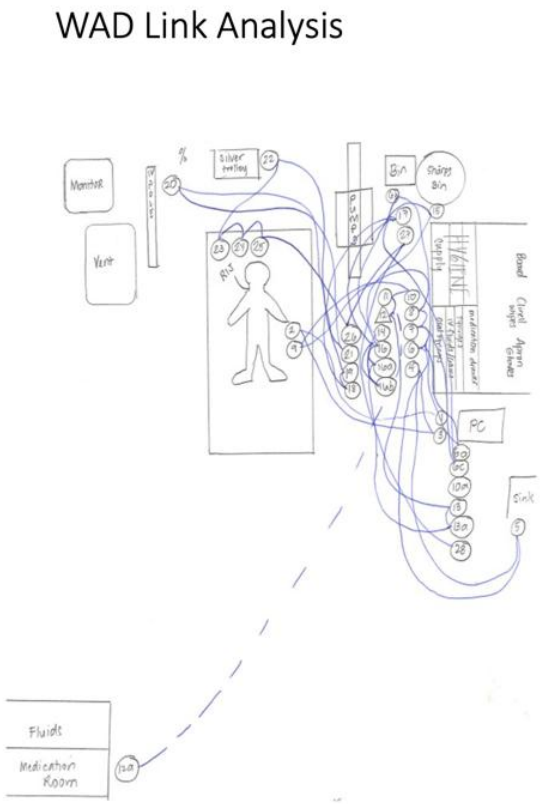


Nurse movement at bedspace
- Planning bedspace

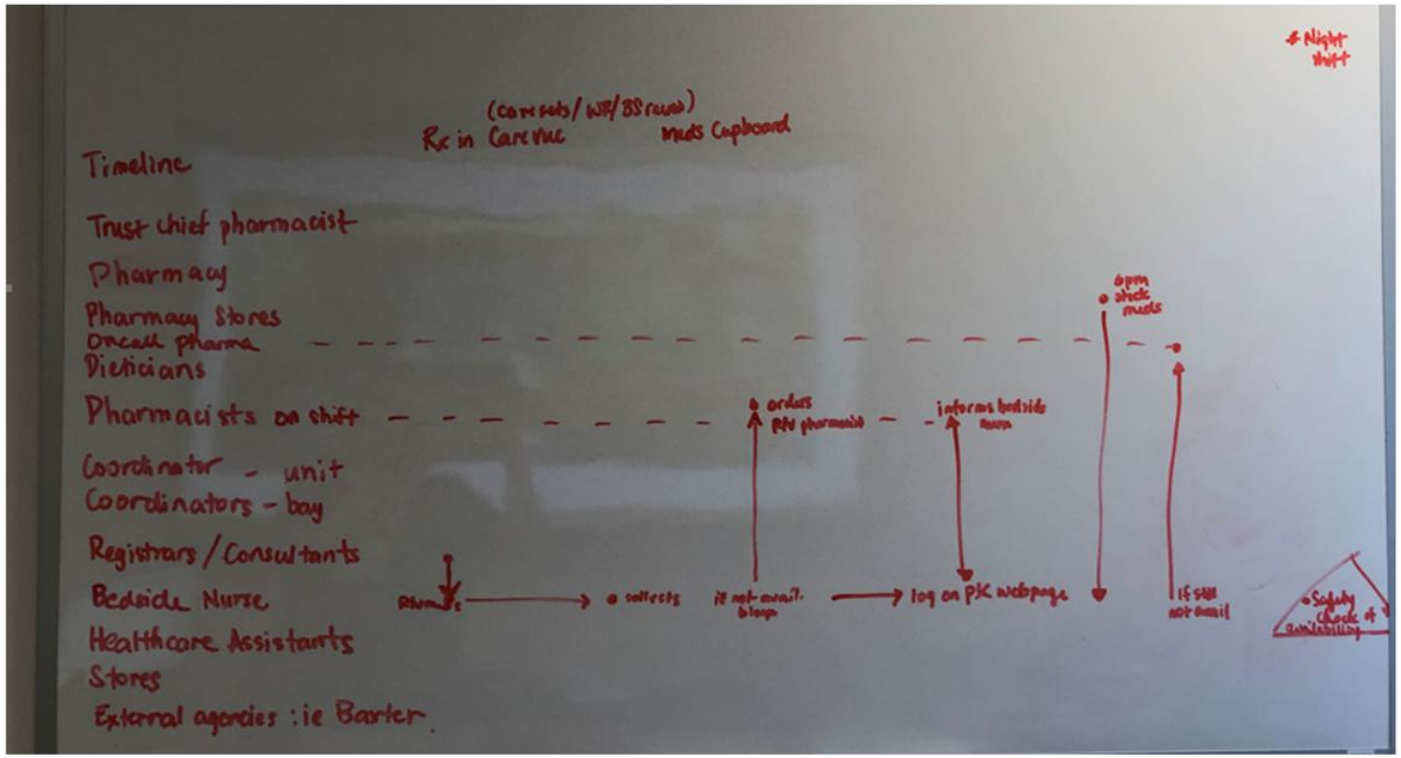
WAI: Based on Independent Double Checking Policy



