Building and Strengthening Leadership

Leading with Compassion

Field Guide

November 2014
Context and approach to developing this field guide

Context

This work sits within the context of supporting NHS England in the development of the implementation plan for Compassion in Practice (Cummings & Bennett, 2012), specifically Action Area 4: Building and Strengthening Leadership (see http://www.england.nhs.uk/nursingvision/actions/area-4/).

The need for the work emerged from a leadership think tank run by NHS England November 2013, and was commissioned by Caroline Alexander, Chief Nurse NHS England (London region), Senior Responsible Officer (SRO) for Action Area 4.

The requirement and challenge

To bring to life what compassionate leadership looks like and feels like in practice, to yield pragmatic, prioritised and actionable recommendations.

Required outcomes

The output was designed to be a stimulating, easy-to-access, engaging paper, that is provocative and encourages people to talk with others.

It set out to:

• distil the essential leadership behaviours, attributes and characteristics that embody a compassionate leader. It was synthesized from the myriad opinions and perspectives from leading thinkers from both inside and outside the NHS, nationally and internationally;

• understand and describe the environmental and cultural factors required for effective compassionate leadership; and

• build on these ideas further with exemplars of compassionate leadership, who have first-hand insight of the challenges and opportunities that accompany compassionate leadership. This Field Guide condenses the outputs from the full paper.

The approach

1. Up front research: what do thought leaders and the literature say? This included academic databases drawing on social psychology, leadership texts, organisational theory. It also searched the grey literature: white papers, articles, blogs, websites and magazine articles. The outcome is a rounded perspective on compassion, patient and staff experience, from the UK and abroad.

2. Compassionate leadership survey: a survey distributed to 140 alumni of the NHS Leadership Academy, based on the premise that they are likely to have spent time reflecting on their own and others’ approach to leadership in the context of the NHS. It intended to draw out key characteristics of ‘the compassionate leader’, the belief in the concept and to identify role models for interview.

3. Interviews with 11 recognised models of compassionate leadership: the intent was to hear first-hand accounts, test our hypotheses and elicit concrete examples with those who role model compassionate leadership (identified through the survey).

4. Thought leadership and recommendations: we built on the above data with our own insights gained from working with health care organisations in the UK and across the globe, and our tested approaches to establishing clear and robust leadership systems.
The approach: four lenses and levers for bolstering compassion

No one attribute, force or mechanism has a monopoly on truth about the actions needed to instil compassionate working. Rather, it is the sum total of mindsets, values, capabilities, practices, systems and structures that determines whether compassion thrives or withers.

“I am very interested in how and why people lose their compassion, as in my experience this happens to some people but not to others, at varying lengths of time after joining the NHS. Is it due to pressures on individuals, vulnerability, poor leadership and support, poor alignment of the individual’s purpose with that of the organisation, personal traits, or combinations of many factors?”*

In this paper, we explore from four angles. These are the levers that collectively create the conditions for compassion to be the norm and through which the practical steps can be taken.

The four dimensions around which our recommendations are anchored are therefore:

**Self**: the self-awareness, resilience, mindfulness and emotional intelligence that allows you to be present and available to the needs of others.

**Manager/leader**: the ability to notice the explicit or unspoken concerns of others, with sufficient emotional resources and practical tools in one’s repertoire to proactively create a constructive and supportive climate.

**Team**: the capabilities, practices and norms that promote and contribute to the formation and effective working relationships of teams, such that they are able to work compassionately with patients, service users, families, partner organisations and each other.

**The organisation**: the collective, robust set of systems, processes, practices and disciplines that enable an environment which is supportive of compassionate care.

Compassionate leadership is everyone’s business

Creating cultures of compassion is not the sole domain of care givers and clinicians. It’s not even the sole domain of those that lead and manage others.

As Dr Michael West’s work shows, for staff to be attentive, feel empathy and take intelligent action for patients (the key elements of compassion), they need high levels of positive emotion at work. Optimism, cohesiveness, humour, support and a sense of efficacy all contribute to this (West, 2013). There is an unassailable link between patients who are treated with compassion and employees who are treated with compassion. You cannot have one without the other. Everyone in the workplace – from the board to the ward – contributes to creating the climate.

The emerging wisdom is that compassion in practice is not restricted to institutions that deliver patient care either. As one of our respondents so aptly put it:

“Compassionate leadership is as needed amongst commissioners and throughout arm’s length bodies, assurance and oversight bodies as their actions can either reinforce and encourage collaborative leadership at the front line or significantly undermine it.”

It is not just the domain of those at the frontline of patient care.

Simply put, compassionate leadership is everyone’s business. So this paper is for anyone who cares deeply about compassion in the health and care system.

* Quotes from our interviewees and survey respondents are shown throughout the report in a similar shaded box.
**Self: the field guide for improving self-mastery**

### What it means in this context

The personal attributes, practices, behaviours that keep the individual rooted to their core purpose and focused on their impact on others. It relates to an ongoing set of personal disciplines that build self-awareness, resilience, mindfulness and the emotional intelligence that enables one to be present and available to the needs of others.

