

A (Very) Temporary Operating Instruction



Practical Application of a Systems Thinking Approach

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Contents

Level Busts & Altimeter Setting Error

Putting the risk in context

Addressing the Risk

The use of a Temporary Operating Instruction (TOI)

Unexpected Consequences

Impact of the TOI

Taking a Systems Thinking Approach

Outline of a process

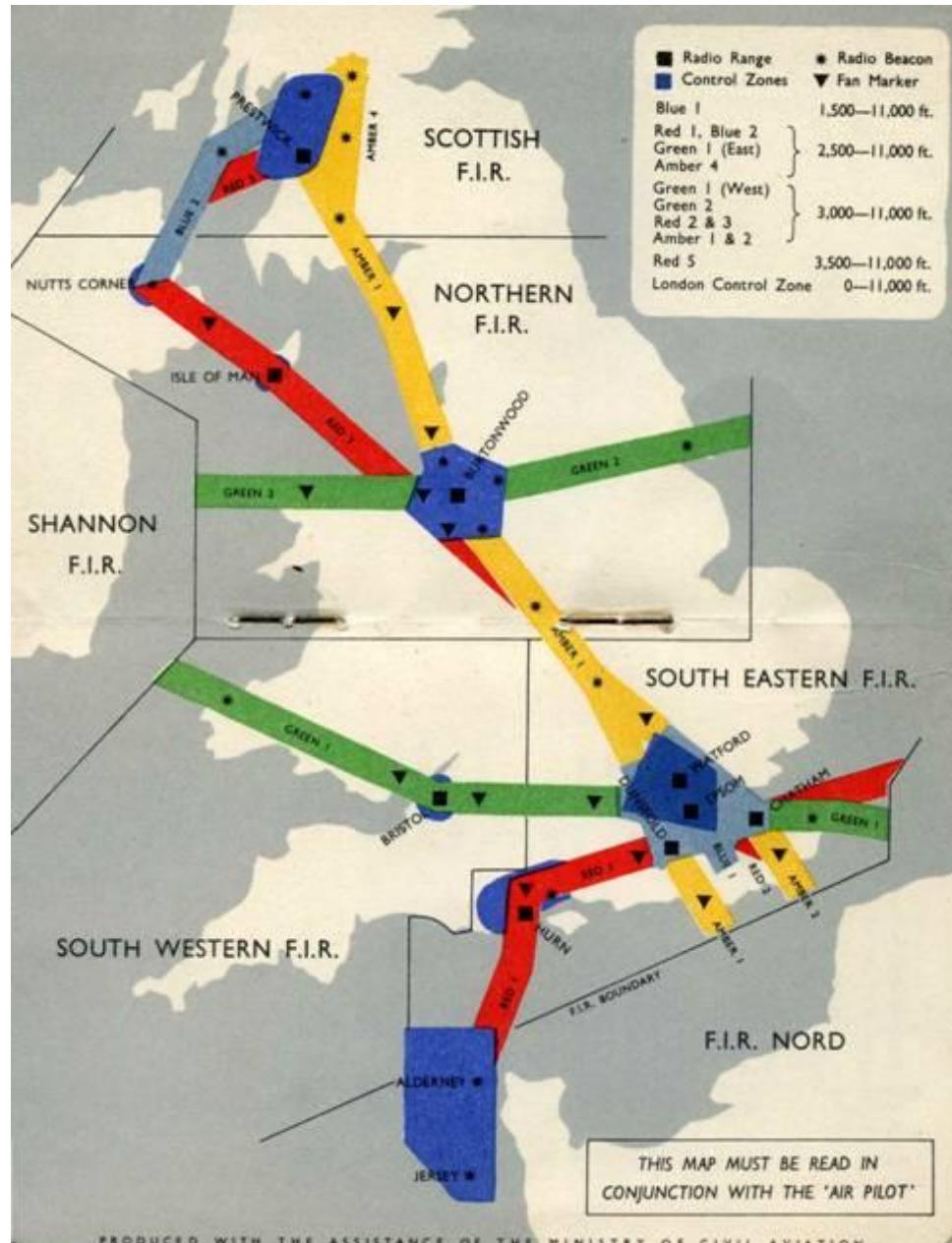
Conclusions from Thinking in Systems

Summary & reflections on the approach

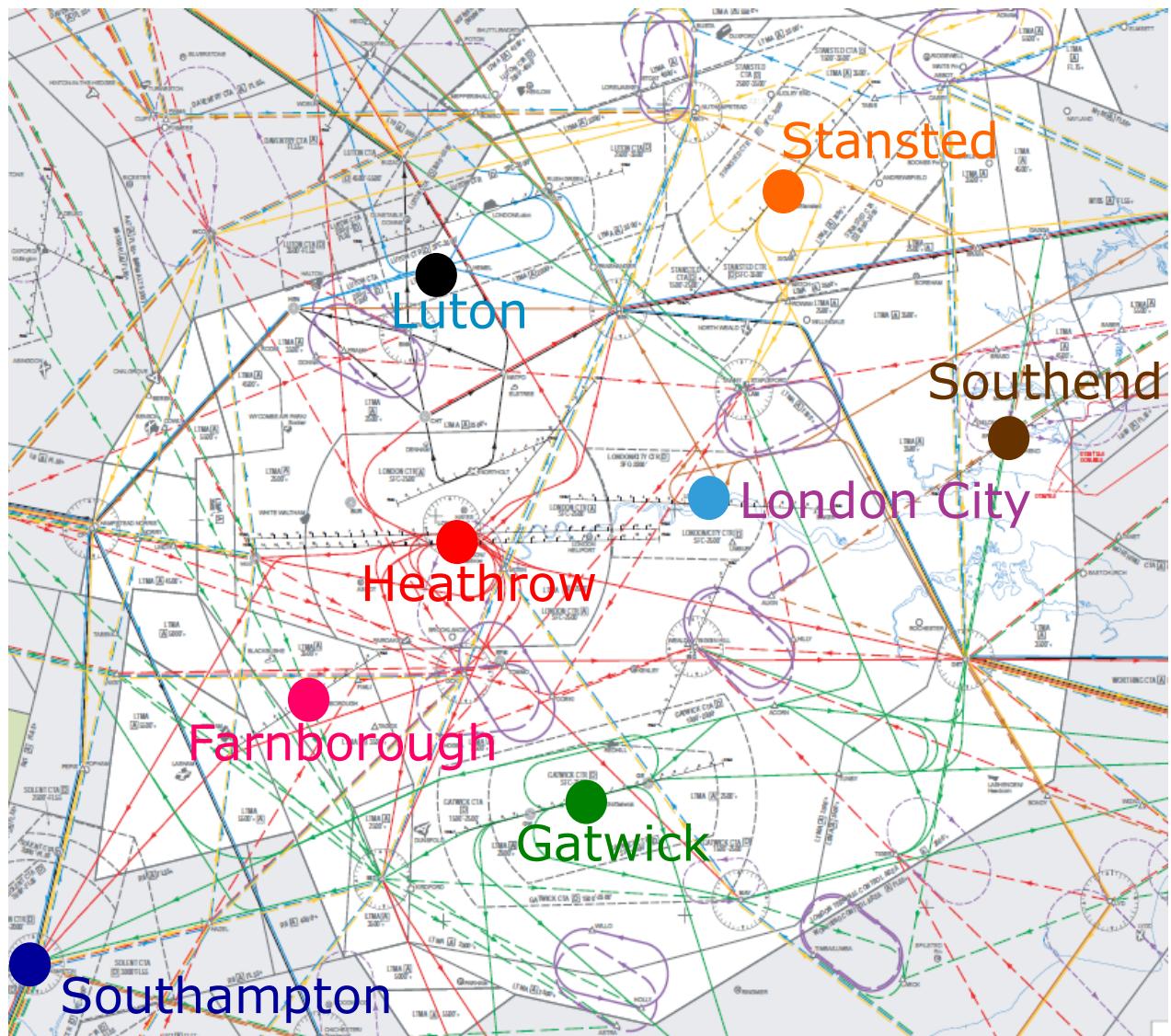
General Conclusions

On systems thinking, Safety II and our next steps

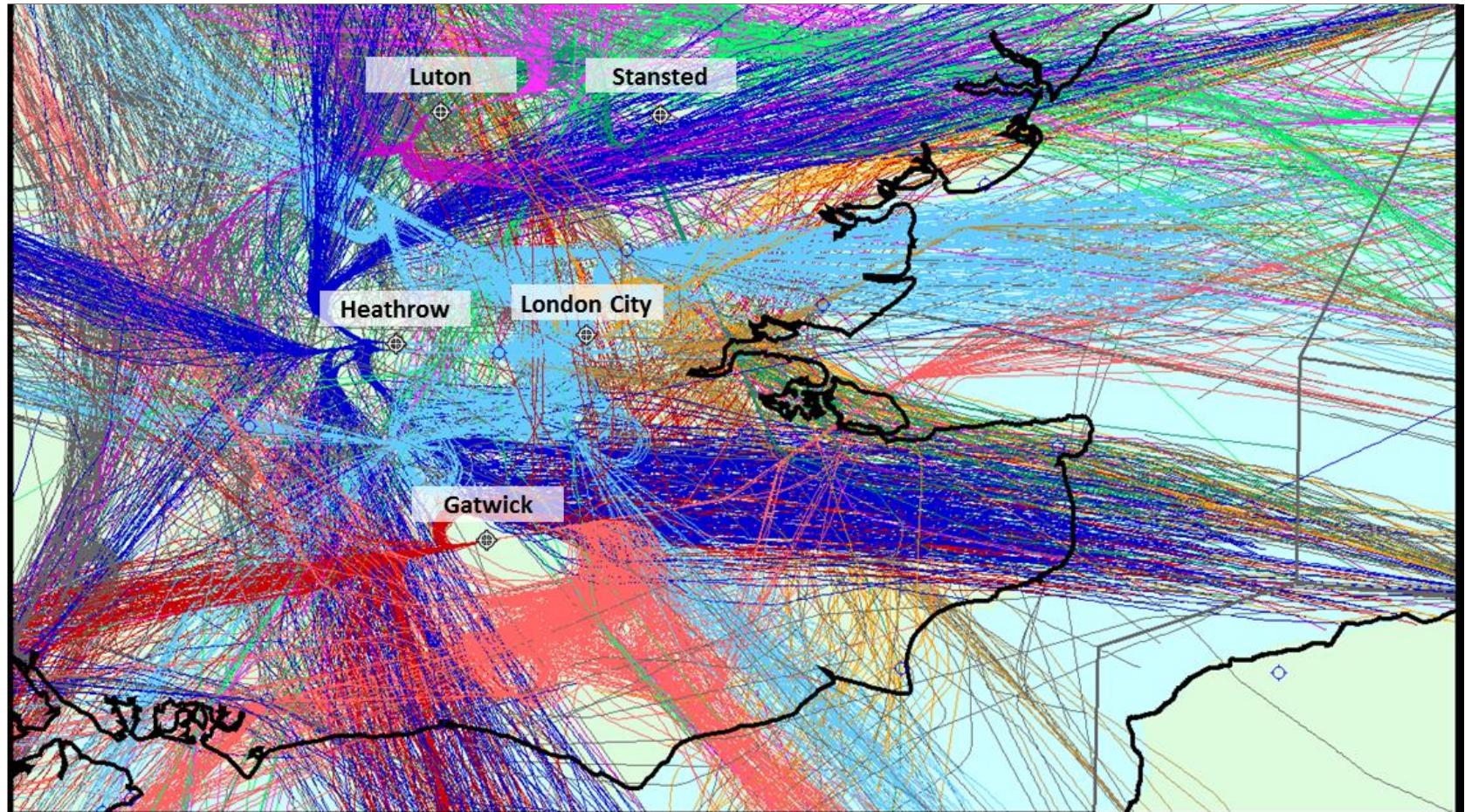
Managing the traffic



Managing the traffic



Managing the traffic



Work as done



NATS

Level Bust

- Altimeter Setting Error (ASE)

