**Helen: Eve, tell me why you’re so passionate for patient and staff safety, and your journey to where you’ve got to now.**

Eve: My passion for staff safety was actually borne out of frustration…frustration with organisations making decisions based on finances as opposed to patient and staff safety. And that was really the heady days of turnaround… a glossy way of phrasing transformation. But that whole idea of, almost, ‘death by a thousand cuts’, and not thinking about what that would actually mean for the staff on the ground or even the patients… It was just ‘if we remove X amount then we’ll be able to make £10,000 per ward’ or ‘we can save £50,000 here’. And just not paying attention to stuff… poor quality care costs money. And if we don’t focus on staff and patient safety, it costs us more. So why start with death by a thousand cuts? Why not concentrate on improving our patient and staff safety, and then we’ve surely got a win-win?

**Helen: So what you did is kind of go ‘It’s not going to work on the basis of what we’re doing now; there are some ways of thinking that need to be changed; and we need some alternative ways of working’. And you helped create some of that?**

Eve: Yes, going into somewhere and saying, ‘What I need you to do, Eve, is we need to save five million pounds in nursing, biggest budget, off you go’. I said, ‘Stop, let’s look at things differently. Can we look at care levels first of all? So, what care do we need?’ Let’s break through the words around ‘we must’ and [ask] ‘what care do we need’? And ‘how are we going to provide that?’ And then ‘how many staff does that need?’ So looking at care levels first, then looking at costs, then looking at the number of people.

And, after doing this a number of times, I ended up stopping and saying, ‘Can I do something, can I create something, that’s going to make that easier. So, working with a colleague, [we] created a tool called Establishment Genie that is about workforce planning; bringing clinical and corporate colleagues together to look at workforce planning and safe staffing and outcomes… It’s used across all settings of care and it’s been an amazing experience to be able to use that data and use those outcomes to change the conversation. But also to show the impact of, if we really focus on that and we focus on the right number of staff and our staff wellbeing, that actually the patient care that comes out and the quality improvement that comes out, and really involving our staff in those conversations, is absolutely huge. So that’s really where it came from – just not allowing that level of ridiculous decision-making around finances to happen and actually having an informed discussion where you can say, ‘Would you want your mother to be looked after on that ward, or by that team?’ And if the answer is ‘no’, then what are we going to do about it? And that just absolutely is a game changer.

**Helen: And so, if someone said to you, ‘What do we mean by staff safety?’ What’s your take on safe staffing? What does it look like?**

Eve: There’s just not enough research out there. There’s a fair amount on patient safety; not enough. But there really is very, very little on staff safety. And, often, what we mean by ‘staff safety’ is ‘safe staffing’. And we know there’s stuff around mandated staffing levels, campaigns… to make that happen. But actually it’s more than that. It’s talking about making sure we’re looking at the whole picture; to make sure that our staff feel valued, to make sure they understand their role in the organisation and how they participate in that whole; to make them feel supported; to have a culture where there is no blame so they can speak up and they can do things that make things better. Because, actually, if we really think about patient safety and staff safety, people really understand it, and where there are holes and gaps, people working on the front-line. And if they don’t have the confidence or the support to talk about it… warts and all… Those best organisations don’t hide behind gagging orders… They speak openly about what has happened and what they’re doing and how they’ve learnt from it… So that’s part of it.

We know that our nursing staff experience higher levels of sickness than any other group. Why is that? It’s not just about not having the right number of staff on a ward or in a team, there are other pieces that go with it. Is it because they didn’t have the right PPE, so they’ve been sick during Covid? Is it because they haven’t had the right training, so maybe they’re off sick because they didn’t have lifting and handling training?... Have they been listened to when there’s been a problem? Is it stress, about their mental wellbeing? Is it about the environment they’re working in? We know, right at the moment, there’s an awful lot of anger and so [nursing staff, our care staff, are often absorbing that anger](https://www.pslhub.org/learn/coronavirus-covid19/273_blogs/are-we-suffering-compassion-fatigue-the-impact-emotional-labour-is-having-on-staff-wellbeing-r2844/). Who’s helping them with that? And who’s helping them with some of their experiences over recent times? So safe staffing and staff safety are slightly different things.

There’s also something that says… We know that the experience of our healthcare staff is absolutely strongly connected to the way they care for their patients. We also know that staff who are consistently cared for themselves provide better care. So **those organisations that prioritise staff health and wellbeing perform better.** They have improved patient satisfaction scores; they have stronger quality scores; they have better staff retention; they have better outcomes and lower absence levels. So why wouldn’t you invest in that?

