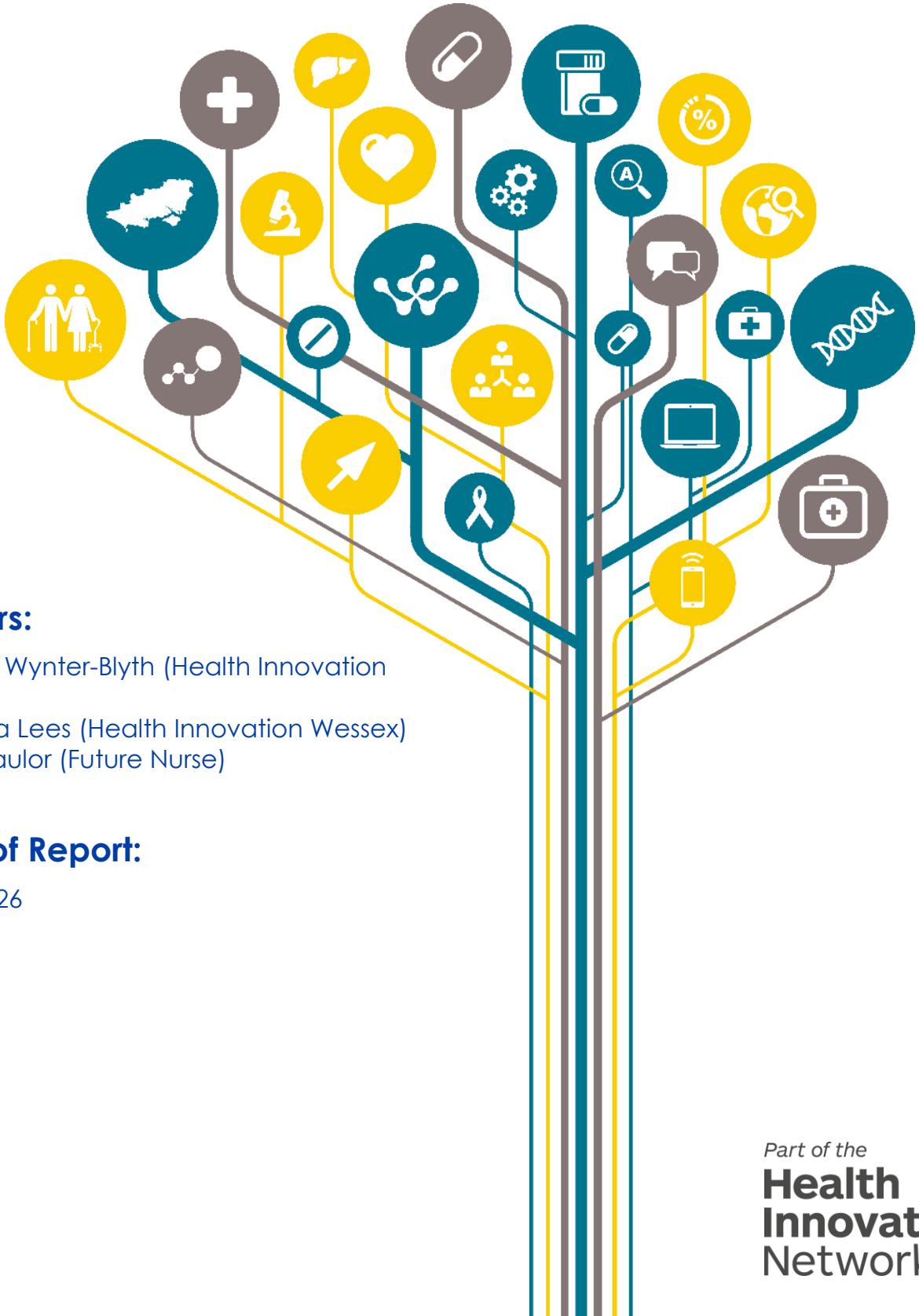
Wessex nurse-led innovation engagement events

Short report with mind maps



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Date of Report:

June 2026

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Acknowledgements

This work was funded by a Wessex Health Partners Small Grant. We would like to thank the project's stakeholder group for dissemination of invitations and extend our gratitude to the staff who gave their time to share their views and experiences with us at the engagement events.