QNH Atmospheric Pressure = 1013 hPa
Standard Pressure

9000ft

8000ft

6000ft

5000ft

BPS: QNH = 1013 hPa

Time margin to input new pressure

BPS: Standard Pressure = 1013 hPa

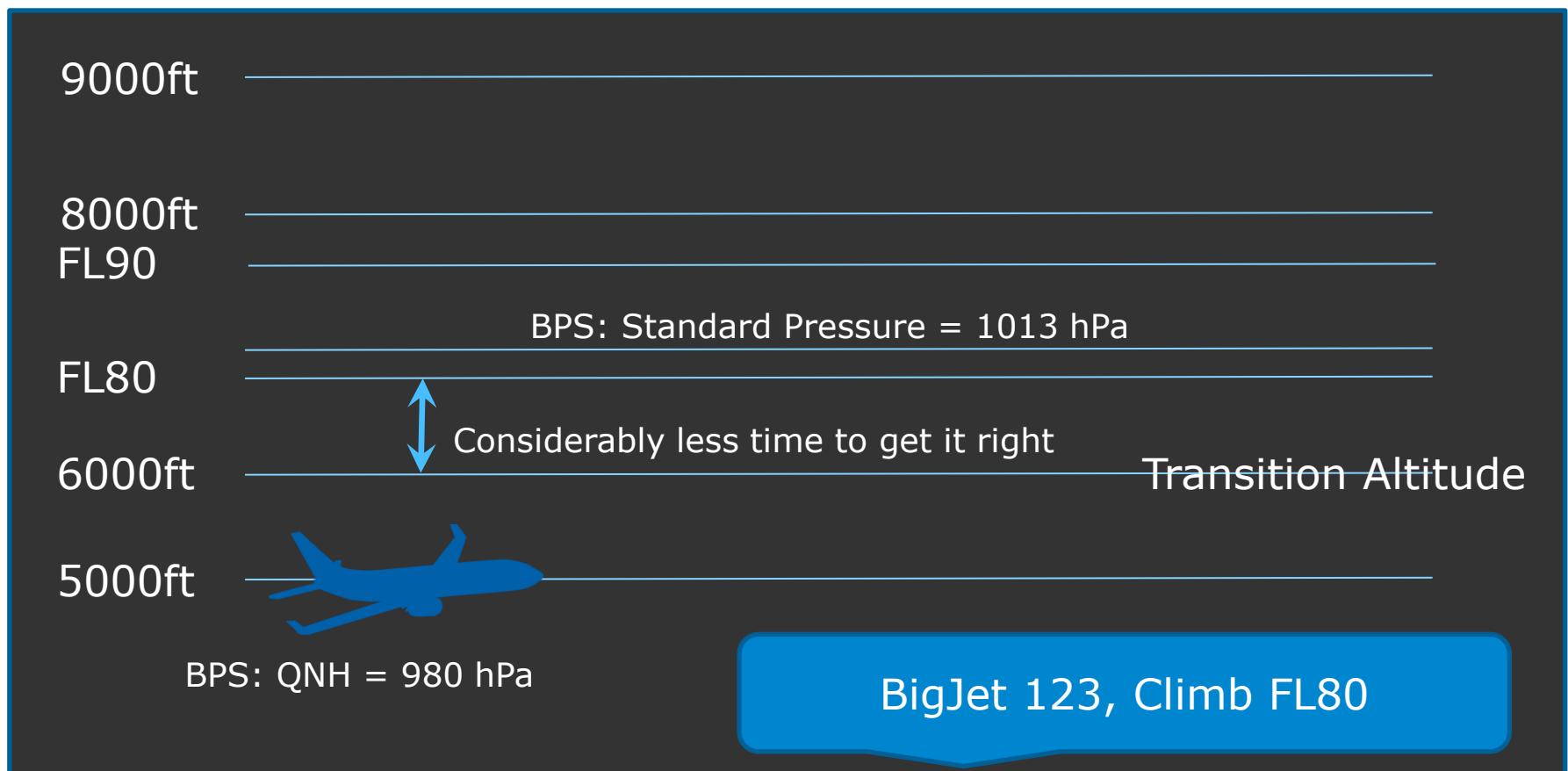
Transition Altitude



BigJet 123, Climb FL80