### Derailed by

**From the literature**
- Perception of threat and chronic anxiety pushes individuals into a defensive position, focused on self-preservation, or overly controlling behaviour (e.g. Firth-Cozens & Cornwell, 2009).
- Over-emphasis on technical mastery, and transactional components of care (Feifel & Eells, 1963).
- De-sensitisation and detachment, as a result of unprocessed emotions from seeing the distress of others (Sabo, 2006).
- Limited ability for personal organisation and planning, pushing energy into a difficult-to-escape reactive loop (Allen, 2001).
- Acquiescence to authority figures (Milgram, 2009).

**From the field**
- Hurriedness and urgency overtaking the non-judgemental inquisitiveness to understand need, whether of patients, families, care givers, or other staff.
- Lack of confidence in knowing how to raise difficult issues and constructively give feedback on unhelpful behaviours.
- Not removing barriers to genuine listening and communication, with over-dependency on emails; not stepping out from behind the desk.
- Failing to perceive the impact of personal behaviour on working climate.

### Enabled by

**From the literature**
- Emotional intelligence – ability to read verbal and non-verbal behaviours; self-control and regulation (Goleman, 2006).
- Mindfulness – being present, available to be aware of own and external states. Evidence from the military suggests better decision-making, lower stress and incidence of post-traumatic stress disorder (Senge et al., 2005, Johnson et al, 2005).
- High self-efficacy – the inherent belief in one’s personal effectiveness and ability to influence outcomes – even if unfounded (Bandura, 1994).

**From the field**
- Use of a coach to process personal feelings; scheduled time and space to reflect on alternative responses.
- When aware that self-control is wavering, having the means of rebalancing, walking away before exhibiting ‘toxic’ behaviour.
- Ensuring a psychosocially rich life, and opportunities to refresh, e.g. walking the dog; living fully both in and out of work.
- Attentiveness and the ability to notice. Acts of compassion are almost impossible without seeing the opportunity.
- Keeping connected first-hand with the experiences of patients and the realities of staff in caring for them.
- Development and connection with clear personal ‘mission’, aligned with role and organisational objectives.
What people are already doing

- Consciously building a network of optimistic, affirming and appreciatively challenging people; surrounding themselves with ‘good’ people and offering mentoring to others, so they too have a safe place to be.
- Making time and space to listen without an agenda to staff and patient experiences; to stand back, observe and reflect (cited as important by a ward manager and a board chair).
- Regardless of seniority or role, remaining actively involved in delivering care, or contact with patients, e.g. a director of nursing still runs a weekly clinic.
- Committing to personal development, whether internal/external courses (e.g. mindfulness, or tailored support, e.g. coaching).
- Being personally disciplined about the use of phones and responding to emails (i.e. to be present in the activity they are choosing to undertake).

In their own words…

**Being awake to the opportunity to make a difference**

“We had a patient whose diet meant our food wasn’t suitable. Our catering manager went to the ward to understand more. He was stumped about what he could do. He ended up going to Sainsbury’s to get something. His main concern was that he needed to help that patient eat.”

“I ask myself ‘What things can I pick up from this person that helps me understand what they are feeling, what their needs are, that informs what help I can give?’ ”

**Keeping core purpose alive and well**

“[xxx] is our patient champion. The NHS saved his life. He works with groups of frontline staff. He talks as a patient and starts by thanking people and gets them to reconnect with why they joined the NHS, and the difference they make. ”

**Resilience**

“I see people in periods of duress resort to bad behaviours. They shout louder, and control more as they feel threatened. I said to myself: ’I’m not going to let this organisation turn me into someone I don’t like.’”

What would that look like for you?

- How can you build on existing ways, or build new practices to process your emotions, sustainably and healthily?
- Remembering specific, recent difficult work experiences, what was it about the situation you found to be personal stressors and triggers?
- When you have felt at your best at work, what made it so positive? How can you build in some of those sustaining aspects into your current work?
- When does your ‘inner critic’ surface? Where do those judgements come from?
- Thinking back to situations which provoked disproportionate responses in you, what can you do to reduce the impact? What assumptions or drivers underpin that, e.g. a need to be perfect, to be right, to be liked?
- When does your work feel most meaningful? And most futile? How can you stay connected with your core purpose?
- How is your body posture and tone of voice when relaxed? And when under pressure? What would help you notice, in times of stress, to choose to act differently?
Self: the field guide for improving self-mastery (continued)

Recommendations for action

Develop routine habits to stay balanced

- Develop the habit of daily mindfulness practices. This might include easy-to-integrate behaviours:
  - stopping for lunch! Eating meals without trying to do other activities at the same time – TV, emails etc.
  - 10 minutes sitting quietly at the beginning of the day, focussing on breath; slowing the pace and improving the quality of thoughts
  - noticing the sounds, smells and sensations as you move from one space to another
  - monitor your level of presence when interacting with others.

- Build in regular practices which tend to your physical, psychological and social wellbeing, such as:
  - regular physical activity, which for some may be walking the dog or getting off the bus one stop earlier
  - being aware and disciplined about how much sleep you need.
  - making time to keep connected, to family and friends, or the people where you live
  - Finding ways to process your emotions e.g. journaling, friends.