Contents

Background and introduction

The 10-Year Health Plan highlights the ability of the NHS to adopt and scale innovation as vital to its future. Nurses are central to this, yet relative to other professions, nurses are less likely to access innovation development opportunities.

Data from the NHS Clinical Entrepreneur Programme shows that across seven years of the programme, nurses have made up no more than 6.6% of the cohort. Whilst nurses often create practical solutions in practice, these innovations rarely spread beyond their immediate environment, ultimately limiting their wider impact.

This project aimed to understand the enablers and barriers to nurse-led innovation across Wessex and to identify priorities for action. Its objectives were to:

- Convene a steering group of stakeholders across Wessex
- Hold two online engagement events with nurses, students, educators, innovators, and patient representatives to understand the enablers and barriers to nurse-led innovation and agree key priorities for action.
- Produce a report to inform the next phase of the project, which is to co-design solutions.

If the findings of this project are acted upon, the potential long-term benefits include improved nurse satisfaction and retention through the wider spread of nurse-led innovations.

Approach

Steering group formation

In line with the requirements of the small-scale funding awarded from Wessex Health Partners (WHP), in the early stages of the project we engaged a broad range of WHP member organisations. Early discussions included chief nurses, research and innovation leads, and academics involved in pre- and post-registration education of nurses. From these discussions the steering group was convened.

Due to the busy schedules of steering group members, we engaged with them asynchronously throughout the course of the project, asking for their advice and input at various stages including to assist and guide dissemination of event invitations. The majority of the steering group attended at least one engagement event.

Online engagement events

Participants attended a one hour Microsoft Teams webinar. At the start of each session a short introduction was presented, setting out the aims of the project and the format for the event. Participants were then given each question in turn, a brief moment to consider their response, and invited to enter their answers in the Teams chat. This approach, adapted from the Health Innovation Wessex Rapid Insight methodology, allowed all participants to respond simultaneously, without the dynamics of spoken discussion influencing individual contributions. Responses were downloaded from the chat after each event.

Analysis was conducted by three members of the team (Venetia Wynter-Blyth, Amanda Lees, and Ada Ukaulor). Responses were reviewed and organised into thematic categories in Excel before being transferred into mind maps, one per question, to provide a visual summary of findings. In this report, findings are presented thematically rather than question by question, as responses frequently cut across multiple questions.

To enable broad participation, a reimbursement was offered to all attendees (excluding steering group members). Events were held at different times of day to maximise accessibility.

Questions covered:

- Q1: What does innovation mean to you?
- Q2: Do you see yourself as someone who innovates, if so why, and if not why not?
- Q3: What helps when you're trying to do something new?
- Q4: What gets in the way when you're trying to do something new?
- Q5: If you could change something tomorrow to make nurse-led innovation easier, what would it be?
- Q6: What is designed to support you to innovate, and what is your experience of accessing it? (Event 2 only)
- Q7: What additional support, inside or outside your organisation, would help you to innovate? (Event 2 only)

Participants

Event 1 (11 May 2026, 19 participants) drew participants who identified mainly as leaders, working across digital transformation, quality improvement, service development and operational leadership in acute trusts and an ICB. Just over a third were nurses in frontline or specialist roles, with a smaller group of educators. Discussion gravitated toward the wider system, including hierarchy, permission, governance and culture.

Event 2 (18 May 2026, 14 participants) had a different composition. Half of contributors identified as educators, practice development leads, clinical practice educators, an education quality lead, alongside a smaller group of nurses working in critical care outreach, primary care and ward leadership. The conversation was more clinically grounded and focused on practical service improvement, mentorship and coaching, and how to make innovation feel accessible rather than rarefied.

Findings

What does innovation mean to you?