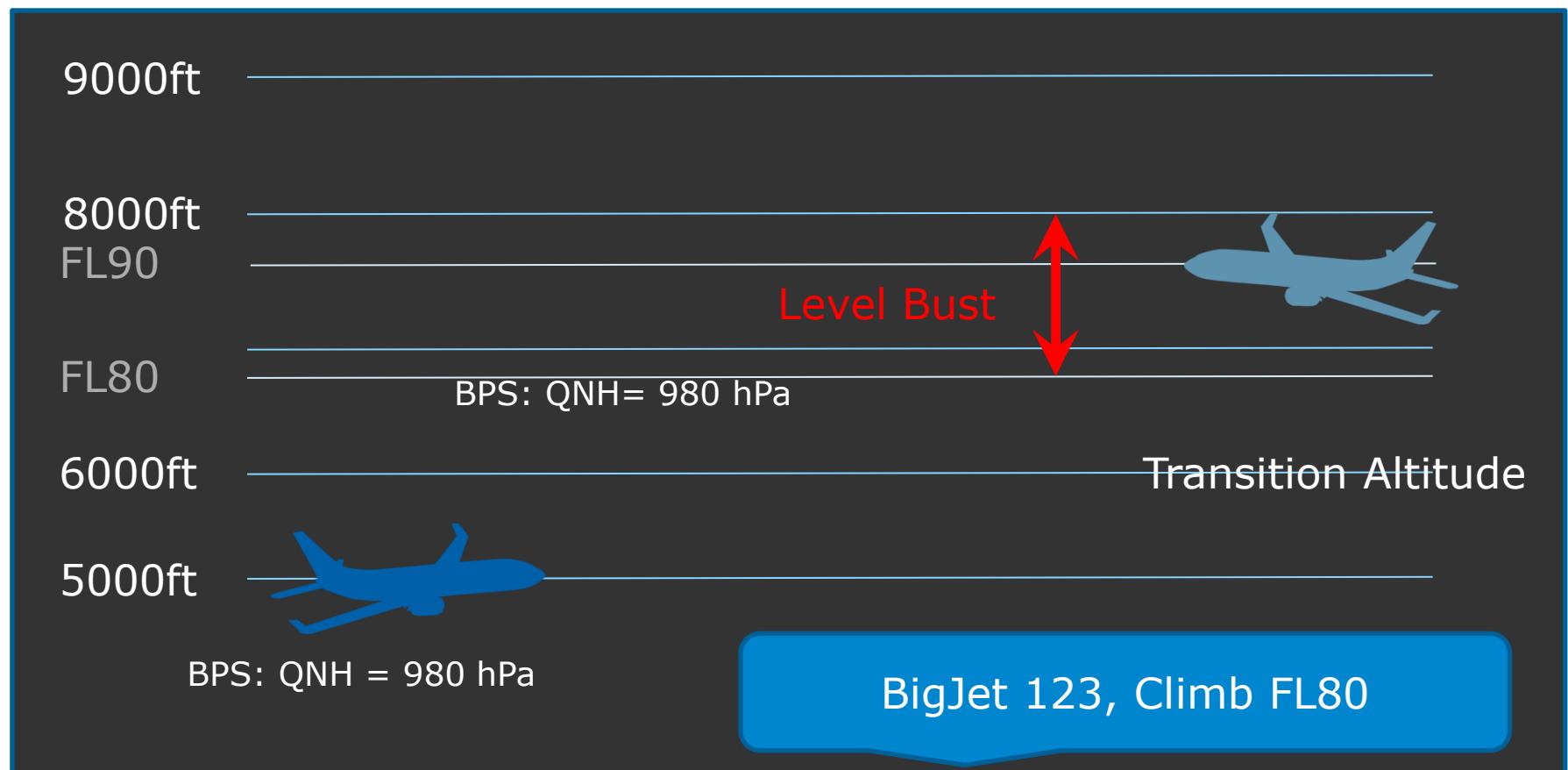
Level Bust due to ASE

QNH Atmospheric Pressure = 980 hPa
Typical Low Pressure



Level Bust due to ASE

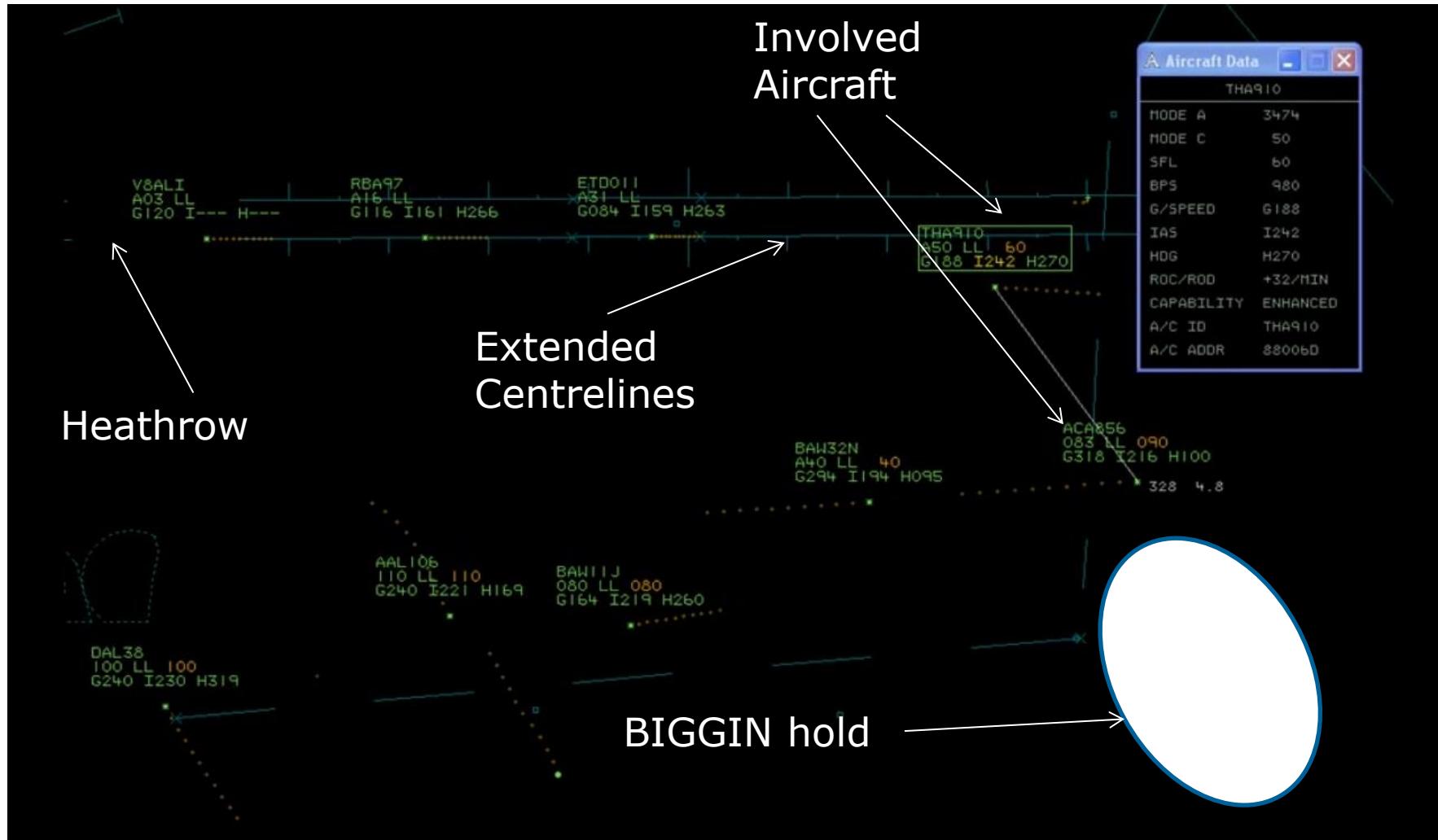
QNH Atmospheric Pressure = 980 hPa
Typical Low Pressure