Nurse movement at bedspace
- Actual movement

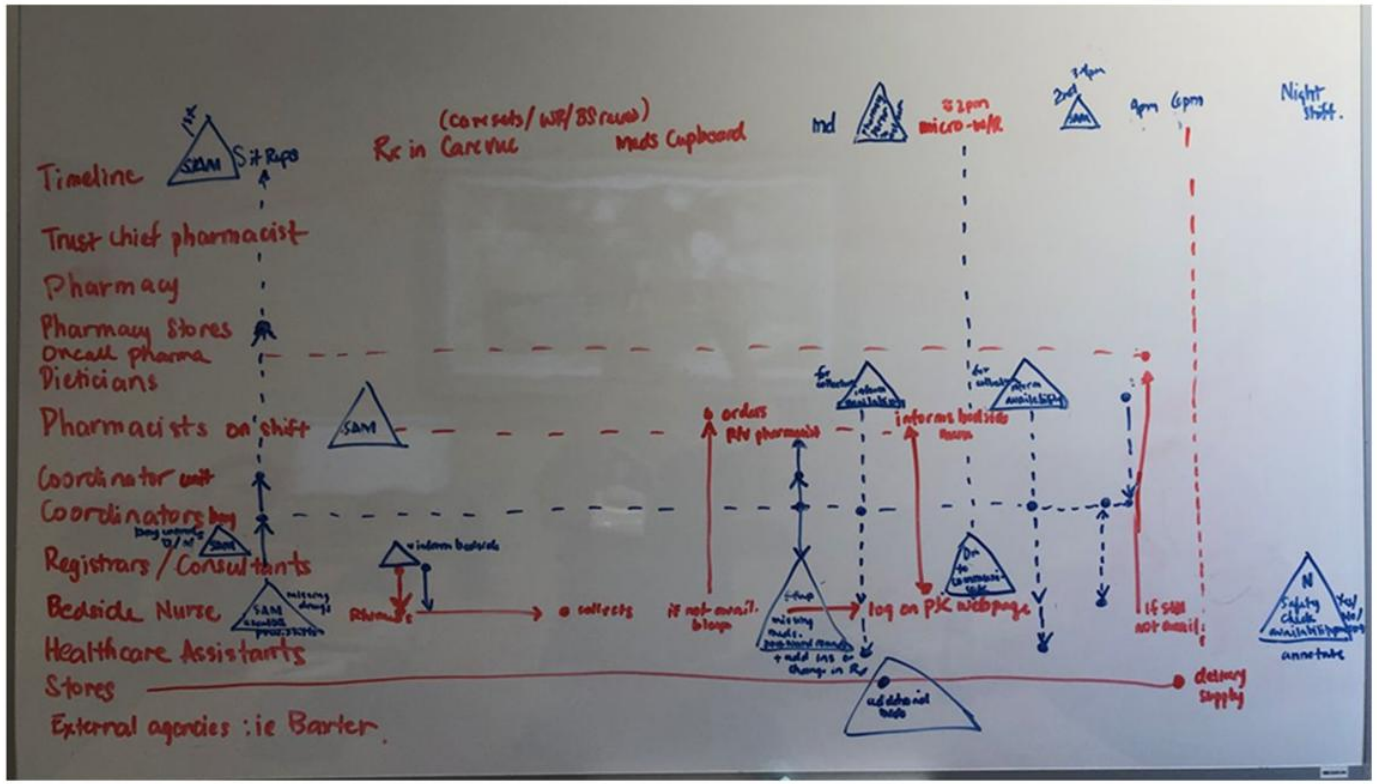


Swimlane Diagram of Medication Management in OCC



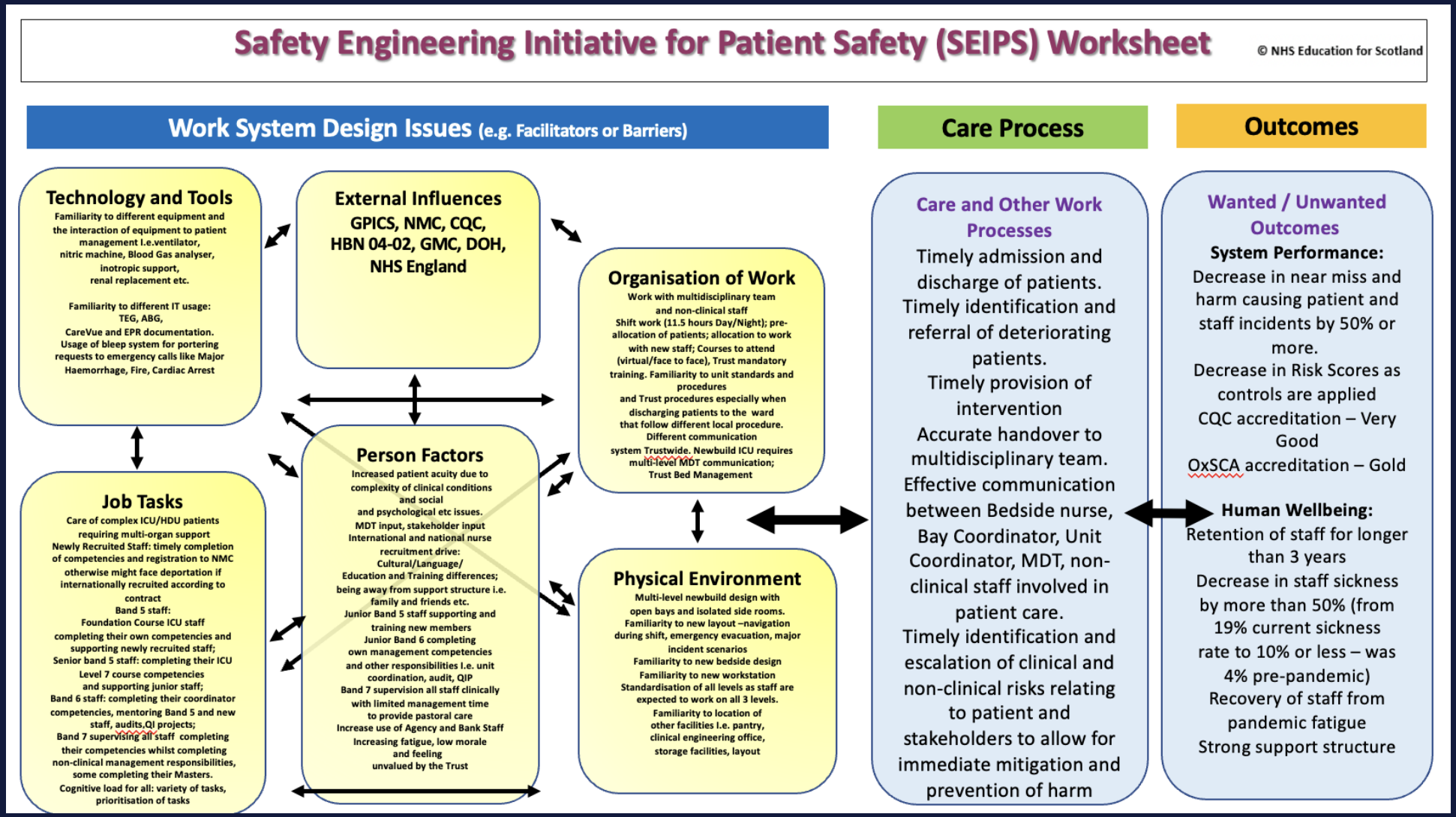
Cherry.Lumley@ouh.nhs.uk

Swimlane Diagram of Medication Management in OCC



Cherry.Lumley@ouh.nhs.uk


Systems Approach Meeting (S.A.M.) using Systems Approach
Recommendations based on:
http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4097725/SEIPSworksheet.pdf
For feedback/suggestions, please email:
Cherry.Lumley@ouh.nhs.uk (author)
290722


Safety Engineering Initiative for Patient Safety (SEIPS) Worksheet
© NHS Education for Scotland
Work System Design Issues (e.g. Facilitators or Barriers)
Care Process
Outcomes
Technology and Tools
Familiarity to different equipment and the interaction of equipment to patient management I.e.ventilator, nitric machine, Blood Gas analyser, inotropic support, renal replacement etc.
Familiarity to different IT usage: TEG, ABG, CareVue and EPR documentation. Usage of bleep system for portering requests to emergency calls like Major Haemorrhage, Fire, Cardiac Arrest
External Influences
GPICS, NMC, CQC, HBN 04-02, GMC, DOH, NHS England
Organisation of Work
Work with multidisciplinary team and non-clinical staff
Shift work (11.5 hours Day/Night); pre-allocation of patients; allocation to work with new staff; Courses to attend (virtual/face to face), Trust mandatory training. Familiarity to unit standards and procedures and Trust procedures especially when discharging patients to the ward that follow different local procedure. Different communication system Trustwide. Newbuild ICU requires multi-level MDT communication; Trust Bed Management
Job Tasks
Care of complex ICU/HDU patients requiring multi-organ support
Newly Recruited Staff: timely completion of competencies and registration to NMC otherwise might face deportation if internationally recruited according to contract
Band 5 staff: Foundation Course ICU staff completing their own competencies and supporting newly recruited staff; Senior band 5 staff: completing their ICU Level 7 course competencies and supporting junior staff; Band 6 staff: completing their coordinator competencies, mentoring Band 5 and new staff, audits,QI projects; Band 7 supervising all staff completing their competencies whilst completing non-clinical management responsibilities, some completing their Masters.
Cognitive load for all: variety of tasks, prioritisation of tasks
