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LETTERS

MID STAFFS INQUIRY

Changing behaviour with a human factors approach

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The Francis report identified multiple problems relating to the safety culture of Stafford Hospital during 2005-09.[1] In a safe culture, system leaders are sensitive to the unintended consequences of policy, and staff at every level share responsibility for safety.[2]

The aviation industry began to recognise 30 years ago that certain behaviours were required by staff to preserve safety. Three observations are also essential to keep patients safe.[3]

1 Analysis of accidents should include an examination of "human factors issues," especially workplace behaviours

2 The findings from these analyses must be linked to ongoing training of the behaviours that constitute non-technical skills in healthcare

3 Humans will always be prone to fail in systems that have not been designed using ergonomics/human factors principles.

These interventions have been the main focus of an NHS expert panel, the Department of Health Human Factors Reference Group, which submitted an interim report to the Department of Health in April 2012.[4] It recommends building expertise in clinical human factors in the UK to deal with these problems.

No specialist human factors group exists in the NHS, in contrast to every other safety critical industry, where human factors inspectors, committees, and courses are now found. However, the Clinical Human Factors Group (www.chfg.org), an independent campaign group, raises awareness and promotes the role of human factors in safe practice. The Institute of Ergonomics and Human Factors (www.ergonomics.org.uk/), the professional body in the UK, is also building representation from within the healthcare sector and providing a systematic approach to the design of safer sociotechnical workplaces.[5]

Competing interests: None declared.

1 Godlee F. A change of culture, but how [Editor's Choice]? *BMJ* 2013;346:f1152. (20 February.)
2 Agnew C, Flin R, Mearns K. Patient safety climate and worker safety behaviours in acute hospitals in Scotland. *J Safe Res* [forthcoming].
3 Flin R, Mitchell L, eds. Safer surgery: analysing behaviour in the operating theatre. Ashgate, 2008.
4 Clinical Human Factors Group. 2012. www.chfg.org/news-blog/dh-human-factors-group-interim-report-and-recommendations-for-the-nhs.
5 Buckle P. Systems approaches to risk assessing healthcare, how far have we come? *Work* 2012;41:3847-9.

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