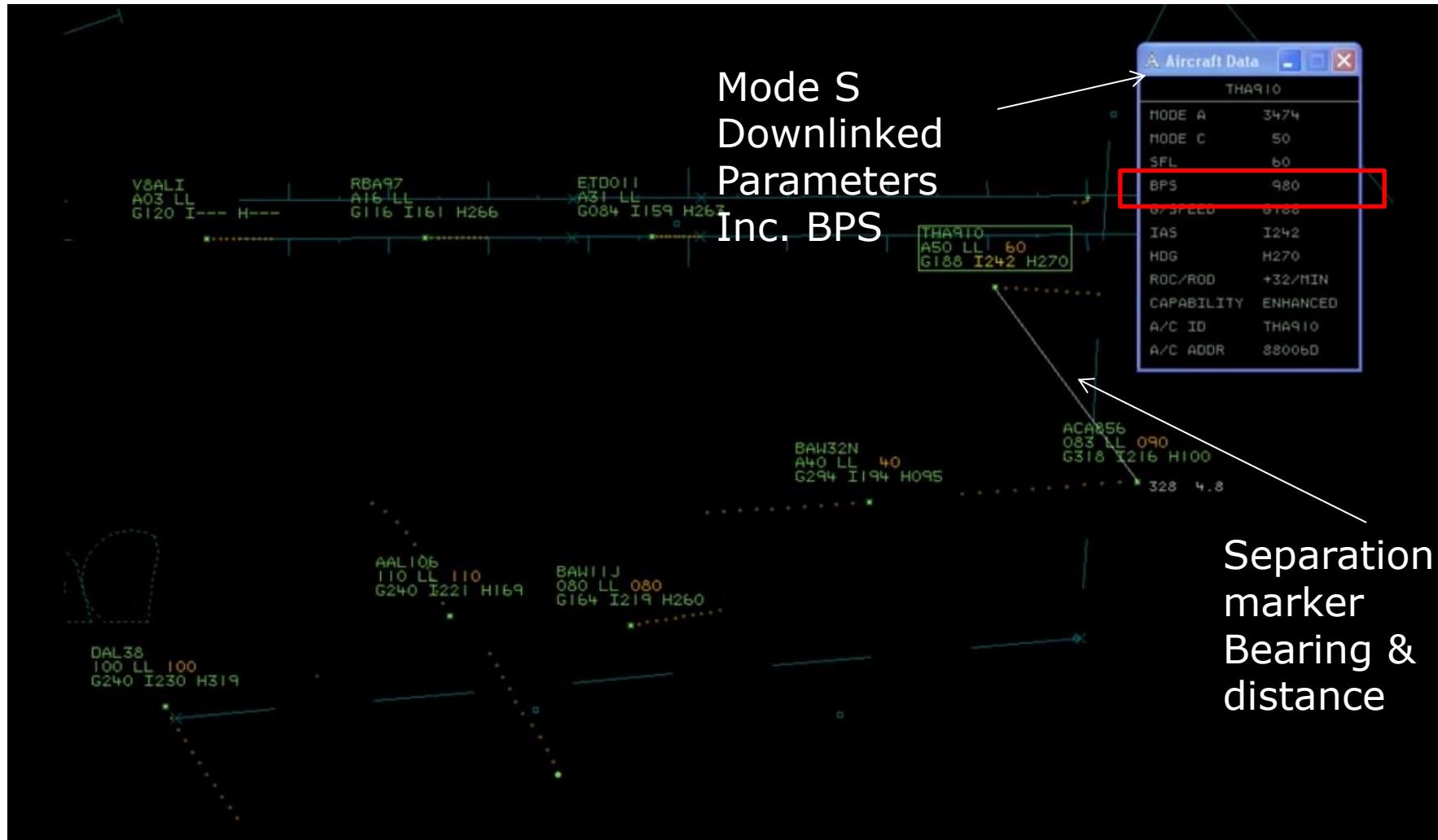
Level Busts in the London TMA - A Real Risk

- > A B747 in strong headwind conditions after a long flight
- > Low pressure
- > Tail end of the night shift
- > Morning of the storm nicknamed 'St Jude'
- > 5 go-arounds from 27L in a row
- > Both aircraft had gone around within the last 5 minutes and wanted to return to the holding pattern to wait for the weather to improve
- > Change of hold, extreme weather and fuel concerns contributed to high cockpit workload