Person Factors
Increased patient acuity due to complexity of clinical conditions and social and psychological etc issues.
MDT input, stakeholder input
International and national nurse recruitment drive: Cultural/Language/ Education and Training differences; being away from support structure i.e. family and friends etc.
Junior Band 5 staff supporting and training new members
Junior Band 6 completing own management competencies and other responsibilities I.e. unit coordination, audit, QIP
Band 7 supervision all staff clinically with limited management time to provide pastoral care
Increase use of Agency and Bank Staff
Increasing fatigue, low morale and feeling unvalued by the Trust
Physical Environment
Multi-level newbuild design with open bays and isolated side rooms.
Familiarity to new layout –navigation during shift, emergency evacuation, major incident scenarios
Familiarity to new bedside design
Familiarity to new workstation
Standardisation of all levels as staff are expected to work on all 3 levels.
Familiarity to location of other facilities I.e. pantry, clinical engineering office, storage facilities, layout
Care and Other Work Processes
Timely admission and discharge of patients.
Timely identification and referral of deteriorating patients.
Timely provision of intervention
Accurate handover to multidisciplinary team.
Effective communication between Bedside nurse, Bay Coordinator, Unit Coordinator, MDT, non-clinical staff involved in patient care.
Timely identification and escalation of clinical and non-clinical risks relating to patient and stakeholders to allow for immediate mitigation and prevention of harm
Wanted / Unwanted Outcomes
System Performance:
Decrease in near miss and harm causing patient and staff incidents by 50% or more.
Decrease in Risk Scores as controls are applied
CQC accreditation – Very Good
OxSCA accreditation – Gold
Human Wellbeing:
Retention of staff for longer than 3 years
Decrease in staff sickness by more than 50% (from 19% current sickness rate to 10% or less – was 4% pre-pandemic)
Recovery of staff from pandemic fatigue
Strong support structure

What is SAM?

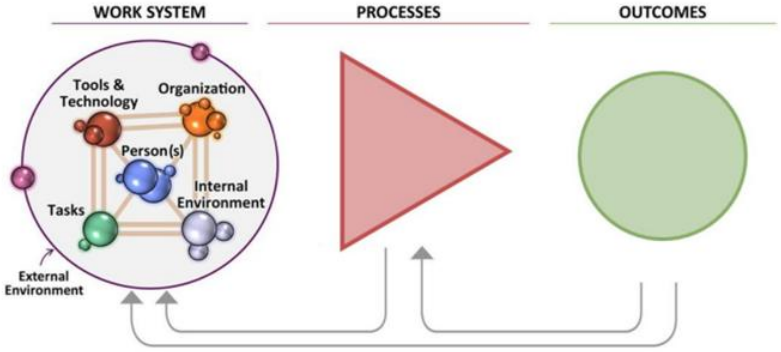
SAM stands for Systems Approach Meeting (Previously known as Situational Awareness Meeting) (Lumley, 2022).

SAMs principle is based on Systems Engineering Initiative for Patient Safety (SEIPS) which is a framework for understanding outcomes within complex socio-technical systems (NHS England, 2022).