Across both events, definitions of innovation were wide and largely confident. Common framings included "change for the better," "thinking outside the box," "working smarter not necessarily harder," "adding value to an existing thing," and "to

be disruptive, but in a good way." A clear theme in Event 2 was scale-agnosticism, that innovation can be small as well as big:

> *"Innovation can be a small thing, it doesn't have to be big or huge. It doesn't have to be tech-inclined, but it should have impact and value."* Nurse, Event 2

> *"Innovation is the start of something, not the end point — a journey to improvement for patients, staff, students and others. It does not need to be complex; simple is often best."* Educator, Event 2

Sitting alongside these were two of the more striking quotes:

> *"It feels like an invitation to the future."* Leader, Event 1

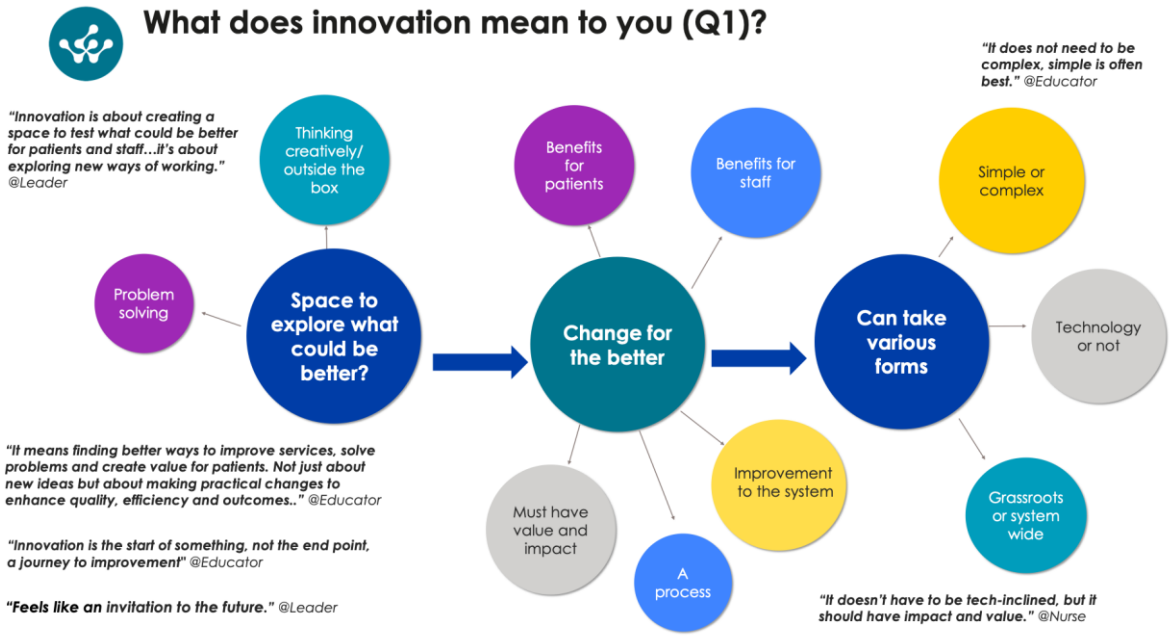
And from the very start of the Event 2 conversation about identity, a candid challenge to the language itself:

> *"Innovation sounds a big and complex word - is there another word that reduces this and makes it more accessible to all?"* Educator, Event 2

> *"When I hear the word innovation, it sounds like something big, new and relevant to me, and I can partake when the innovation process is all complete."* Nurse, Event 1

Most participants had no trouble owning the work. But for a notable minority, the vocabulary itself signalled something big or complex, making the smaller, everyday improvements they were already making harder to recognise as part of the same activity.

Figure 1: What does innovation mean to you? Mind map of responses



Do nurses see themselves as innovators?

In both events the dominant answer was yes, often with specific examples. Leaders described actively building conditions for others to innovate (*"I am working on providing the right environment for my team to be the innovators"*). Frontline nurses cited direct experience (*"as nurses, due to our experiences on the job, we have the capacity to innovate"*). Educators described continually adapting teaching, communication and processes.