Keep rooted to core purpose

- Routinely have first-hand experience of patients, particularly when distanced from delivery of care.
- Find opportunities to mentor others.
- Consider receiving coaching, whether internal or external.

Plan ahead

- Ensure both you and your line manager know activities that you find depleting and outside of your natural preferences, and those which are restorative. Where possible, plan activities so that depleting activities are interspersed with those you find energising.

- Use a personal development plan to consciously create opportunities and personal commitment to:
  - develop behavioural skills development, around quality of listening, questioning, and being able to mentor others
  - seek regular, timely behavioural feedback (both appreciative and corrective) from trusted colleagues and team members about your personal impact.

- Test alternative behavioural responses to personal triggers, initially in small, relatively safe environments.

Notice the signs and activate your plans

- Notice when you are staying later at work, becoming more dependent on caffeine, alcohol, eating much more or less. Use this as a clear sign that you need find ways to re-balance.

- Consider a plan of action which might include:
  - accessing your wider network of support. Who else might be able to support you?
  - slowing down, possibly with a trusted colleague, and consider: can I complete this task differently?
  - reprioritising existing commitments with others, at the earliest opportunity
  - an open and honest conversation with your line manager to determine whether it’s temporary or more chronic and what support you might need.
“You can inspire, and awaken. There is something about the passion and the fire within. They may have an ember and my job is to make a roaring fire and keep it alight.”

Professor Nancy Fontaine, Director of Nursing and Quality, Princess Alexandra Hospital; Professor of Nursing, Anglia Ruskin University and University of Essex
Manager/leader: the field guide for engaging and developing people

What it means in this context
The ability to notice the explicit or unspoken concerns of others, with sufficient emotional resources and practical tools in one’s repertoire to proactively create a constructive and supportive climate and the capability to respond to situations and emotions requiring special care and attention.

Derailed by

**From the literature**
- If feeling under threat, compassionate perspectives are ‘switched off’, and motivation targeted at self-protection and survival (e.g. Beal, 2010).
- Their own resilience being compromised from working in challenging environments and responding to high levels of stress.
- Formal leaders have a dual role of managing the system and the duty of care to teams and individuals. For example, organisational pressure (and systems of measurement) to ‘feed the beast’ with metrics and reports, at the expense of people and without drawing conclusions about what the data might be saying (Ballatt & Campling, 2011).

**From the field**
- In pressured environments, with high levels of anxiety, there is a tendency to exert higher levels of coercive management, control, and focus on risk.
- Power and status differentials, leading to failure to speak out against unacceptable behaviour of senior clinicians.
- The disconnect between new values and behaviours being modelled by executives but that fail to be embodied by pressurised middle managers. It risks cultivating cynicism.
- Managers performing additional tasks and responsibilities (due to less staff from cost pressures) that considerably reduce time with their own team, and reduce accessibility.

Enabled by

**From the literature**
- Comfortable with ambiguity. Questions more than answers, as a way to harness collective wisdom and develop the ‘right’ solutions.
- Willingness to embrace risk, accepts failure (and learning) as part of the process and to let the team do so as well (Catmull, 2014).
- Able to offer different levels of support, dependent on the task and the experience of individuals and the group, whether directing, mentoring, coaching or delegating (e.g. Hersey & Blanchard, 1977).
- Communicating in ways that respond to different thinking preferences (analytical, creative, empathetic and preservation of order and stability) (e.g. Hermann-Nedhi, 2009).

**From the field**
- Skills and willingness to provide regular, timely, objective feedback (both appreciative and corrective). “People often don’t see the impact of their own behaviour.”
- Establishing clear expectations and standards. “This needs to be blind to seniority, but is particularly important in Exec and senior teams.”
- Building capability and confidence for decisions to be made at the right level, and carried out with respect.
- Middle managers in tough, pressurised roles receiving specific interventions, development and support.
What people are already doing

- Practical skills development of new commissioning leaders, to be able to advocate effectively for patients: “So we heightened their political awareness, the ability to read body language, the key items to address on the agenda, what questions to ask and issues to challenge.”

- Welcoming new members to the team/division/organisation, even if they are transient (e.g. student medics/nurses, or bank/agency staff at the beginning of a shift). They make sure they feel part of the team, establish the standard, and in places, are systematic about inviting feedback from these ‘fresh eyes’.

- Moving beyond tokenistic patient stories at the beginning of board meetings but bringing staff and patients in to understand the human realities of policy decisions, e.g. the use of patient restraint and what that means for staff and patients. “It’s easy to get caught up in procedural items.”

What would that look like for you?

- In what ways are you able to role model the behaviours you wish to see demonstrated by others?

- How can you help your team establish what ‘great’ looks like, and the expected minimum level of performance, for the context you work within?

- In what ways do you help others keep a clear focus on quality of service for patients when there are many other quantified business drivers and pressures to achieve? How could you keep the patient focus alive?

- What processes or practices will help you step back from default means of problem solving, to open up new ways of seeing and acting?