SAM is designed to assist in improving timely communication of hazards and risks across the MDT and hierarchy of management and is used in OCC by the nursing team that replaced the group hug.

https://sho.co/1FKYB

Figure 1. Overview of the SEIPS framework



Bay Safety Huddle: Topics for consideration (but not limited to)

(Using SEIPS: Systems Engineering Initiative for Patient Safety)

Author: Cherry Lumley
cherry.lumley@ouh.nhs.uk

Bay Coordinators: must have a copy of handover sheet.
To give the team an update of unit acuity of each level I.e., Level 2 has 5 patients, 2 discharges, 2 electives, 2 side rooms, and 1 very sick patient on Nitric

Please read aloud the Safety Reminders prior to starting individual S.A.M.

Patient Safety – airway, resus status, rolls, infusions, medications availability, planned tasks, risk of fall/self extubation, IPC etc.

Staff Support Requirement – RRT, transfers, medication checks, discharges/admissions, etc.

Equipment Safety – availability, usability, PPE, supplies, faulty equipment etc.

Task Factors – complex tasks to be completed, workload, need for attention if there are risk of delays, rehabilitation requirement, etc.

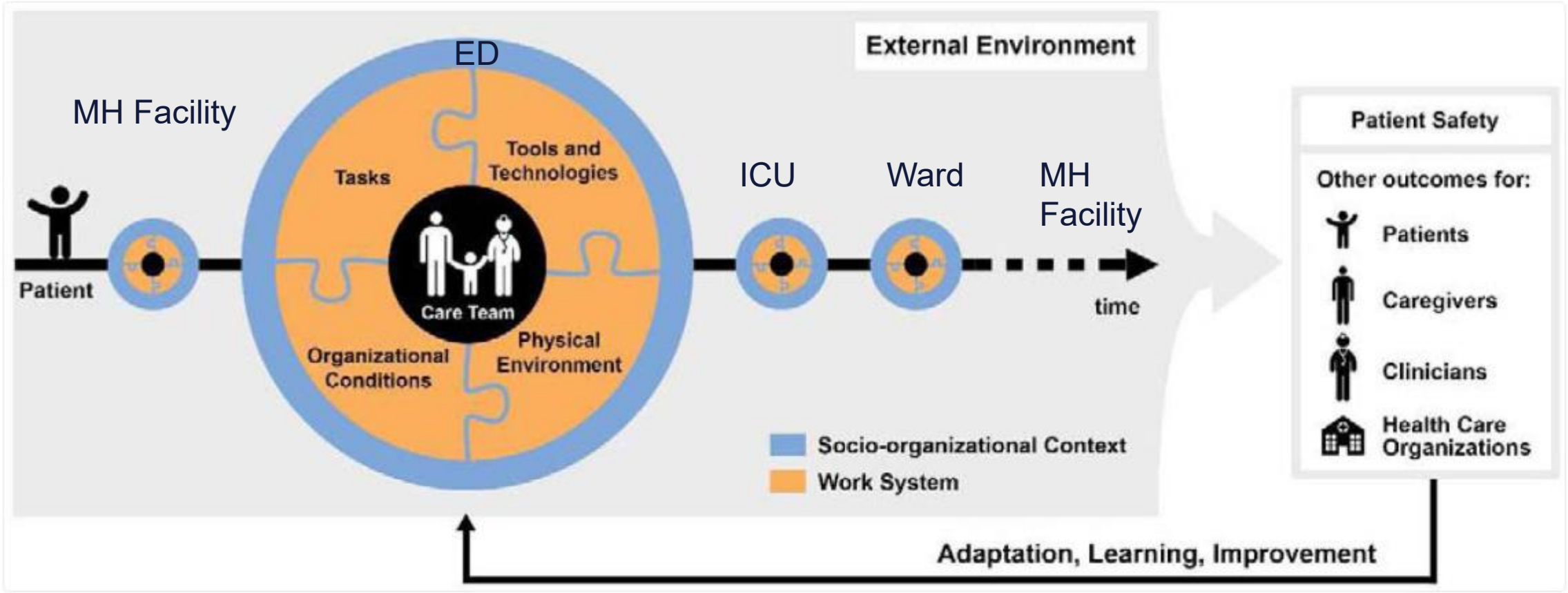
Physical Environment Factors – Side room, clutter, workspace, lighting, temperature, noise level, isolation requirement, stores top up/supplies etc.

Organisation of Work Factors – work priorities, plan procedures, skill mix, staff training and competencies, discharges, admissions etc.

External Influences – other risks and influences, potential for delayed discharges/admissions, NOK, Family issues, etc.

Please escalate hazards/risks identified if unable to mitigate in a timely manner

The challenge: examine set of work systems throughout patient journey

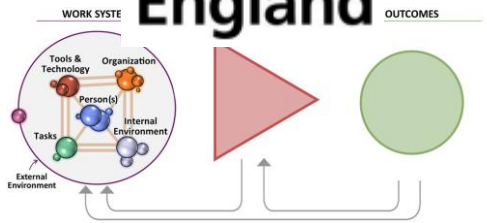


SEIPS 3.0 Model: Sociotechnical Systems Approach to Patient Journey and Patient Safety

- Carayon, et al., 2020

Risk Assessment

NHS England



Tools & Technology

- Equipment used by the patient – restraint kit - usability
- Room
- Equipment used to care for patient
- Trust approved video cameras
- Removal of items within easy reach by the patient
- Alarm/Call for Help

Organisation

- Risk Assessment: multi level system – involvement of stakeholders
- Care Plan – MDT input
- 1:5+1 nursing
- Rotation of staff
- Incident reporting
- Regular checks by MH Staff on restraint kit used for patient
- Staff support - Wellbeing

Person

Mental health patient with complex needs
Other patients/visitors
Specialists (Medical, Nursing, Safeguarding, Health and Safety)
MH staff in attendance – permanent and non-substantive staff (training and wellbeing)
Critical Care Permanent and non-substantive staff in attendance (training and wellbeing)

Tasks

- Nursing care/medical procedures/rehabilitation – close proximity to patient
- De-escalation techniques
- Administration of sedation
- Documentation