A recurring theme across both events was that innovation is tied to permission. Event 1 raised this most explicitly:

> *"Yes at different times. It relates to being in a role where you have permission from line manager/organisation to take the leap of faith."*
>
> *"For me it's having a naturally inquisitive mind, not being afraid to ask 'why'… Again this is tied to 'permission'."*
>
> *"Sometimes it's better to ask for forgiveness than permission!"*

Event 2 added an important variation, permission can be something you grant yourself:

> *"Some of it is giving yourself permission to do something, not needing to get permission from others."* Educator, Event 2

A smaller group across both events hesitated to claim the role. Sometimes this was a journey (*"I did not use to be an innovator as I worked within a team in a clinical area and I just followed suit"*). Sometimes it was confidence, one educator described

herself as "partly yes" and added, "sometimes it is about confidence." And one nurse described the limits of being heard beyond their immediate team:

> *"I can often make small suggestions or have ideas about how to improve the way we work within my immediate team, however when attempting to have my voice heard on a larger scale there seems to be a barrier to being listened to due to hierarchy and organisational demand."*

These hesitations were a minority view, but a significant one. They point to where capability is already present and confidence, permission or recognition has not yet caught up.

A pattern across both events is worth noting. The participants who claimed "innovator" most readily tended to be either in roles where permission was already structural, service development, digital, advanced practice, ward leadership, or personally disposed to ask "why" regardless of the environment. The participants who hesitated were earlier in their journey, explicitly named confidence as the issue, or were running up against the ceiling between local influence and organisational influence. This suggests an inflexion point: some nurses can compensate for poor conditions through personal disposition or positional authority, but some cannot. Investing in conditions therefore disproportionately benefits the group whose innovation activity is currently least visible.

Figure 2: Do you see yourself as someone who innovates? Mind map of responses

What enables innovation?

Proximity as currency. Nurses are well-placed to identify what needs to change because of their closeness to patients, teams and systems. That proximity is a form of

innovation currency: it surfaces inefficiencies, risks, unmet needs and opportunities that are harder to see from further away.

Innovation in most accounts began not with strategy or technology, but with noticing. Event 2 extended this point: noticing is sharpened by different perspectives, and students were named as a particularly valuable source, bringing fresh eyes from outside the team to problems insiders have stopped seeing.

> "*Students often come and work in areas for the first time and are a fresh pair of eyes for problems we have normalised or do not recognise as problems. The rotational aspect of their training gives them an advantage.*" Leader, Event 2

Supportive leadership and psychological safety. The single most consistent enabler across both events was the environment people were working in:

> "*An environment that is psychologically safe encourages me to be innovative.*" Nurse, Event 1

> "*The support of the system around you (senior managers, colleagues, staff). What we often don't recognise is the necessity of having 'headspace' to innovate.*" Leader, Event 2

Time to think. Across both events, "time" meant something specific, not just hours, but headspace.