Now we know that we haven’t got enough nursing staff; we haven’t got enough doctors… and that’s not going to be cured overnight. So how do we do things differently? How do we work with our non-clinical and clinical staff differently, to do our best to change what that looks like, but also to make sure that they’re safe and secure and comfortable and cared for in their roles so they can provide the best possible care too?… So safe staffing and staff safety isn’t just one strand; our health system is too complex. It’s many, many things. **And we need to be cognizant of all of those things in order to make healthcare a great place to work that make our staff want to stay and want to continue providing the best possible care.**

**Helen: So from what you’ve seen in your variety of different roles, working in consulting and as a healthcare leader and now with Establishment Genie, what do you think are some of the areas where we could improve patient and staff safety?**

Eve: There are two things. When the phrase ‘patient public involvement’ or ‘engagement’ come up, how loudly do you hear the eyes roll in the room? And how often have you heard ‘If we didn’t have to deal with the patients, then our job would be easy’? So **when we talk about patient engagement, often what we mean is we sent out a survey and we changed the menu options because more people wanted jacket potatoes**. No, when we’re talking about patient engagement and public engagement; this [should be] right at the beginning; this is in the design phase; not some random feedback loop at the end where we say ‘Do you actually *like* jacket potatoes?’ This is the, ‘How do we design something around you and your needs?’ Because, actually, this is all about you, as opposed to us telling you…

And it’s really hard. It’s really hard to engage patients. Generally speaking, people experience healthcare when they’re sick. So it’s a really tricky thing. How do we do that differently? And how do we move away from that tick box – ‘Did we engage patients? Yes, we sent a survey’. Or ‘We emailed and three people responded, and that’s what we’re building out entire response on, the three responses we got’. That drives me bonkers. If we could get that done better, that would be brilliant.

**Helen: This week, I had an out-patent experience myself… They sent me a text message, ‘How was your experience, rating one to six?’ So I said four because, clinically, it was quite good but the risk side of it was not so great… And I got an automated responses saying, ‘Would you like to tell us why?’ And I said, ‘Yes, I will, but give me an email and I’ll write to you’. Nothing.**

Eve: No. And there’s nothing worse than being asked for feedback and then either not being able to give it or not hearing what happens. It goes into that ‘feedback ether’. And you think, if you’re not going to do anything with it… Actually, that leads into my number two of what I would change.

It’s around celebrating and communicating success. How do we communicate? If we asked you for feedback… If you have given it, what do I then say back to you? What do I tell you about that? Does it just go into the [feedback ether] and then we can say in our survey, ‘We sent out surveys and we received 500 responses’? There isn’t a bit that then says ‘Well, what did you say and what did you do about it?’

And… incident reporting… this is a really good thing because if we’re reporting stuff, we’re capturing it, we can learn from it, but also the likelihood is we’re having less really serious issues and the stuff that’s being reported… It’s interesting, around healthcare support and nurses and who reports what and all of those things, it’s really interesting stuff. But if we’re just saying ‘Yes, we know what we’re doing because we put some stuff on a staff noticeboard about number of incidents reported’ that nobody sees, it means nothing. If we’re sharing what’s going on, warts and all, those really rubbish things that happen. Because they do, those near-misses, all of that stuff. Are we sharing it? Are we learning from it? Are we sharing when somebody’s come up with a great idea that we’ve implemented? How are we doing it? Where are we doing it? Because, actually, by doing that, that gives a really great message. That gives a great message to our staff; to the patients who use our services. **If we’re talking about it, they know we care. If they know that we care, and everybody knows that we care, they know that we’re going to make changes and it’s going to be for the better.** So, again, why wouldn’t we tell people?