Internal environment

- Review of room to be used (patient and staff safety)
- Away from other patients/visitors
- Ligature risk assessment
- Removal of equipment within reach
- Emergency access
- Lighting
- Noise

External environment

- Input from mental health facility
- CQC
- Health and Safety +RIDDOR
- Regulatory boards
- Safeguarding

Work as done

Desired Outcomes

Safe delivery of care to patient

Safe discharge to home facility

Human Wellbeing:

Patient and Staff Safety

Maintain privacy and dignity

Summary - Impact of HF / Ergonomics

Understand Health and Social Care system

– link the patient's journey (learning shared)

Improve outcomes

– Patient experience and safety and staff wellbeing, safety culture

Assurance

– Evidenced-based management of risks, evidence of systems approach with stakeholder input, influence change of practice, improve morale

= retention, QIP, productivity targets, efficiency savings

Useful takeaways:

Think about how you can apply:

- Concepts of human factors and situational awareness and application across systems.
- Compassionate leadership - how are you applying this?
- Leadership behaviours - How are you showing up?

Prompt for Action:

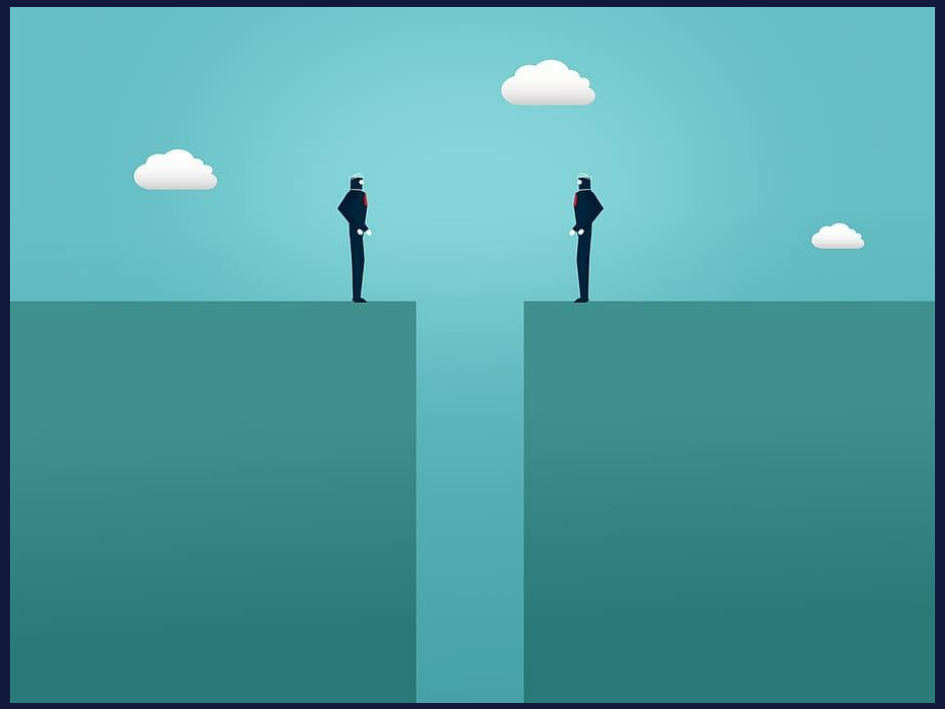
Think about one ‘compassionate leadership’ action you can take to improve collaboration.

What can you implement today or this week?

Part 2 - Complex Environments & Behaviour change

- HF
- Complexities & leading in VUCA environments
- Behavioural change & shifting mindsets

Please comment in chat

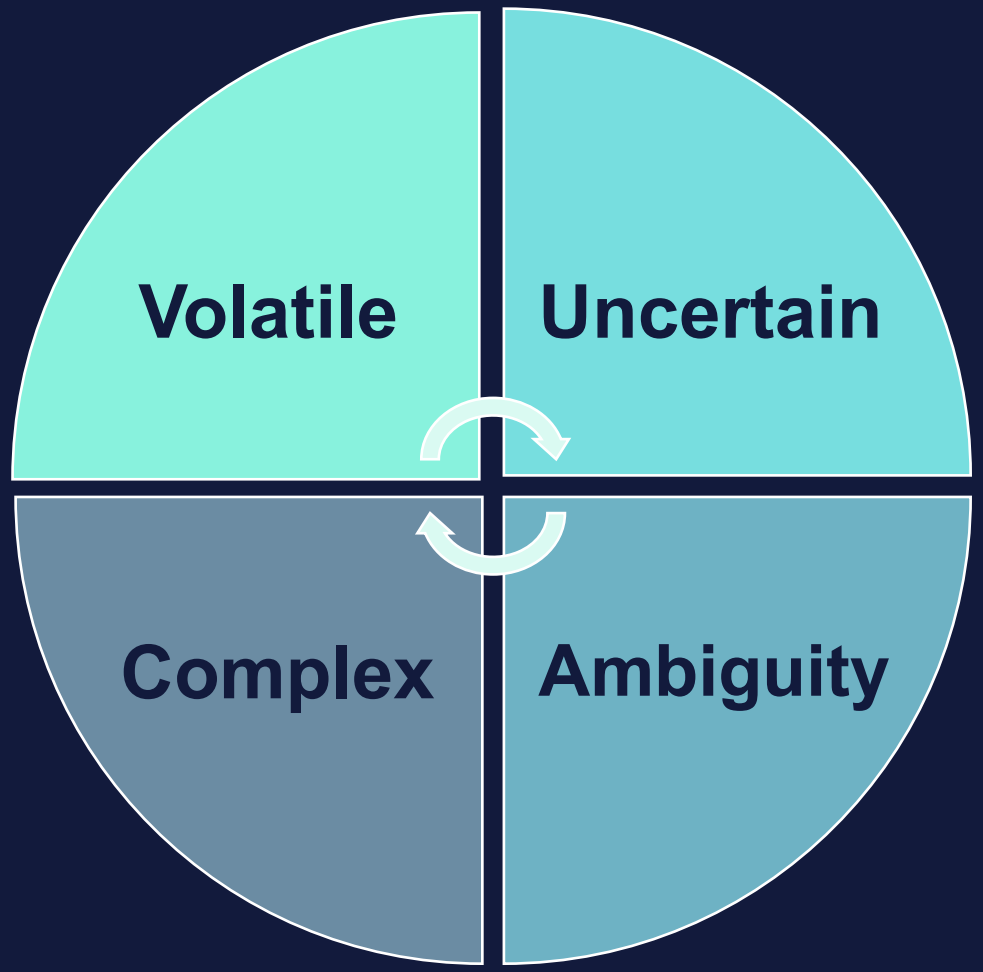


…but what about when it isn't all sunshine and rainbows?