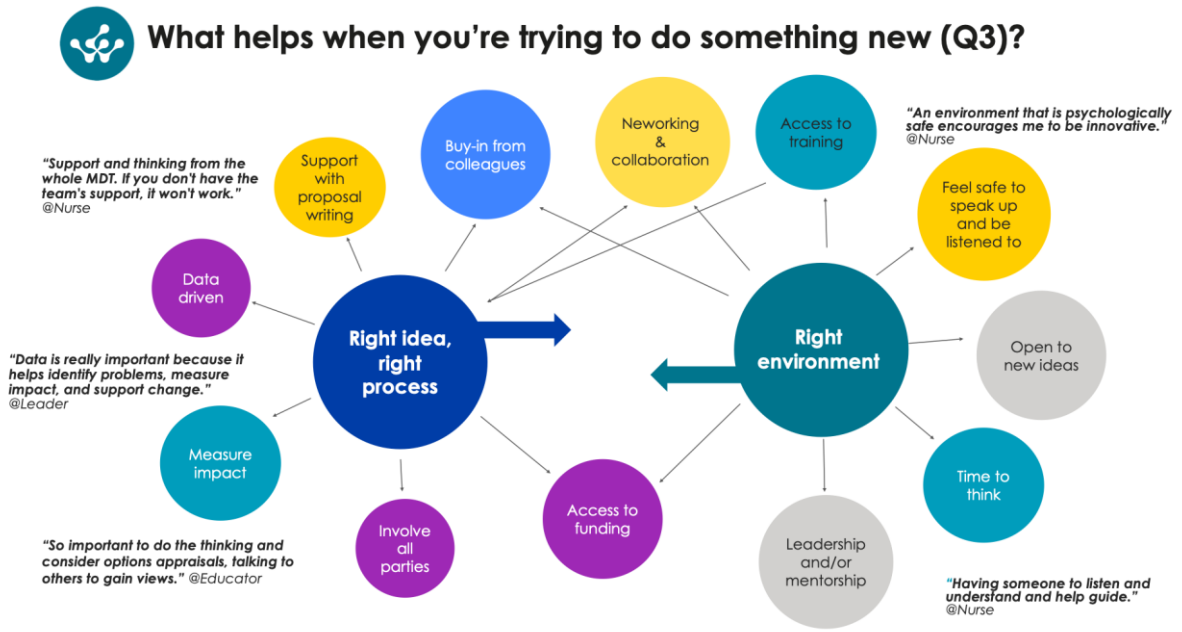
> "*Time to think! So important to do the thinking and consider options appraisals, talking to others to gain views. Think of the end user and put yourself in their shoes.*" Educator, Event 2

The right connections. Event 2 made an additional point about how innovation moves: through relationships and credibility.

> "*Having the right connections with the right people can open a lot of doors that might otherwise be closed.*" Leader, Event 2

Data, storytelling and training. Event 1 emphasised data and storytelling as ways to make the case for change ("data and storytelling to 'sell' the idea"). Formal QI training, leadership programmes (Florence Nightingale Scholar, Windsor Leadership, RADA, CHIME, NHS Leadership Academy) and access to networks like UKONS were all named as valuable, though several participants noted that getting time off to attend training was itself a barrier.

Figure 3: What helps when you're trying to do something new? Mind map of responses



What gets in the way of innovation?

The barriers participants described were structural rather than personal: time and headspace, financial limitations, change fatigue, hierarchy, resistance, and, distinctively from Event 2, interdepartmental politics.

> *"Work pressure to keep doing the day job can hamper the headspace needed to consider change, even when you know improvements can be made."* Leader, Event 1

> *"The hierarchy is complicated, burnout is significant, and productive discussion is often not the way these ideas are managed, instead we have a 'NO' from someone higher up and the conversation is over."* Educator, Event 1

> *"The constant conveyor belt of clinical practice can easily stifle innovation: people may have the ideas but then struggle to have the capacity to actually bring them to fruition."* Leader, Event 2

> *"Interdepartmental politics. I struggled with a recent project with obstetrics, as the consultant body felt that introducing the project would give the midwifery staff licence to 'undermine' them."* Leader, Event 2

Several participants in Event 1 also recognised that healthcare innovation differs from innovation in commercial or software settings: it happens inside *"safety, ethics and governance"*, a constraint that is real and legitimate, not a barrier to be removed.

A separate kind of barrier, surfaced in Event 2, was awareness: not every nurse knows what support already exists.

> *"This is new to me. I am unaware of what is designed to support me to innovate - attending this session to give me an insight."* Educator, Event 2

Figure 4: What gets in the way when you're trying to do something new? Mind map of responses

Enablers and barriers at a glance

Enablers	Barriers
Protected time and headspace	Time pressure and clinical demand
Supportive leadership and explicit permission	Hierarchy and "NO from above"
Psychological safety	Resistance and "we've always done it this way"
Collaboration, MDT support, right connections	Interdepartmental politics
Students and fresh eyes and perspectives	Staffing, workload, burnout
Mentorship, coaching, communities of practice	Limited authority beyond own team
Data and storytelling	Lack of funding and resources

Enablers	Barriers
QI, leadership and project-management training	Bureaucracy, change fatigue, low awareness of existing support

What change would enable nurse-led innovation?