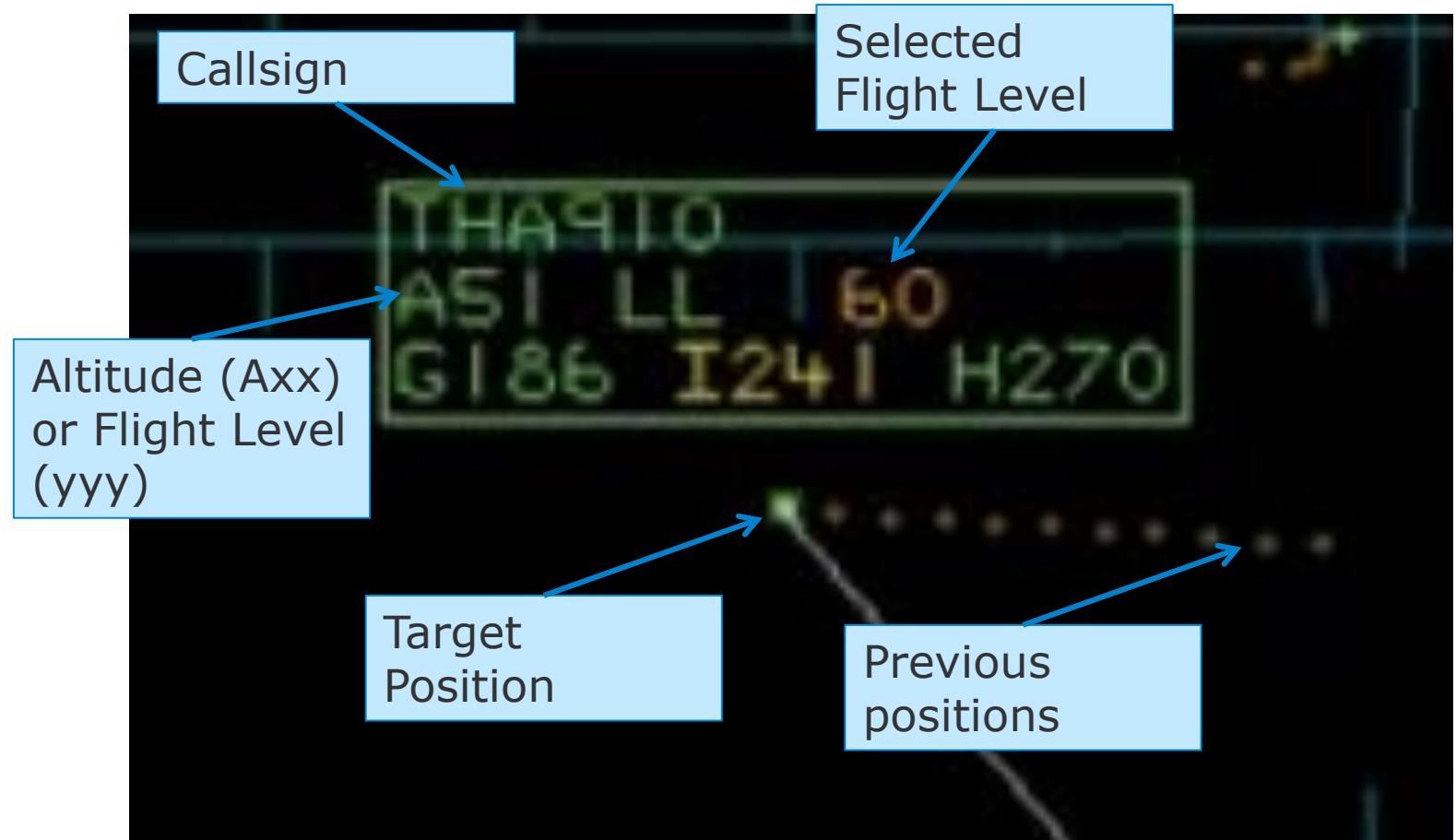
Interpretation 1



Interpretation 2



Interpretation3

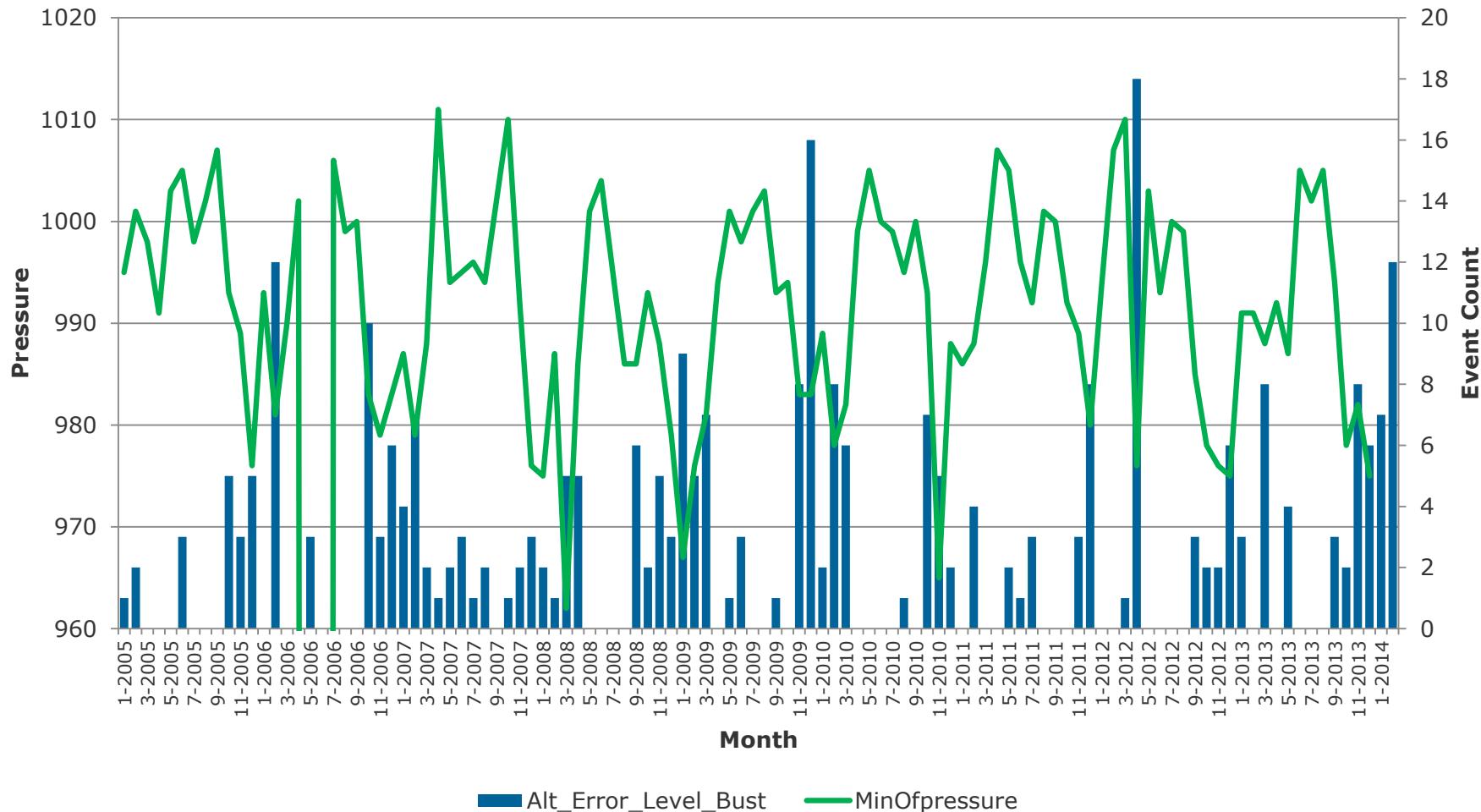


Level Busts in the London TMA

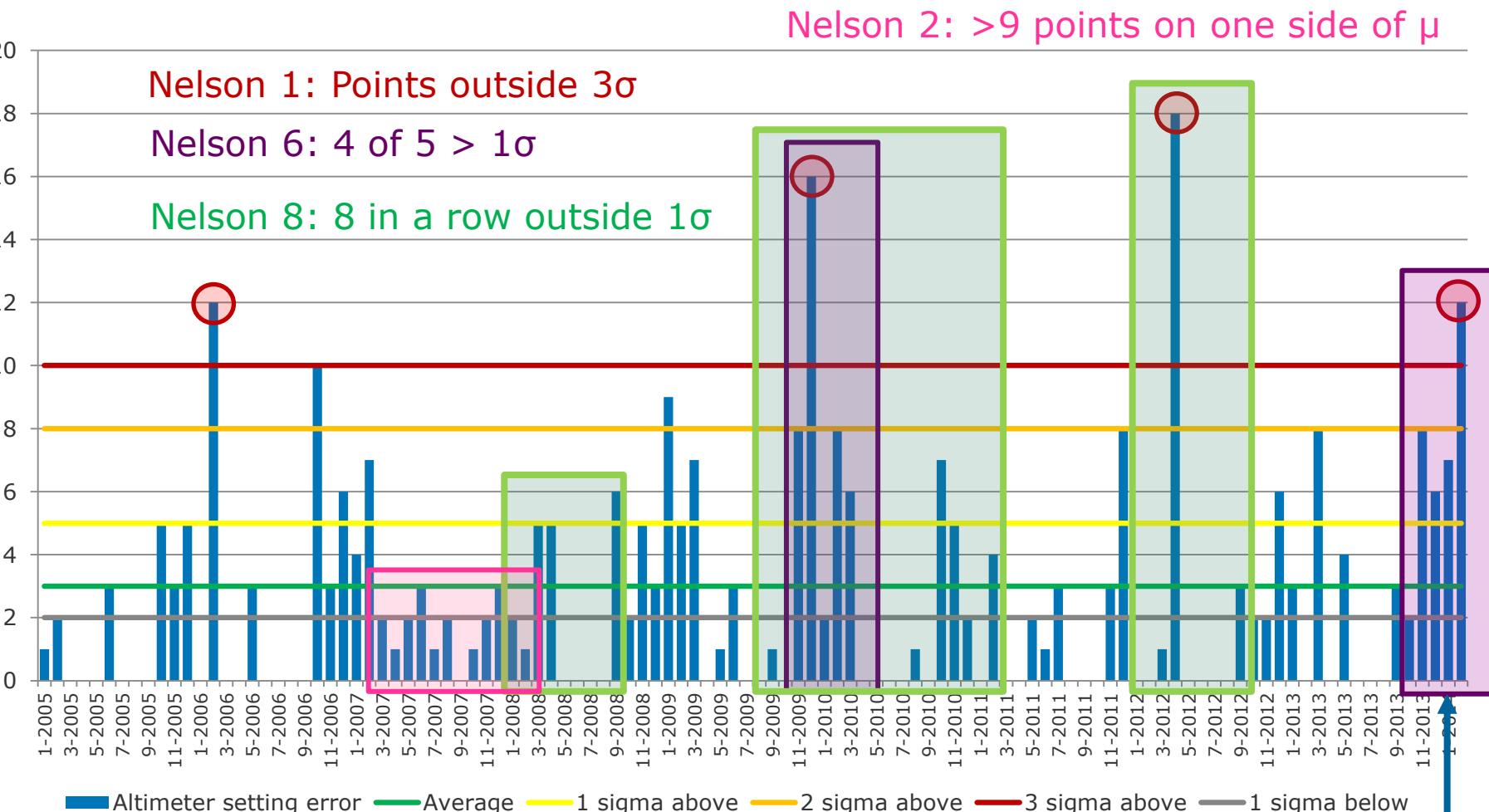
- Actions taken

- > A key risk to the NATS operation in the London TMA
- > Working with aircraft manufacturers to enable all aircraft to downlink barometric pressure settings to NATS systems
- > Expand and standardise the use of Mode S downlinked parameters
- > Transmit transition level on ATIS
- > Conduct studies with airlines, using everyday observations on the flight deck to identify issues and improve altimeter setting procedures and recommend improved SOPs
- > Longer term programmes such as...
 - redesign of the London TMA
 - raising the Transition Altitude
 - ... are expected to provide mitigation

The Numbers



Do we act?



Simple rules applied to the data suggest
an investigation is recommended

Temporary Operating Instruction

- > In early 2014 the UK experienced a prolonged period of low atmospheric pressure
- > At the same time there was a cluster of level busts at the transition altitude
- > Thought to be linked to Altimeter Setting Error
- > Tactical short-term response to address perceived trend issue a Temporary Operating Instruction (TOI) to controllers
- > Safety accountabilities in the operation drove behaviour
 - Pressure & Culture
 - Something must be done
 - What was being done wasn't enough

Level Bust due to Altimeter Setting Error

QNH Atmospheric Pressure < 1000 hPa

9000ft

8000ft

FL90

FL80

6000ft

5000ft

BPS: Standard Pressure = 1013 hPa