- What are you currently working on where there is opportunity to let others take a greater steer in developing and approaching solutions? What level of support might they still need?

- What demonstrations of thanks are you able to perform that encourage behaviours aligned to values?

In their own words...

Putting people before procedures
“Rules and regulations and inspection are ways we reassure ourselves and I see those things as enablers, but we need to keep connecting with our core purpose. The discussion does not begin with ‘Do we have procedures in place?’, but ‘Why are we doing this?’"

It won’t come from a text book
“The truth is you can’t pick it up off a shelf. If you don’t engage people, which takes time energy and effort, you won’t bring about change. You will end up spending more, taking more time, but not getting any real change. You have to listen, feedback, change, develop programmes.”

Ask the question, and listen, and always follow through
“I’m amazed at how creative staff are – but you only have a small window to capitalise on it – if you don’t action it fast enough you lose the energy.”

Setting standards and holding to account
“I know I lead compassionately. Am I a soft touch? No. You mustn’t give the impression you are a push-over, and it’s all fluffy clouds. There is a hard edge.”
Manager/leader: the field guide for engaging and developing people (continued)

Recommendations for action

Make the connection between patient experience data and the team's personal experiences of work

- Review patient experience data with the team. If patient experiences aren’t as good as they need to be – and knowing the link between patient and staff experience – use this in discussions around the team’s experience of work: what personal experiences as a staff member might be feeding this impact on patients?
- Know your staff survey results. They won’t fix the issues, but use them to start a dialogue about why you are getting the responses you are – the stories behind the numbers. Move beyond mere action planning. Instead, take one challenge, tackle it, and fix it, before moving on. Show it is possible to make change.

Get to know your team individually and stayed tuned in

- Learn individuals’ preferences, desires and hot buttons so you can stay attuned to what may spark interest or stifle engagement.
- Make time for and hold regular one on ones.
- Consider exploring some of the following areas:
  - What work related activities give you the most satisfaction or joy?
  - What rewards (tangible or intangible) mean the most to you?
  - What do I do as a manager that motivates you?
  - What do I do as a manager that demotivates you?
  - Where do our styles fit well together? And clash?
  - Professionally, where do you want to be, or what do you want to be doing in two to three years?

Build a plan to close the engagement gap (Gebauer Lowman, 2008)

- Know them: (see above).
- Grow them: in the short and medium term - good for both of you. You’ll have a shared vision for their future in the organisation.
- Inspire them: based on the above, help them to make an emotional connection to their work, their team and organisation, how their current and potential skills and interests contribute to a vision or initiative that inspires others and generates excitement in the organisation.
- Involve them: allow people to use their creativity. The best companies learn daily from their employees and allow their employees real discretion in their work.
- Reward them: the impact on performance from pay increases is relatively short lived and often unavailable. You need to show appreciation, to find fresh ways to keep them engaged, including:
  - recognition of work – for some that is best done publicly, for others privately (you need to know which).
  - access to development opportunities, secondments, placements or shadowing.
  - offer of taking on more stretching roles, possibly coupled with...
  - coaching or mentoring.

Make strategy and targets meaningful

- When setting annual performance objectives, create line of sight’: make the link explicit between organisational goals and individual objectives.
- Be clear about the human impact: have a compelling reason for ‘why are we doing this?’

Notice the signs and respond

- Stay attuned to shifts in habits or behaviours: notice when others are consistently staying later at work, becoming more dependent on caffeine or alcohol, eat much more or less. Use this as a clear sign that they need support in finding ways to re-balance.
- Provide access to counselling or other support to those who are distressed; help them think through alternative behavioural responses to personal triggers.
The team
Teams: the field guide for attentive team work

What is it?
The capabilities, practices and norms that promote and contribute to the formation and effective working relationships of teams, such that they are able to work compassionately with patients, service users, families, partner organisations and each other.

Derailed by

From the literature
- The ‘bystander effect’ where individuals stand by and fail to help someone in distress, and more pronounced with more bystanders, high ambiguity and dissociation from the ‘victim’ (e.g. Rutkowski et al., 1983).
- Basis for high performing teams often lacking: clear purpose for team meetings, conflicting objectives, groups larger than 6–10, frequent shifts in membership (Hackman et al., 2000).
- Inattention to team needs, including shared sense of purpose, and requirements of tasks e.g. time, training, resources (Bornis et al., 2000).
- Leadership behaviours inconsistent with espoused values (Schein, 2010).
- Conflict often left unaddressed (Bion, 2013).
- Attribution of blame, rather than collective learning (Edmondson, 1996).

From the field
- Failing to form a clear mission and purpose, which then fails to make productive use of difference – it becomes turf war.
- Not translating dialogue into intended outcomes and agreeing clearly defined actions. Individuals and teams then disengage.
- Structures and processes that reinforce hierarchy. If it feels difficult to approach others, people are less likely to ask, and ‘stay in their box’.
- Agency staff, who may not speak the patients’ language, migrating to night duty, ‘hiding away’ en masse and not integrating with the community.