What complexities are there in your practice or organisation that make collaboration challenging?

Complexities of the environment – Why it is difficult?

VUCA environments challenge leaders to be adaptable, flexible, and skilled in navigating ambiguity, all while maintaining clear communication and effective decision-making.



It's particularly relevant in healthcare, where leaders need to guide teams through uncertainty while making informed decisions.

Baran, B.E. and Woznyj, H.M., 2020. *Managing VUCA: The human dynamics of agility. Journal/Publisher TBD* (via PMC).

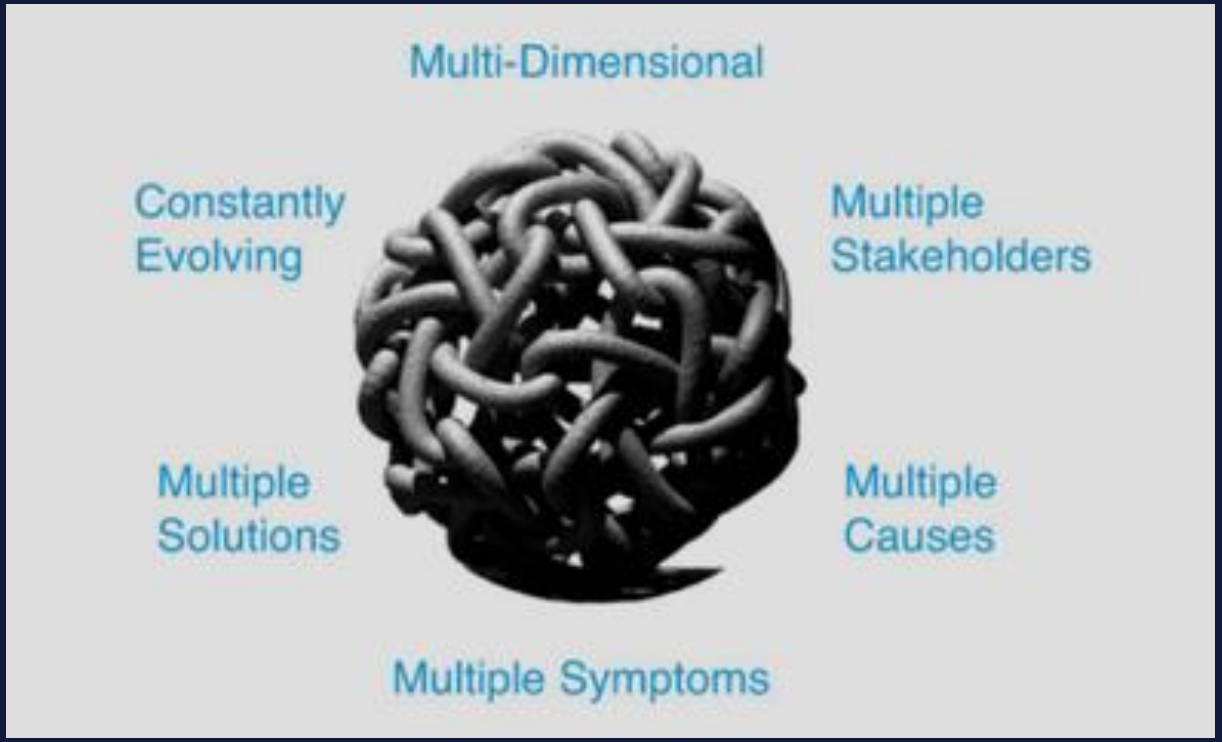
Complexities in our environment - Wicked problems?

HF lens = People 👤 + Systems ⚙️ + Environment 🌍

A wicked problem is:

- **Complex**
- **Multifaceted**
- **Resistant to straightforward solutions**.

The term *"wicked problem"* was first introduced by **Rittel and Webber (1973)** in the context of social policy and planning.



Strategies for Leadership in VUCA environments

Vision | Understanding | Clarity | Adaptability

Address Uncertainty

- Involve stakeholders in shared decision-making, creating clear goals and action plans to reduce ambiguity. Align priorities.

Improve Communication

- Use transparent and consistent communication to align expectations and clarify priorities.

Build Psychological Safety

- Encouraging a culture where individuals feel safe to voice concerns and propose solutions.

Foster Resilience and well-being support

- Provide mental health resources and support to reduce burnout and enhance resilience.

Transformational Leadership Training

- Focus on inspiring and empowering staff to embrace change and innovation.

Navigate Complexity

- Train leaders in systems theory to understand interdependencies and address challenges holistically.