Transition Altitude

Must
Remember to
Change to
1013 hPa

BPS: QNH < 1000 hPa

BigJet 123, Climb FL80
Standard Pressure Setting

Temporary Operating Instruction



- Hoped the introduction of the phraseology would serve as a reminder to the pilot to set standard pressure setting (1013 hPa) and so reduce level busts due to ASE.
- Subject to normal hazard assessment process for a procedural change
- Implemented on 20 Feb 2014 on a trial basis with planned end date 20 May 2014
- Change also detailed in NOTAM

Unexpected Consequences

- > During the first days of implementation several occurrence reports were filed
- > Controllers noted that:
 - Flight crews did not understand the meaning of the instruction
 - Did not read back as required
- > Required:
 - Additional R/T to explain the instruction
 - Additional workload
 - Other unintended consequences

“... Standardised Dressing Setting”

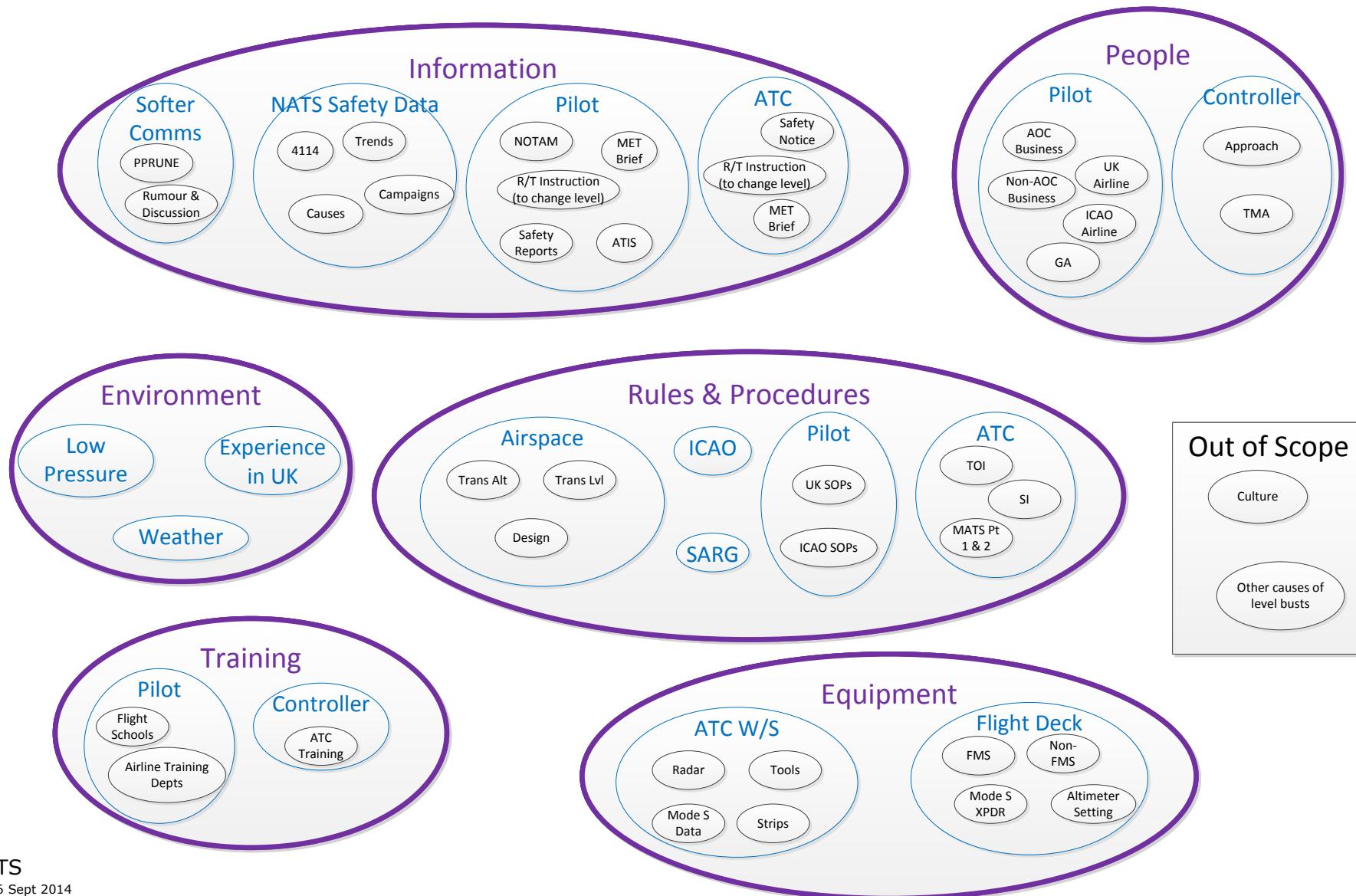
A Systems Thinking Approach

- > Reports served as a weak signal
- > Decided to explore the level bust problem, the TOI and the response to its introduction as events unfolded

- > Used some straightforward Systems Thinking techniques
- > Reflected on the 10 Systems Thinking principles in the White Paper

- > Highlighted that the TOI was
 - Simple, rational, understandable
 - TOIs are normal work for quickly mitigating issues in the operation
- > Outcome: Unfortunately ineffective solution to a more complex system problem
 - Couldn't predict the cause and effect

Purpose: Prevent Level Busts (due to altimeter setting error)