Enabled by

From the literature
- Structures support team learning e.g. after-action reviews/wash-ups, supporting reflective learning, and processing emotions (Collison & Parcell, 2004).
- Adaptive responses to conflict and competing demands (Thomas, 1992).
- Team support balanced to meet the needs of the group, individuals within it and the task (e.g. Adair, 2009).
- Individuals strengths and preferences known by group (e.g. Belbin, 2012, MBTI).
- Balance of focus, support and trust, plus high alignment, capability to perform and autonomy to adapt (e.g. Pink, 2011, West).
- Creating trust for professionals, built on values and principles which enable the outworking of measured clinical risk, rather than failing to act because of fear of it (practical wisdom, Schwartz, 2011).

From the field
- A focus on shared learning, ensuring future-orientation and agreement of concrete changes, in response to adverse events.
- The team is potentially one of the best places to process the difficult emotions experienced through caring for others.
- Not colluding in disrespectful norms: “It is an increasing norm to speak across the patient. Years ago this wouldn’t have been allowed, but has become normal. It requires feedback.”
- Supporting teams that have experienced trauma – significant events that undermine confidence, whistle blowing that undermines trust.
Teams: the field guide for attentive team work (continued)

What people are already doing

- Recognising that when operational issues hit, team stress points become critical. Temporary and bank staff need to be welcomed, introduced to team members and their patients, not just pointed to their bay. It affects team cohesion and emotional availability. As do traumatic team experiences, e.g. ‘Never Events’, and help is needed to rebalance.

- Changing the physical and social environment to avoid team members being separated and stuck behind computers, to make it easier to talk rather than there being an over-reliance on email.

- Bringing patients back in after six months, following feedback, and involvement in improvement work, to let them see what’s changed. Improvements feel more meaningful with a person in mind, and reinforce commitment and accountability.

- Leaders using patient experience and complaints data to be clear when it’s not good enough, but also to help them come up with solutions.

What would that look like for you?

- Where is there interdependency with other teams? How can team members work across boundaries and collaborate with other departments (maintaining focus on core purpose)?

- How are group dynamics affecting our capacity to treat each other and the recipients of our care with care and compassion?

- How can you help the team to be more comfortable, and feel safer to have healthy conflict?

- In what ways can you reward collective action as well as individual effort?

- What opportunities exist to build on the power of the positive – working with the group to identify what already works well? How could that be even better, and what are the things that are holding the group back?

- If the team suffers from a lack of trust, how can you offer a safe way for everyone to reveal what they are feeling, to share honestly with each other?

In their own words…

It starts with trust

“There were significant issues between two senior members of staff. They recognised things weren’t right so asked my team for practical support. We did a capacity and capability review so they understood what needed to happen. But it was done voluntarily. They asked us. That just doesn’t happen without developing trust.”

Shared learning

“If my team had a difficult day, I’d make sure we had time to reflect and consider what would we do differently, as well as what worked and thank yous. It’s not punitive. And I encourage my managers to do the same with their teams."

“We have got fantastic pockets of brilliance in the NHS. It’s ok to say ‘This is the best ward in the hospital and this is why’.”

Creating safety in conflict

“We know there will be tensions in any difficult transformation, that there will be different opinions and organisational drivers. We agreed the things we needed to deliver together, so we agreed up front how we were going to decide – consensus, majority, how to support those managing losses.”

www.england.nhs.uk
Teams: the field guide for building functional and attentive teams

Recommendations for action

Setting up a functional team

• Clarify and align around a clear group goal and mission and outcomes, defined and tested with the group and quantified if possible.

• Identify the skills needed and build capability to meet that goal, investing in development so core skills are present.

• Describe the standards: both performance and behavioural. What does compassion look like in practice?
  • assign roles and responsibilities based on a firm, shared understanding of team members’ interests and capabilities (see page 27).

Making the most from diversity and enhancing inclusion

• Review the case mix of the staff and the population it serves, and the leadership body.

• If not representative, agree concrete ways to ensure that all voices are present in the commissioning, design and regulation of services, and included in decisions about delivery.

“We had a Board item to look at inclusivity on our wards – race, sexuality, age, religion. We knew we had problems on the wards with homophobia. We invited a young black gay member of staff to talk about how his race, his sexuality, his age affects his experience on the ward. It connected us with the human experience. It is easy to get caught up in procedural items.“

Staying connected to each other

• Have team meetings. This is correlated to building trust, improved communication, mutual support and more innovation.

• Use a meeting design that will generate the outcomes needed:
  • team huddle or formal meeting
  • pace – standing or sitting
  • methods – brainstorming, process/value chain mapping, looking through other’s eyes (e.g. how would other industries approach this problem?).

• Conduct an activity with team members, taking Lencioni’s team assessment (Lencioni, 2006); collectively review what may be helping and hindering them from working effectively and what to do with the insight.

