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Building and Strengthening Leadership

Leading with Compassion

November 2014

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Contents

	Page
Foreword from Jane Cummings, Chief Nursing Officer, NHS England	3
Context and Approach	5
Executive summary	7
The elusiveness of compassion: why it is so hard to get hold of	8
What compassion in practice looks like: the story of one man and the people who cared about his care	13
Self	18
Manager/leader	25
The team	31
The organisation	39
Concluding thoughts	49
Appendices: References	53
Survey and results	59

"Cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public – provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients." West et al. (2011)

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Foreword

Compassion in Practice, the national strategy for nurses, midwives and care staff, was launched in December 2012.

Since that time, a significant programme of work through six action areas has created a momentum across the country which has recognised the very crucial role that organisational culture plays in determining the experience of patients and users of our services.

Caroline Alexander, the Chief Nurse for NHS England (London region), is the Senior Responsible Officer (SRO) for Action Area 4 of the Compassion in Practice strategy: building and strengthening leadership. In this role Caroline led a think tank that brought together a range of nurse leaders from across the country to discuss and identify the key issues that we needed to progress in relation to leadership.

This group of influential leaders highlighted the need to describe what compassion in leadership and compassionate leadership looks and feels like in practice and how a model of compassionate leadership could be recognised and implemented.

The document considers the international literature and evidence base and highlights examples of tangible and recognisable leadership/leaders that 'role model' compassion.

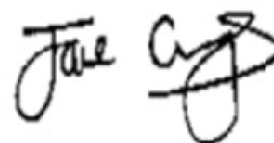
This work, while building on the body of knowledge, expertise and experience of recognised compassionate leaders in nursing and health care, offers fresh insight and perspective into how effective leadership impacts on care and outcomes.

I am delighted to present this document as a handbook and guide for all leaders in nursing and health care who aspire to emulate the recognised attributes of compassion in their everyday practice.

The report makes recommendations drawn from international reviews and the grounded experience of recognised compassionate leaders on a four-dimensional model of self, team, manager and organisation.

The clear message throughout is that compassionate leadership is everyone's business and that everyone in the workplace – from ward to board – contributes to creating a climate of compassion for both staff and patients, drawing on the indisputable links that have been proven to exist between the experience of patients and the experience of staff.

I hope you will engage in the challenges and recommendations, assess yourself, your manager, your team and your organisations against the 'compassion' test and implement the necessary and recommended changes required to make the culture of compassion the norm at every level, in every team and in every service delivered by our organisations.



Jane Cummings

Chief Nursing Officer, NHS England

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Context and Approach

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Context and approach to developing this paper

This work sits within the context of supporting NHS England in the development of the implementation plans 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 in November 2013, where a group of NHS professionals explored compassion at the heart of leadership and how to take Action Area 4 forward. This work was subsequently commissioned by Caroline Alexander, Chief Nurse NHS England (London Region), Senior Responsible Officer for Action Area 4.

The requirement and challenge

To bring to life what compassionate leadership looks like and feels like in practice, with 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 professions working across clinical settings to talk with others.

It set out to:

- distil the essential leadership behaviours, attributes and characteristics that embody a compassionate leader. It was synthesised 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 with insight from exemplars of compassionate leadership/ leaders who have first-hand insight of challenges and opportunities that accompany compassionate leadership.

The approach

1. **Up front research:** What do thought leaders and the literature say? This included academic databases drawing on social psychology, leadership texts and 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 is 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, as identified through the survey.
4. **Thought leadership and recommendations:** We built on the above data with our own insights gained from working with healthcare organisations in the UK and across the globe, and our tested approaches to establishing clear.

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Executive summary

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Executive summary

The ‘call to action’ to put compassion at the centre of how care is delivered and led is widespread. Evidence shows the link between patient and staff experience is inextricable – positive experiences are unlikely to happen to one without the other.

The challenge is *how* to bring it to life in our people, teams and organisations. To create environments where compassion can thrive, practices are needed which ‘reconnect’ people to the values and behaviours that underpin their work and values.

However, it is a *wicked problem that demands a clumsy solution* (Grint, 2008). It demands a new way of leading: to spark and unlock collective wisdom, and release oneself of the expectation that you will have all the answers. There is no silver bullet; it needs a multi-faceted approach. Interventions can be targeted at the level of i) the self; ii) the manager/leader; iii) the team; and iv) the organisation, and usually must be targeted at all four for compassion to truly thrive.

It is unlikely to be brought to life by following a pre-defined ‘recipe’ or process. It is more organic and contextual to the environment. The approach of this report is therefore to recognise and respond to uniqueness, independence and autonomy at the organisational level. To mandate change would be to short-circuit and defeat the intent for engagement at all levels – an essential ingredient for compassion.

It applies to everyone. Each **individual** needs to: develop routine habits to stay balanced; keep rooted to core purpose; plan ahead for situations where work is personally depleting or restorative; and notice the signs and activate plans when off-balance.