**Helen: And why wouldn’t we share that learning, not just only within that organisation but more broadly? A plug for Patient Safety Learning’s *the hub*,but you have to find vehicles for sharing that knowledge and it’s not easy to do that.**

Eve: And there’s so much rich information out there that I think people can sometimes feel overwhelmed. But if you know that it’s related to your organisation and something that you did; and you know that, without fear and without prejudice, you can go and explain something that’s happened or you can go to a patient; you can talk about those things and that organisation will support you and they will make a change. As opposed to saying that they created an action plan. I have read more action plans than you can possibly imagine. At no point, did they change the culture of the organisation for the better… Whereas, if you involve the staff… it’s back to the beginning of our conversation. **If we involve those people in making a difference and they’re engaged in that difference and know what they’re being measured on and know why, that’s when great stuff happens.** As opposed to this very ‘tell’ and ‘control’ kind of environment which doesn’t change anything; it just makes people secretive and they hide things. So how do we change that? **It’s absolutely about celebration and communication and involving patients from the beginning, and not at the end as an afterthought.**

**Helen: And you’ve no doubt, through your own experience over those years and recently, have got examples of where organisations are doing that and are doing that well? [That] could be real beacons of hope and inspiration for others?**

Eve: Absolutely… At the moment, I’m using Appreciative Inquiry to capture people’s stories after Covid. So part of the Genie data is capturing ‘where were we before’ from a staffing point of view, ‘what happened during’ and ‘what did we learn’, ‘what was different’, ‘what changed’. And it’s building on that positive core.

And, absolutely, I can see that, just by having those conversations, and everybody having those conversations, people saying, ‘well, this really worked for us’ and ‘we did this differently’ and ‘it made me feel’… it changes everything. And that buy-in and that feeling of being part of something great means that those changes are sticking.

And we’ve seen the [People Plan](https://www.pslhub.org/learn/culture/patient-safety-learning-does-the-nhs-people-plan-do-enough-to-tackle-the-blame-culture-1-september-2020-r2909/). It talks about keeping hold of the good. I also have some examples where… people do not want to hold onto [the good] because, actually, what it means is change. So I can think of two examples where, in a larger acute trust, some of the stuff around doing virtual ward rounds and critical care stuff, all of those kinds of things, are being scrapped. And they’re changing because the team don’t want to work in that way; they quite like the walking around and the touching and feeling. It’s interesting, to think ‘why is that?’ Is that because it’s going back to a place of security, because ‘actually I know that the outcome measures were better, working in that virtual way’? As opposed to the team going around and doing the outreach. So it’s interesting. Obviously anecdotal stuff, but I know where things have really worked, where there are stories being shared and things are being done differently. And that’s moving around a group, versus the ‘I don’t really want to change’ and ‘no one’s going to make me do it’ and so ‘I’m going back to the way I did things before’. And I think that’s just a huge shame.

**Helen: And I think you talked before about the importance of research, and the need to move from Appreciate Inquiry, from stories, from anecdotes – valuable as they are – but to have a data and an evidence base for different ways of doing these things?**

Eve: Absolutely. And capturing different models of care; capturing the outcome measures over the top; doing that over time and with the same organisations…

Some of the work I do is with care homes. I’ve been working with a few of my care homes for four years now, and [have] four years’ worth of data. And seeing how the trends have changed and the staffing levels have changed, and the impact that’s had on retention, all of those things, is absolutely fascinating. And their sharing that amongst the group and saying ‘this is what the benchmark group looks like’, ‘this is what happened here’, ‘this team moved to shorter working days’, ‘this team implemented a twilight shift’, ‘this team implemented an assistant practitioner role’, whatever it may be….

And it’s just amazing because one size doesn’t fit all and leadership’s part of that, culture is part of it, numbers of people, different roles – they’re all part of that very complicated web that we have. Relationships with other organisations – incredibly important. Attitudes between different organisations.

And I know we spoke before about almost a hierarchy of nursing that says ‘If you’re a care home nurse, you’re nowhere near as good as a nurse in A&E’… And you hear nurses speaking about each other in that way… And it’s the piece that says ‘You’re a care home nurse, couldn’t you get a job anywhere else?’ Where does that attitude even come from? How would you know? You’ve not walked in those shoes. And why would we do that to a colleague who shares the same professional group? That’s not just with nursing. I’ve seen that with colleagues in consulting, all sorts of things. We do that to each other, whereas actually we should be thinking… ‘what do we bring to the table?’ ‘Where’s our unique piece and how do we share that appropriately and in the best way for the care of the patient?’

**Helen: And I think some of the insights we’ve had, certainly in the early stages of the pandemic, were about people breaking some of those barriers down and working in a very outcome-focused way; working more effectively as a team. Do you see some of that continuing or do you think some of those initiatives are going to be more fragile than we would like?**

Eve: I hope they’re not going to be fragile. But I’ve really seen, where it has been so successful, an attitude to change.