• Structure team meetings and discussions in a way where it safe to offer alternate views, where opinions are not in competition with each other, e.g.:
  • strengths, weaknesses, opportunities and threats (SWOT) analyses
  • brainstorming (knowing that evaluation of ideas comes later. The encouragement is that more is better)
  • use creative thinking tools to develop new solutions, such as:
    • ‘others’ points of view’ (e.g. how would a six year old, air flight attendant or manager of a fast food restaurant see this?)
    • ‘breaking the rules’: identifying underlying assumptions, mental models, unwritten rules and thinking that maintains the status quo. What rules can be bent, or broken? Walk around the new world and see what possibilities it opens up (NHS Institute for Innovation & Improvement, 2007).
Teams: the field guide for building functional and attentive teams (continued)

Recommendations for action

Staying connected to the patient

- Stay connected to your patients and diverse staff.
  
  Set up and run In Your Shoes sessions:
  
  - Invite staff from black and minority ethnic, disadvantaged, or under-represented groups to share their experiences at your team meeting.
  
  - Encourage the team to walk the journey from entering and navigating premises and buildings from the perspective of a non-English speaker, someone with disabilities, etc. Notice the sounds, visuals and feelings.
  
  - Revisit the team’s purpose and values before collectively reviewing the patient feedback, at the level of the patient, not just themes. Give enough time both to help the group share their reactions and what they heard, as well as develop action plans that support the team to work compassionately with each other and patients.
  
  - Ask the group how they are going to stay connected (e.g. bringing patients in, going to where they are), and if clinically facing, going beyond the functional delivery of care.

“...What things can I pick up from this person that helps me understand what they are feeling, what their needs are, that informs what help I can give?...”

- Encourage team members to talk about their own, or their family’s experience of care and what really mattered to them at different points in the journey.

- Ask team members to share where they have seen other team members going ‘above and beyond’ to meet the needs of a patient, or another team member.

- Revisit the team’s purpose and values before collectively reviewing the patient feedback, at the level of the patient, not just themes. Given enough time both to help the group share their reactions and what they heard, as well as developing action plans that support the team to work compassionately with each other and patients.

Review progress

- Keep testing with the team whether the group norms are supporting the ability to work compassionately with each other and patients:
  
  - Are we open to new people and new ideas?
  
  - How well do we cooperate?
  
  - When does communication work well, and when are there gaps?
  
  - Are we making best use of our skills and talents?
  
  - What are the current grumbles?
  
  - Are the real issues being tackled or avoided?

Provide mutual support

- Create time in each meeting for reflexivity.

“...Personally, I still do a clinic every Friday. Also, I just turn up on wards and just speak to patients...”
The organisation
The organisation: the field guide for aligned, enabled organisations

What is it?
The collective, robust set of systems processes, practices and disciplines that enable an environment which is supportive of compassionate care.

Derailed by

From the literature
- An emphasis on targets and the bottom line out-ranking all other priorities, as opposed to constraints to work within, for the benefit of the service users (e.g. Illes, 2011).
- Insufficient time, resources, and capacity to deliver expected outputs.
- Medical education which emphasises technical mastery as the source of effectiveness, though patients ascribe most importance to calm sympathetic listening, support and encouragement (Ballatt & Campling, 2011).
- Targets and single metrics only provide a key-hole view into a complex environment (Dilnot, 2010).

From the field
- In reconfiguration managers default to a loss model (I’m going to lose my A&E service). It leads to an unhelpful territorialism that impedes a health system adapting to the needs of their population.
- Successive turnover of executive leaders, and whole boards. Energy is spent avoiding destabilisation in divisions and departments. It can be an uphill struggle to keep the patient central.
- A misplaced and wide-spread focus on keeping bosses happy (for advancement or survival). Appraisal systems often don’t pick this up.
- Heavy use of agency staff is a high risk. The level of loyalty to the organisation is less, and they may not see patient again. An organisation needs people from the community to care for members of the community.

Enabled by

From the literature
- Systematising places where difficult emotions can be processed e.g. Schwartz Center Rounds.
- Initiation of action inquiry into knotty organisational challenges as a means of developing a learning organisation, at the same time as developing those in the group (e.g. Fisher, Rooke & Torbert, 2003).
- The development of a set of organisational values, translated into behavioural terms and integrated within HR processes and systems from behaviourally based appraisal processes to reward systems that provide immediate and valued reinforcement (Welbourn et al, 2012).

From the field
- Looking at organisational data and get to the story behind the numbers: “I held a ‘Never Event’ sharing evening. I invited the directors of nursing and medical directors to present their own cases. We could see the common human factors.”
- Leader-led change and facilitation, clearly signalling the value placed on engaging staff around embedding values and behaviours. It also begins to reduce the apparent distance between the Board and the front-line.
- Middle managers have a big impact on the daily working experience of staff. “It’s not good enough to meet targets if our staff end up on Prozac.” So changes were made to the interview process, and appraisals, with more time afforded to middle managers, to interpret and internalise values and behaviours, asking what it meant to them.
The organisation: the field guide for aligned, enabled organisations (continued)

What people are already doing

- Systematic means of recognition and reward, for example line managers being able to award Costa Coffee vouchers; all staff nominated by colleagues for recognition, or named in patient compliments are sent a thank you card from the CEO and director of nursing. They are automatically entered as nominees into the staff awards.
- ‘Stepping off the edge of the map’, not knowing the outcome but recognising the need to build momentum and effect wholesale transformational change in her organisation, to “revolutionise patient experience and put it back at the heart of the organisation” (see pages 41–42).
- Development of tools and measures to help managers and teams broker conversations about culture, making it more manageable and actionable, e.g. the cultural barometer. It remains a freely available tool, but is a local choice as to whether to use it. Otherwise it risks alienating, rather than engaging.