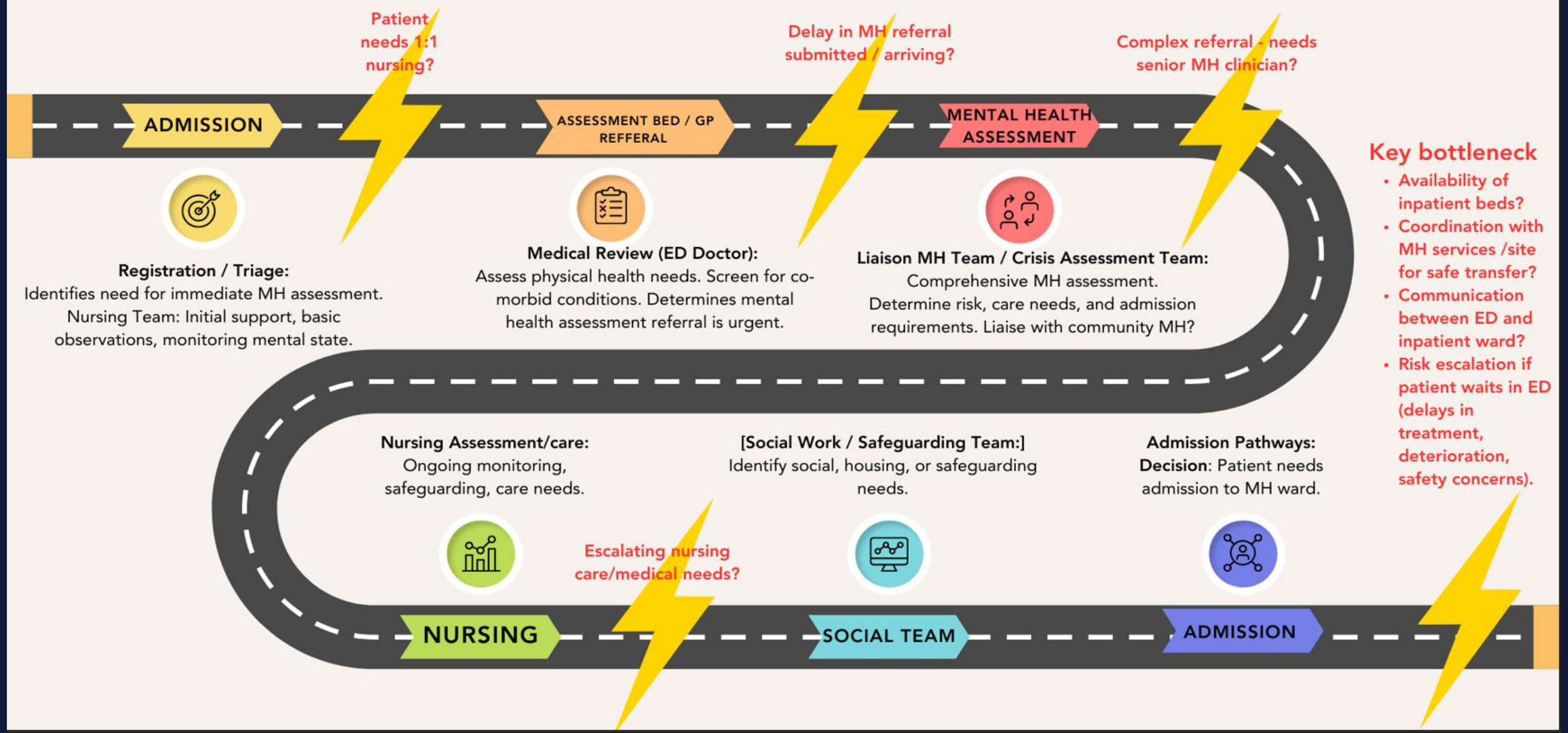
Multidisciplinary Collaboration

- Facilitate collaboration across teams to integrate diverse perspectives and find balanced solutions.

MENTAL HEALTH SERVICES / EMERGENCY DEPT

PATIENT JOURNEY

Example



Key bottleneck

- Availability of inpatient beds?
- Coordination with MH services /site for safe transfer?
- Communication between ED and inpatient ward?
- Risk escalation if patient waits in ED (delays in treatment, deterioration, safety concerns).

Group Activity

Page 13-14

HF lens = People 👤 + Systems ⚙️ + Environment

25 mins

Activity objective:

In your teams, identify challenges and co-create practical solutions that improve **collaboration, patient outcomes, and service flow**, by **considering human factors principles** such as communication, teamwork, decision-making, and safety culture

- Use your Driver Diagrams

Step 1: Your challenge

Think about your team focus area.

What is the core issue we are trying to address?

Can you write a statement?

Frame the issue not only in terms of system outcomes, but also human experience and behaviours.

Step 2: Map the patient journey

•Using your driver diagram to identify the secondary issues.

•?Communication breakdown

•?Ambiguity

•?Process control

•Use human factors categories.

•i.e. human, cultural, and behavioural contributors, not just processes / resources.

Step 3: Apply a HF lens

Discuss in your groups how human factors could have influenced or affected the root cause pinch-point.

What human factors are in play here?

Why?

Step 4: HF change solutions

• Focus on 1 or 2 pinch-points, work through change solutions, with a system-thinking approach / HF lens.

• Prioritise impact vs feasibility.

• What can we do to make changes to improve this using HF lens?

• What will make the most impact?

Focus on your challenge

Driver diagram

Discuss the HF elements

Create actionable strategies

Challenge discussion

- Guidance for discussion of change solutions with HF Lens

What is the core issue we are trying to address? - Step 1

What are the secondary issues?

Determine the ‘cause & effect’?

What are the systemic interdependencies?

What are the contributing factors?

Who is most affected by this issue? - Step 2

How are we listening to the patient voice?

How might ‘lived-experience’ voices describe or reframe this issue?

What evidence or data do we have about the scale or nature of this issue? - Step 2 / 3

What assumptions are we making about the problem, how might we test them?

Which parts of this challenge are within our influence, which are beyond? - Step 3

Who can help us with the issues ‘out of our control’?

Who needs to be involved? What strengths and assets does each partner bring?

What would have the biggest impact? - Step 4

What would success look like for each of us in 6-12 months?

What shared outcome can unite us?