Participants were specific. The most-named change across both events was protected time to think, to develop ideas and to follow through. (Responses below draw on Q5 from both events and Q6 and Q7 from Event 2, which explored existing and additional support for innovation. Mind maps for these 2 questions are presented in the appendix)

- Cultures that listen and remove tribalism, with a "real desire from management/organisation to listen and learn from their staff" and frontline staff involved at the early stages of any project.
- Innovation embedded into the day job, written into job descriptions, person specifications, appraisals and revalidation, and supported by project-management education for all.
- Making innovation the "norm", accessible to all staff, not the preserve of senior or digital roles, with some participants asking whether innovation work should expand beyond nursing to all professions, since projects cross professional boundaries.
- Student involvement as a deliberate source of fresh-eyes innovation.
- Mentorship, coaching and peer-to-peer support, including an innovator peer mentorship / innovation champions model, coaching expanded into innovation specifically, and a community of nurse innovators.
- Practical infrastructure to share what works, communities of practice, bite-sized CPD, opportunities to showcase projects, clear innovation pathways, and easier routes to small pots of funding.

They also pointed to working examples worth borrowing:

- A "Dragons' Den" model at Portsmouth Hospitals, supported by the hospital charity and a local business.
- CSI 7 at University Hospital Southampton, a monthly showcase where staff present QI projects in seven slides and seven minutes.
- Quality, Service Improvement and Redesign and other formal QI training.
- Transformation teams (where they exist and have capacity), the NHS Leadership Academy, and specialty networks e.g. UKONS.
- The aspiration of an "innovation support lab" accessible to all nurses, with published success stories.

Figure 5: If you could change something tomorrow to make nurse led innovation easier what would it be? Mind map of responses

Conclusions

These events surface a consistent and coherent picture. Among those who took part, the barriers to innovation were not individual or motivational but structural. People pointed to time pressure, hierarchy, a lack of permission and limited awareness of what support already exists. The enablers they described were structural too: protected time, psychological safety, supportive leadership and good working relationships.

What also came through strongly is why nurses are so well placed to lead innovation in the first place. Their proximity to frontline care means they often notice what needs to change before anyone else, seeing the inefficiencies, risks and unmet needs that are harder to spot from further away. This closeness is not incidental to innovation. It is the source of it. In most accounts, innovation began not with strategy or technology but with noticing.

Yet one of the clearest messages was about the word itself. For some, innovation is "*an invitation to the future*" ambitious and transformative. But for others, that same language gets in the way. As one person put it, "*innovation sounds a big and complex word. Is there another word that reduces this and makes it more accessible to all?*" A nurse described a similar feeling, *that "when I hear the word innovation, it sounds like something big, new and relevant to me, and I can partake when the innovation process is all complete*." The word makes innovation sound big, finished and complex, and harder to see in the small everyday improvements people are already making. If nurse-led innovation is to become the norm rather than the preserve of a confident few, the concept needs to feel accessible to everyone. That means rethinking how

we talk about innovation and embedding it in everyday practice rather than treating it as something separate or specialist. It also means encouraging one another to recognise and name the changes we make. Sometimes it is the simplest change that makes the biggest difference, and that deserves to be celebrated just as much as the visionary one.

Encouragingly, when participants turned to solutions, they reached instinctively for one another. The changes they asked for were rarely individual. They wanted communities of nurse innovators, peer mentorship and innovation champions, chances to share what works, and cultures that listen. Innovation was understood not as a solitary act but as something done together, sustained by connection and collective thinking. The way forward they described is therefore as much about building community as it is about removing barriers.