In their own words...

Tokenistic behaviour stands out clearly. It needs more than a memo for people to commit
“Although communications have been sent from our Chief Executive about the goal of compassionate leadership, the experience at grassroots is that our organisation is driven by financial goals in order to become an FT, rather than improving patient care.”

The whole system need to be awakened to how it supports or undermines compassionate practice
“Compassionate leadership is as needed amongst commissioners and throughout arm’s length bodies, assurance and oversight bodies as their actions can either reinforce and encourage collaborative leadership at the front line or significantly undermine it.”

Spotting organisational distortions of purpose
“We create a system where success is a financially sustainable organisation, but not necessarily doing the right thing for the population. So system leaders need to be clear about what we are trying to achieve, and not colluding in objectives with distorted purposes.”

Absolute clarity on expectations and consequences, though the process is managed with humanity
“ “In protecting standards, sometimes we have to dismiss individuals. They are still people, with homes and families, and we will try to support them manage that transition.”
“I had performance meetings yesterday, but you don’t need to do it by bringing people to their knees.”

What would that look like for you?

- How alive are your organisation’s values and the behaviours that relate to them? Have they made it into appraisal systems? How can they be kept central to strategic and operational decisions and activities?
- How explicit are the expectations and consequences relating to standards of behaviour?
- What range of resources, systems and processes could be enhanced to support employee welfare, e.g. employee assistance programmes, Schwartz Rounds, quiet spaces?
- What are the consequences for speaking out? (For the whistle blower, the individuals under investigation and the teams they work in?)
- How would you know if, organisationally, it’s succeeding?
The organisation: the field guide for aligned, enabled organisations (continued)

Recommendations for action

Listen

• Build a shared understanding, first-hand, of the experiences of patients and staff.

“As a Director of Nursing I spend a lot of time on wards. I was on duty a couple of Saturdays ago, on the escalation ward. I had a good team on with me. What was fascinating – we didn’t have enough soap on the ward, there was a stack of venous thromboembolism assessments to do. One thing after another.

Fast forward to the Board meeting. I might have been saying ‘all wards need to be doing x’. But seeing the reality, it’s not hard to empathise.”

Engage the leadership body

• Persistently and without apology, reaffirm the need for organisational level action:
  • talk to individuals using their personal values as a base
  • bring the human realities of care (staff or patients) into senior leadership meetings to contextualise policy or strategic decisions, going beyond tokenism.

Define, revisit and re-affirm the organisational values

• If the organisational values seem only to exist on paper:
  • go out to staff, patients or carers and hear what matters to them
  • ask leaders and managers whether they know the values, and how they interpret them.

• Define the values in terms of the behaviours you would want to see, and the behaviours you wouldn’t.

Embed the values and behaviours and incorporate into organisational life

• Build the values and behaviours into people processes, e.g.:
  • align recruitment and selection processes to the organisation’s values and behaviours, not just behavioural interviewing, but how the candidates are treated, who the interviewers are and whether diversity is represented
  • recognition and disciplinary practices.

• Run engaging events which provide opportunity for individuals to consider what those behaviours might look like in their role, where they work, to create clarity and cohesion around the values and behaviours.

• Mobilise a network of champions, offering energy, focus and visibility.

• At key meetings in organisational life, in the paper work and on the walls, share the resources, support and development programmes that are available to staff.

Connect the organisational strategy with individual goals and objectives

• Cascade strategic imperatives as goals and objectives. Set and embed performance and behavioural expectations.

Assess individuals on performance and values

• Support managers so that the appraisal itself is run in a way that is consistent with the values and behaviours.

Conduct a leadership and talent review

• Review the top talent (in terms of performance and values – as opposed to the typical performance and potential) in different staff pools.

• Match top talent to key organisational opportunities, signalling to the organisation the attributes and styles of leadership that are valued as well as supporting retention of talented role models.
**Concluding thoughts: where is a sensible place to start?**

We have not attempted to offer a standardised means of closing the compassion gap. Firstly, it undermines the very need for engagement, and individual and collective opportunities to reconnect with a core purpose. Secondly, it will very much depend on who you are as a reader: the organisation you are in; the role you fulfil; your access to partners and networks; plus the opportunities you have or can create to interact with colleagues and users of your services will affect the opportunities that are open to you. And finally, a standardised means simply doesn’t exist.

So we offer up this multi-pronged approach to dealing with the complex issue. There may be aspects in this paper that pique your curiosity or fire your imagination – to do something differently. Equally, there may be parts you disagree with.

Use that to fuel what it is that you feel would work where you are. To start or continue the dialogue.

**Personal action is needed up front to take compassionate leadership beyond just a worthy idea – but don’t wait for a perfect solution**

To look for or wait for a solution is to let opportunities to make a difference slip through one's fingers. The people who were identified as role models are mindful of making each day, meeting, encounter and decision embody that perspective.