Sharing of progress and thoughts from breakout activity

References & Links

References

- West, M., Eckert, R., Steward, K., & Pasmore, B. (2017). *Developing Collective Leadership for Healthcare*. The King's Fund.
- Edmondson, A. (1999). *Psychological Safety and Learning Behavior in Work Teams*. Administrative Science Quarterly, 44(2), 350–383.
- Leading Change by John P. Kotter, Boston: Harvard Business School Press, 1996.
- Salas, E., et al. "The Science of Teamwork in Healthcare: Importance to Patient Safety and Outcomes." *Annals of Surgery*, 2008.
- Baran, B.E. and Woznyj, H.M., 2020. *Managing VUCA: The human dynamics of agility. Journal/Publisher TBD* (via PMC).
- Bass, B.M. and Riggio, R.E., 2006. *Transformational leadership.* 2nd ed. Mahwah, NJ: Lawrence Erlbaum Associates.
- Heifetz, R.A., Grashow, A. and Linsky, M., 2009. *The practice of adaptive leadership: Tools and tactics for changing your organization and the world.* Boston, MA: Harvard Business Press.
- Health Education England and CIEHF - Human Factors and Healthcare Report.pdf

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Group reflection

- What are your reflections from today?
- What was discussed in your breakout sessions?
- What could hold you back over the coming months?
- What have you done or will you do to set yourselves up for success?

Please raise your hand and/or share answers in the chat

Summary & Questions

Leadership behaviours	**Systems thinking**	**Psychological safety**	**VUCA environment**
Relational solutions	**Behavioural change**	**Communication**	**Culture**

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Looking forward: Action Learning Period 3

24 September – 26 November

What next: action learning period

Between this session and the next one on 26th November you need to use your workbook to complete the following:

Make sure your previous actions are completed from the last sessions: project aim, project charter, outcome measures and driver diagram, and **send to your facilitator as soon as you can.**
NEW TASK: Attend the webinar on 22 October on leading through change
NEW TASK: Finish the change solutions with a human factors lens activity (begun in the learning session) (page 13 – 14 in the workbook)
NEW TASK: Begin to prioritize ideas and begin to test out ideas in practice (page 15 – 16 in the workbook)
NEW TASK: Complete your reflective log questions – see page 17

Next steps

- The next webinar is **22 October 11:00 – 12:30** – the focus is on exploring how behavioural approaches and systems thinking can support leaders through change. You will discover strategies to strengthen leadership capability, build resilience, and foster collaboration to deliver sustainable transformation. Please use the link to register for the webinar (it is open to all).

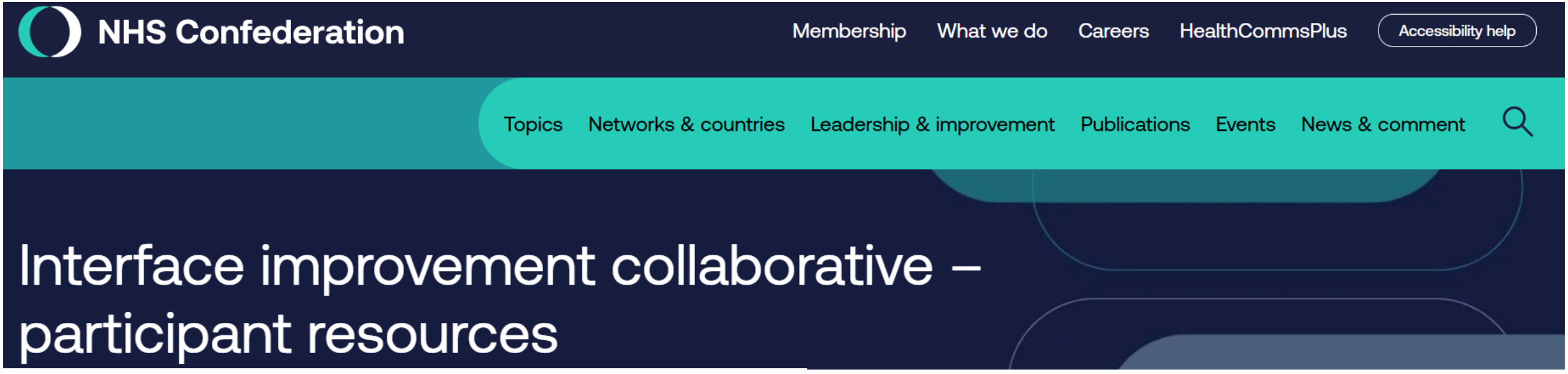
- The next learning session is **26th November 1:00pm - 4:00pm** – the focus will be on testing out change ideas, using the PDSA cycle, building in ongoing measurements and learning from existing good practice improvement initiatives in our best practice café sessions.

- Your facilitator will contact you during the action period (this is the time between this session and the next session) to check in on how you are progressing. It is essential that you meet with your Facilitator **at least once** in between learning sessions – they are there to help and guide you, and also share updates on your progress with the central team so we can have a collective overview of the 12 interface teams.

- You will get an evaluation form straight after this session – please do complete it. It's important to help us ensure we tailor sessions to your needs.

Evaluation – please complete

Interface Programme Webpage



Session One: Introduction

Session recording

Part 1: Setting the scene – Improving across the boundaries of Acute and Mental Health

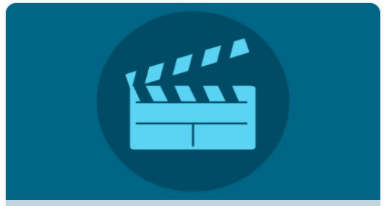
Session recording

Part 2: Introduction to 'system of profound knowledge' and defining your aim, purpose and 'why'

Resources

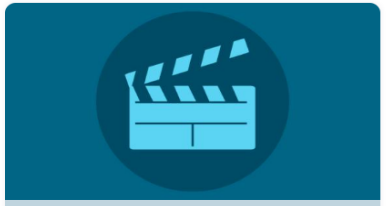
Presentation slides: Understanding the problem

Session Two: Understanding the problem



Session recording

Part 1: Measurement and scoping out ideas



Session recording

Part 2: Measurement and scoping out ideas

Video

Relationships and collaboration

Dr Charlie Jones and Dr Eirini Kontou on informal relationships, collaboration and overcoming barriers to building these links.

Thank you

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