One of my care home groups implemented a nursing associate role, a band 4 role. And… the registered nurses as part of the group absolutely hated it; thought it was inappropriate… During the pandemic, all of that has changed. And I heard three of those nurses, as part of our round-up call, say ‘This is the best thing that’s ever happened to our homes’, ‘Our nursing associates were amazing’. It sends goosebumps; the change. Because everybody proved their worth and their value to the organisation because they worked differently. It wasn’t about ‘I am a band 4 and you are a registered nurse’… It was brilliant… And **it became about names and skills, as opposed to roles and bands**. That’s groundbreaking stuff for this organisation… It wasn’t about hierarchies; it was about the care of the patient.

**Helen: So what advice have you got for organisations to keep their staff safe?**

Eve: Listen. **Listen to them. Communicate with them. Be open with them.** Sit down. Don’t sit in your ivory towers in a corridor that’s somewhere elsewhere. Don’t pretend it’s not your problem. Have the conversation. Talk to your patients. **Don’t send them a survey where they put a smiley face in. That tells us nothing. Sit. Talk to them. Engage them.** They might even want to join as part of your trust in order to design services that work…. Be compassionate leaders. Think about flexible working. Do a temperature check with your staff and find out if they’re OK. Look at your sickness ratios and find out why. Don’t frown and shake your finger and tell your operational manager to go and sort it out, or get HR to do back to work interviews. Let’s have a conversation; get people to really discuss what’s going on. It’s being human. It’s humanising it. Right now, we know that our healthcare staff have a number of safety risks. There’s risk of being infected; they’re working in stressful environments. There’s a stigma attached to some health workers…. Are we checking in with people to make sure that’s OK, but also are we checking in with our public to make sure that they’re OK too because there’s a way of managing this together… So, organisations talking to their staff and talking to their patients. Wouldn’t that be great?

**Helen: How do you think we can help as Patient Safety Learning?**

Eve: I think *the hub* is already amazing… having an opportunity to share those stories. And I know, at the moment, it’s relatively small but it’s growing all the time. I think that’s really important.

I think, helping organisations at the top really understand that patient safety is integral; staff safety is integral to their organisations performing well. And it will save them money. It’s having those conversations at the top level… and helping to put the evidence together that shows that, actually, this will improve outcomes but also save money.

**In a world of finite resources, both physical and financial, how do we do things differently? And I think Patient Safety Learning has a huge part that they can play in that; in rattling those cages and getting people to listen.**

**Helen: Is there anything I haven’t asked you around staff safety that you’d like to add?**

Eve: I think we’re a long way, in many organisations, from what I would term a ‘culture of safety’… and that makes me feel really sad… And we won’t change and we won’t improve until we reach that culture of safety… So, Patient Safety Learning helping people, helping organisations, to understand what a culture of safety is and helping them implement that. And whether that be through a framework, or however that might be, or accreditation, that could only be for the good of everybody.

**Helen: During, certainly the early stages of, the pandemic, people were really attending to staff wellbeing and staff safety for obvious reasons. But what was your experience of what you saw was happening and how well was that received and what impact has that had?**

Eve: I have seen some organisations; they have just had the most wonderful response to their staff. They care, they’ve had helplines put in, they have put champions in place, all sorts of things. Just brilliant responses. Mental health trusts offering their support to all of the organisations in their footprint. How cool is that? And whilst not everybody has taken it up, that resource is something that’s there and I think that’s wonderful and I think as time goes on, more of our staff will need to use that.

Now, that kind of ‘burning emergency’ stuff is gone and there’s a reflection on what that actually means… But… I was speaking to a colleague in one acute trust who, in response to Covid, had put wellbeing spaces, had put breakout rooms, free coffee machines, water machines, all of those kinds of things. And this is something almost precedented… But they’ve taken them away! So you *did* have all of this stuff and now the peak of Covid has gone, ‘we’re going to take away your tea and coffee and your breakout room because we did really care about you but not so much anymore’. What?! How much money have you saved by taking away that coffee machine? How much ill feeling have you left? And what does that say about the way you care about your staff?

**Helen: It’s nuts! And what happens? Do you wait for a second spike or a winter flu spike and then bring it back in?!**

Eve: It reminds me of those heady days of turnaround where suddenly you found everyone in the office was; the stationery budget being cut, so seven people were sharing one stapler. And the effort it takes to get up from your desk to walk over to use that person’s stapler, obviously the cost of the 99p stapler…

**Helen: It’s not often I’m speechless, Eve, but that’s as close to it…**