**Attend to yourself, and the environment around you**

It is not easy to do this as a single agent of change, and takes incredible resilience when working in an environment which has become disconnected from its purpose. That may be a sensible place to start. Find those things you personally need to attend to, to ensure you are grounded and balanced, connected with what matters to you personally. Connect with people that inspire and restore you.

And then, as leader/manager, look around you. Be curious and notice what is going on, for your people, for those they serve. What does the data say? What stories are told? What do people expect of themselves and each other? It is hard to start talking passionately when your starting point is an abstracted notion of ‘compassion’. It is far easier when based on concrete experiences and observations.

“A leader displaying compassion will win the respect of staff and allow them to deliver good quality care and feel more aligned with the organisation’s objectives. The leader will be more credible, more authentic, and more likely to be followed!”

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.” (Margaret Mead, 1901-1978)
Concluding thoughts: where is a sensible place to start? (continued)

You won’t be able to ‘solve’ this alone. Engage early, listen and challenge and orient around core purpose

The people we spoke with talked passionately and personally about the importance of orientating and aligning services around core purpose: taking care of the people in their care, who in turn offer care to patients. They also were able to talk from personal experience about what they and their teams had done to make a difference.

“The truth is you can’t pick it up off a shelf. If you don’t engage people, which takes time energy and effort, you won’t bring about change. You will end up spending more, taking more time, but not getting any real change. You have to listen, feedback, change, develop programmes.”

Asking questions enables people to tap into their own personal experiences and values. The catalytic role of the leader/manager is as much about ‘pull’ (drawing things from others, non-judgementally and creatively), as it is about ‘push’ (clarifying expectations and holding to account).

So share this paper as an opener for you to begin or continue the conversation with others.

“For greatest effect, influence the system-wide variables

Finally, both in the literature and throughout our work with others, it is clear that creating environments where compassion can flourish is most profoundly affected by culture – which, through our actions, we either collude in and reinforce, or challenge and influence to reshape.

No matter how procedural the area of work appears to be, repeatedly asking “For what ultimate reason are we doing this?” and “What is the human impact?” has to be key to informing those decisions. The way incentives, targets and measures are designed and used, the way services are commissioned and monitored, the opportunities created for service users to inform how services are run influence how people perceive the work of caring for others.

And then design systems, processes, policies and rewards that reinforce that.

“Compassion and caring for people in need is at the heart of the NHS and is what brought the majority of us to work within the NHS. Along the way some or even many have lost this compass, or at best it has become less important due to the focus on targets, financial balance, efficiency.
Not that these are not important but if we get the compassion and caring at the centre many of these will become more achievable.”
And a final thought: treat this as a programme of transformational change

Experience shows that laying a solid foundation in change management philosophy and practice lies at the heart as a way to engage, build support, manage resistance and ultimately shape fit-for-purpose approaches that will help deliver the shift you seek: a transformed health service that has reconnected with its core purpose of compassion.

Indeed, our own experience and the research shows that organisational transformations rarely fail because of poor intentions and solutions per se. It’s because the organisation didn’t understand and put in place the key elements that will galvanise support and ensure acceptance of the change.

This is transformational change, and needs to be approached as such

Drawing upon Kotter’s (1995) work of transformational change, one overarching reason that transformation efforts only deliver middling results is that leaders typically fail to acknowledge that large-scale change can take years. Moreover, a successful change process goes through a series of eight distinct stages.

His work shows – as does our own experience – that stages should be worked through in sequence. And since the success of a given stage depends on the work done in prior stages, a critical mistake in any of the stages can have a devastating impact.

Skipping steps creates only the illusion of speed and never produces a satisfying result.

So the challenge for most organisations is having the know-how to unlock and ‘institutionalise’ the good practice that happens in pockets and to make compassion part of the organisation’s DNA.

We offer Kotter’s model as one way to shape your thinking and plan your own journey.

Eight steps to transforming your organisation

1. Establishing a sense of urgency
   - Examining market and competitive realities
   - Identifying and discussing crises, potential crises or major opportunities

2. Forming a powerful guiding coalition
   - Assembling a group with enough power to lead the change effort
   - Encouraging the group to work together as a team

3. Creating a vision
   - Creating a vision to help direct the change effort
   - Developing strategies for achieving that vision

4. Communicating the vision
   - Using every vehicle possible to communicate the new vision and strategies
   - Teaching new behaviours by the example of the guiding coalition

5. Empowering others to act on the vision
   - Getting rid of obstacles to change
   - Changing systems or structures that seriously undermine the vision
   - Encouraging risk taking and non-traditional ideas, activities and actions

6. Planning for and creating short-term wins
   - Planning for visible performance improvements
   - Recognising and rewarding employees involved in the improvements

7. Consolidating improvements and producing still more change
   - Using increased credibility to change systems, structures and policies that don’t fit the vision
   - Reinvigorating the process with new projects, themes and change agents

8. Institutionalising new approaches
   - Articulating the connections between the new behaviours and corporate success
   - Developing the means to ensure leadership development and succession