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Highlights what might work

- The most influential aspects of the system

Highlights what to be careful with

- Stopping criteria

Strong & Weak links

- Areas for improvement or action

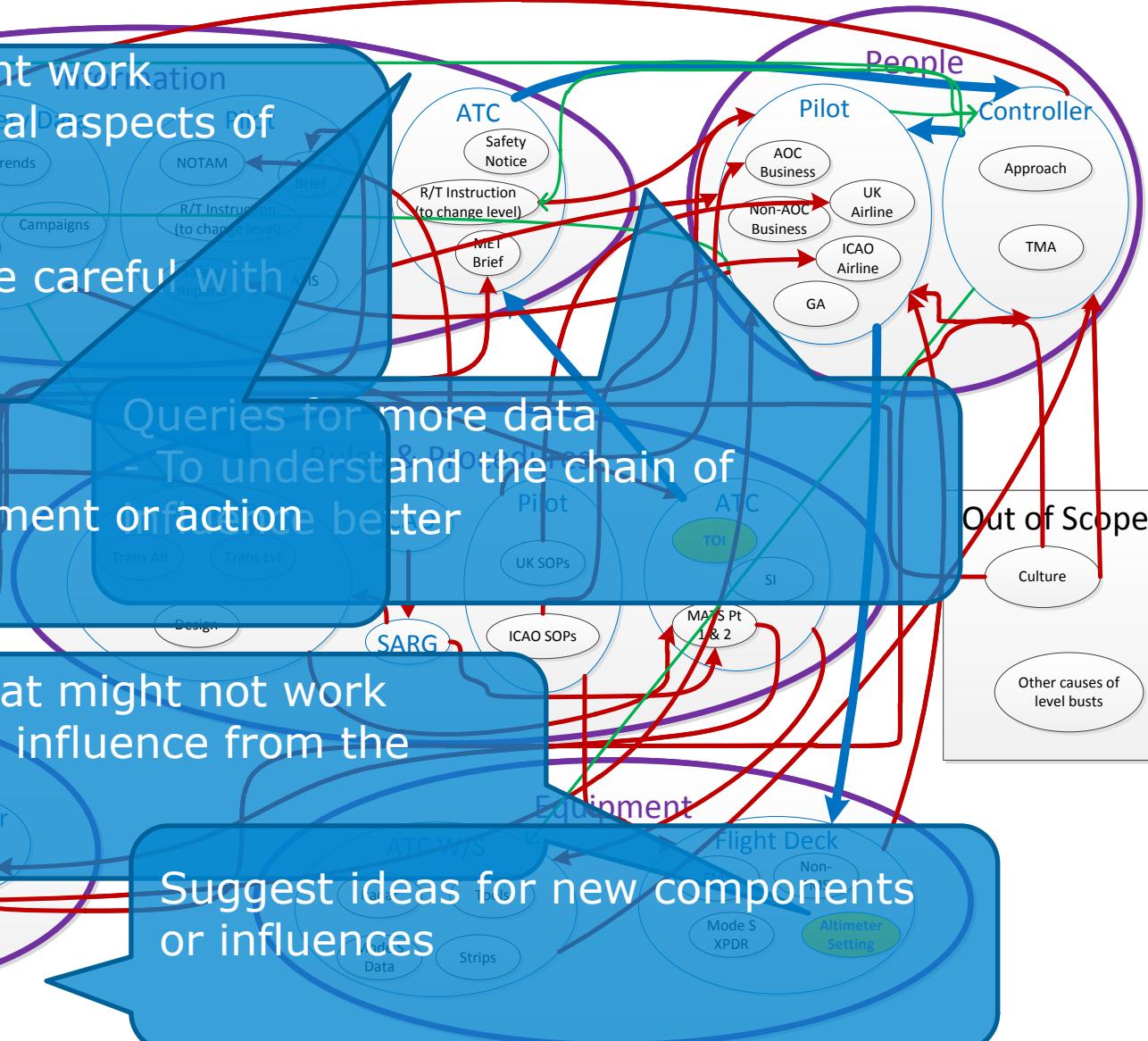
Queries for more data

- To understand the chain of influence better

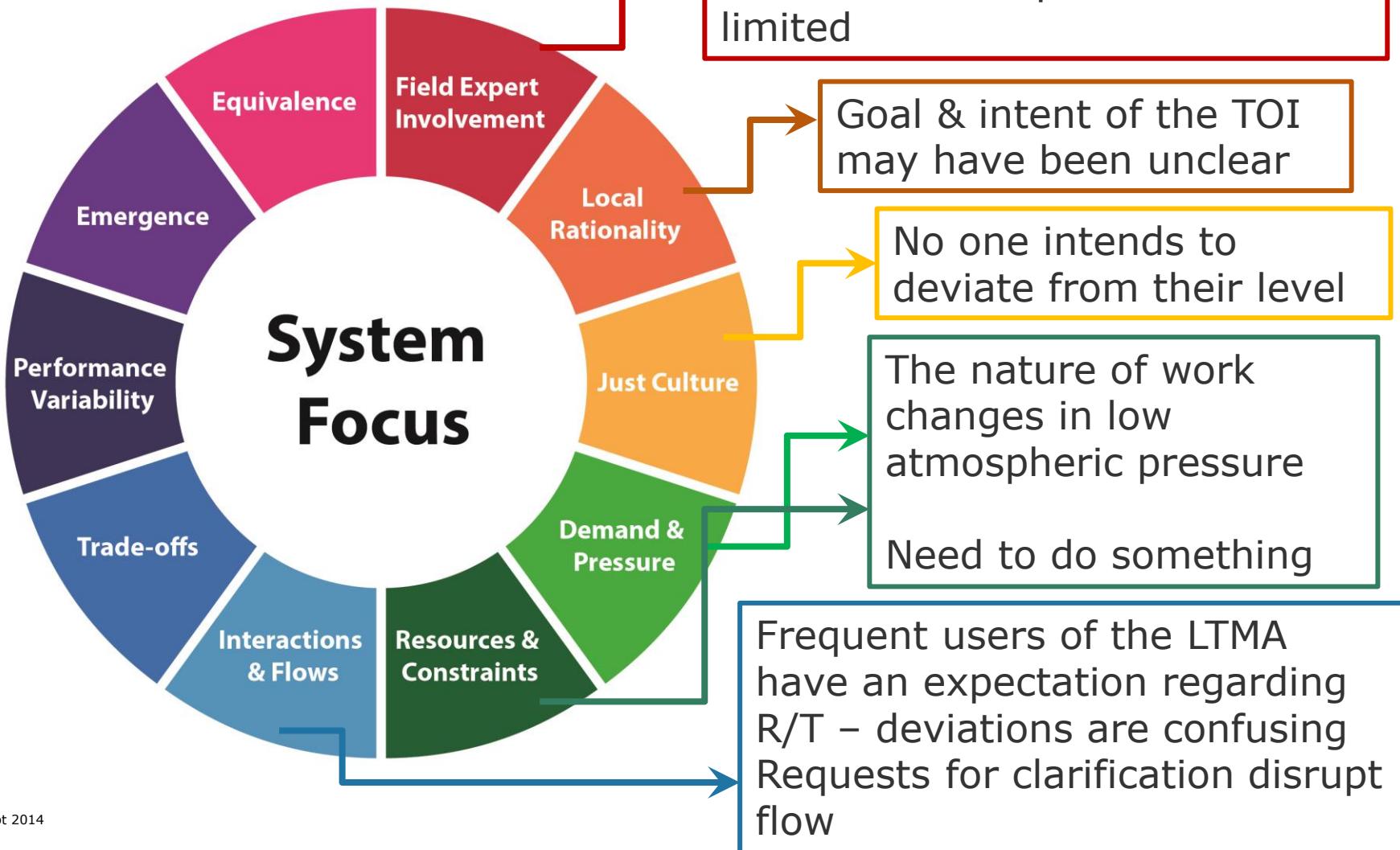
Highlights what might not work

- Distance in influence from the target

Suggest ideas for new components or influences



10 Principles - A few findings



10 Principles - A few findings

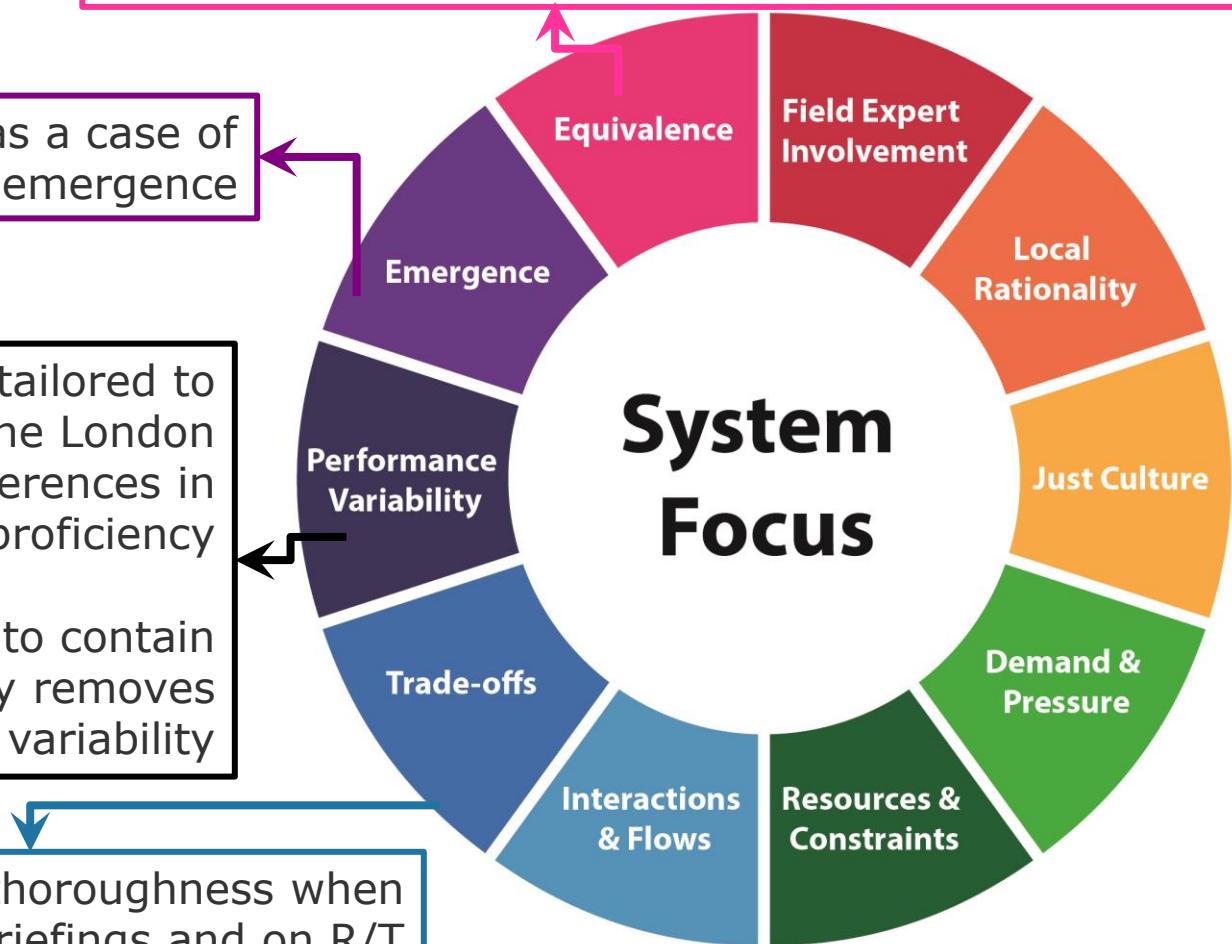
Analysis of normal work as source of both success and failure
Initially 'work as imagined' - next stage to consider 'work as done' via observational techniques

Outcome can be seen as a case of emergence

R/T is already deliberately tailored to pilots unfamiliar with the London TMA or due to differences in perceived English proficiency

Requiring all instructions to contain the new phraseology removes flexibility and performance variability

Efficiency and thoroughness when reading briefings and on R/T



Systems Focus:

- Overall Impressions



- > Systems Thinking & the 10 principles present a:
 - New Language
 - New Philosophy
 - New Mind-set

... which can be integrated and/or run in parallel with our other safety management activities
- > New perspectives and new questions
 - Allows 'total system' view
 - Socio-technical view not just equipment
- > Pictorial & Positive view of the way the system works
 - Helps communication & shows how work is really done
- > Systems safety principles guide a conversation about how components are influential on the system