Two voices

To close, two composite voices drawn directly from participants' words, using an I-poetry approach informed by the Listening Guide. I-poetry involves extracting and re-sequencing first-person (I) statements from qualitative transcripts to trace participants' voices and subjectivities across their narratives. We used AI to support the development of these I-poems from the meeting chats. The left hand voice belongs to the nurse the report describes as positionally resourced; the right to the one whose innovation activity remains least visible. These are all direct quotes, only small connective words have been added.

I ask why

The confident voice
I hear the word
it feels like an invitation
I ask why
I am not afraid
I give myself permission
I do not wait to be asked
I have the capacity
I would rather ask forgiveness

I followed suit

The hesitant voice
I hear the word
it sounds big to me
I am partly yes
it is about confidence
I worked within a team
I just followed suit
I can partake
when it is all complete
I make small suggestions
I have ideas
but my voice does not carry
this is new to me
I am unaware

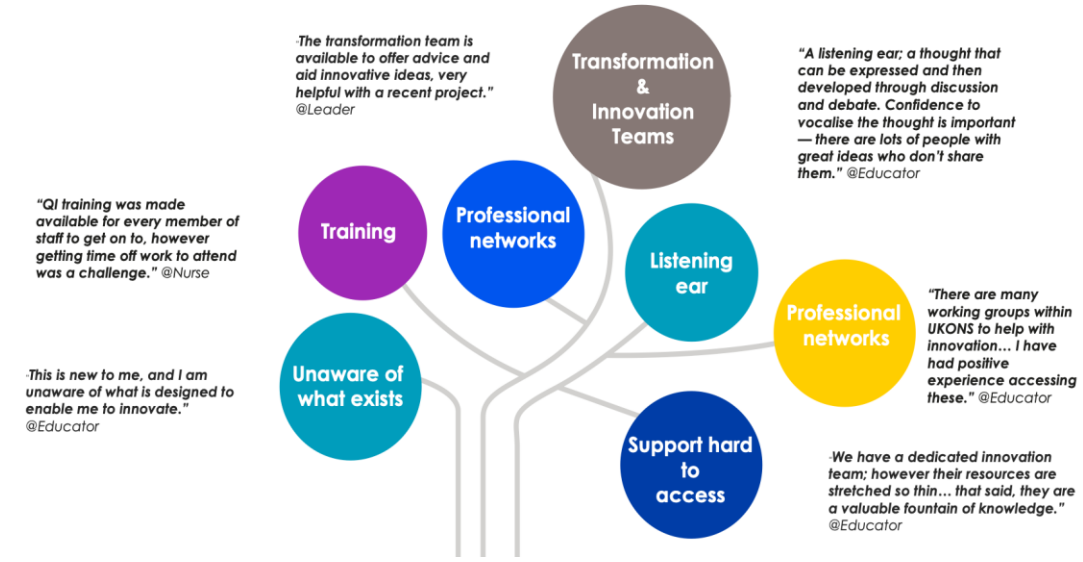
Next steps

- Share findings and seek comments from steering group and event attendees.
- Extend reach to underserved groups. The patterns identified here need stress-testing with audiences this round did not reach: student nurses, newly qualified staff, community and primary care nurses, internationally educated nurses, and nurses outside the "engaged-with-innovation" networks that surfaced this group.
- Target those least visible. The pattern that confident, positionally resourced innovators compensate for poor conditions while everyone else cannot has a clear policy implication. An intervention designed specifically for the less visible group, through coaching, peer mentorship, permission-granting from line managers and structured space to bring local ideas forward, is a different proposition from the leadership-academy and Clinical Entrepreneur model, which mostly reaches those already confident and positionally resourced.
- Further discussion with the steering group to determine the collaborative next phase, including grant funding focus and co-design priorities.

Appendix
Mind maps from Event 2 (Q6 and Q7)

Mind maps for Questions 6 and 7, asked at Event 2 only, are presented here. Their findings are woven through the sections on enablers and on what change would enable nurse-led innovation.

What is designed to support you to innovate, and what is your experience of accessing it (Q6)?



What additional support, inside or outside your organization, would help you to innovate (Q7)?