 - Weaknesses and strengths of the system
 - Areas for possible action
- > A way of probing for unintended consequences

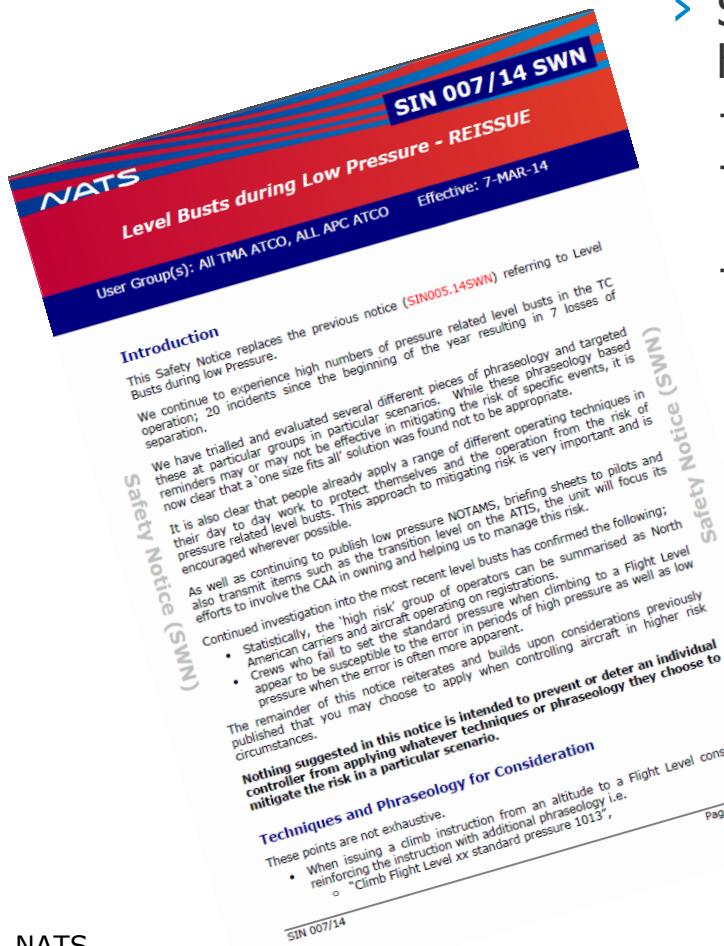
Systems Focus:

– Overall Impressions



- > There is still value in the 'Old Way' but should consider incorporating these ideas into our existing processes
- > Current focus has been on investigation
- > Further work is needed on embedding these ideas into the design and assurance of procedures & equipment
- > Benefits go beyond safety
 - Discussion of flow (and interruptions to flow) possibly highlights requirements for processes, systems, actions etc. to improve how the work works

What happened to the TOI?



- > The 'one size fits all' approach of the TOI was not sustainable
- > It was withdrawn
- > Subsequently, a safety notice was issued highlighting:
 - Level bust issue
 - Range of operating techniques available and already applied in day-to-day work
 - Reiterated possible risk mitigation actions including:
 - possible phraseology options
 - changes to controlling style
 - consideration of the cockpit workload

Summary, Conclusions & Next Steps



- > Systems Thinking, Safety II & Resilience Engineering present a welcome challenge to the accepted safety management principles used in NATS
- > Work shows considerable promise and ...
- > ... has been embraced within NATS Safety Strategy
 - Available on-line from www.nats.aero
- > But new approaches must
 - Be practical
 - Address more than just investigations but also the design of new systems & procedures
 - Be usable by people whose day job isn't safety management processes
- > Tentative, but positive, steps in this direction have been made

<http://nats.aero>