The role of the **manager/leader** is pivotal. They connect individuals and teams to their own humanity and core purpose; they align people to organisational purpose and they leverage organisational infrastructure to embed patterns of behaviour. They will need to: make the connection between patient experience and the team’s personal experience of work; get to know the team individually and stay attuned to their needs and opportunity to contribute; build a plan to close the engagement gap; to make strategy and targets meaningful; and notice and respond to signs of need.

Team norms, practices and capabilities contribute to the formation of effective working relationships and determine the micro-climate as to whether compassion can thrive. For this to happen, attention needs to be paid to the foundations of a functional team; to find ways to stay connected with each other; to develop effective methods for creative problem solving, and to be able to air alternate views safely; to stay connected to the patient; to review progress and to provide the means for safe challenge and mutual support.

The culture itself, and therefore the environment at the **organisational** level has the potential to ‘trump’ other determinants of whether compassion will thrive. Good people, for example, in corrosive or toxic environments have been known to collude in undesirable behaviour. It is the collective set of systems, processes, practices and disciplines that establish the boundaries of action.

To bring this to life at an organisational level, there is the need to: listen to first-hand experiences of staff and patients together; engage the leadership; define, revisit, re-affirm or clearly articulate organisational values in behavioural terms, and incorporate them into organisational life; connect the organisational strategy with individual goals and objectives, which includes holding people to account on both performance and values; signal what is valued and retain your best people.

It is hard work and people need support and space. It requires both going back to basics and establishing core working principles, as well as transformational change – and needs to be planned for as such.

Leading with compassion is an outcome not an input. If you get the basics right, and help people reconnect with their work, it can truly transform patient care.

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The elusiveness of compassion: why it is so hard to get hold of

"Organisational culture in its simplest definition is 'the set of members' beliefs about the way we do business around here'." Morgan (1997)

The current status of compassion in the NHS and why this paper

It's easy to keep being drawn back to the headlines:

Express & Star
STAFFORD HOSPITAL SCANDAL: THE FRANCIS REPORT
Patients paid with their lives as hospital cut costs to hit targets
SACRIFICED
Nurses had no respect or care

The Daily Telegraph
3,000 more patients have died needlessly in hospital

JAIL THREAT TO STAFF AT DEATH SCANDAL HOSPITAL
Smile that says Philip's on mend

The Francis Report, the Keogh Report, and the Berwick Review into patient safety point to the multitude of factors that led to nurses, doctors and managers losing sight of quality and the need to learn lessons from these failings.

The response: a re-dedication of the NHS to living its core values, with compassion being central within this and policymakers, commentators, conferences and blogs making genuine personal and organisational declarations that we can and will do better. And rightly so. The revelations were shocking and so the call to action was needed.

The status of compassion in health care however is not yet secured. Compassion (and the human realities of care, for patients and for staff) still fight for space on crowded board agendas. Although progress has been made, on some wards, the challenge for stretched teams is to move beyond transactional care, beyond risk mitigation and compliance to protocol. Equally, how services are commissioned, regulated and inspected will either reinforce or undermine the environment that supports patient care and respects frontline staff.

Interventions around compassion also risk being annexed by being seen largely as the province of those responsible for delivering care, especially nurses and midwives, **without** equal focus on the context within which that work happens.

The challenge is how do we really understand what will make a difference in personal, deliberate choices to act and lead with compassion? What should individuals, teams and organisations ***do***?

Recommendations need to be practical, based on best practice, and evidence-based, to have credibility across the service and with the public.

This is the challenge and purpose for Action Area 4 of Compassion in Practice; to: "**strengthen leadership at every level of health and social care. Every person involved in the delivery of care needs to contribute to creating the right environment and providing clear leadership to patients, carers, staff and colleagues. This ensures safe, high quality care and a positive experience for patients and staff**."

The purpose of this report is to provoke in its readers practical action:

- to provide examples of it already alive in the NHS, leaders (formal and informal) engaging with others to find ways to shape their environment;
- to offer ways of rooting conceptual notions of compassionate leadership in tangible actionable terms; and
- to stimulate leaders and teams to align their real, day-to-day working environment, behaviours and culture to their core purpose – the duty of care to patients and staff.

A few working assumptions

Compassionate leadership has the capacity to transform service-user and staff experience

One of the first things to explore and confirm was whether the notion of compassionate leadership was truly worthy of all the focus and attention, or simply the cause célèbre du jour. So we did our own research (see Appendix 2, pp. 59–69). The perception among respondents is that greater compassion within and through leadership has the potential to (re)align the NHS to its core purpose and truly transform patient care. It is seen to be at the core of a set of essential attributes that are needed for the NHS, social care and the independent sector, without which quality issues and sustainability cannot be achieved.

Compassion is a result, not an input: it is the culmination of all the things we do

As an input, compassion would need to be tightly defined, make itself amenable to quantification, establish the standard of exactly how much compassion is needed in any situation. Treated in this way, the search for and implementation of compassion becomes narrowing, a cerebral process. This entirely misses the point.

Treated as a result, a culmination of activities, it represents a host of opportunities to engage people, to understand what drives them and what could be done to reconnect and realign their work with the reason they became health and social carers in the first place. It is a broadening, expansive series of thoughtful actions that finds myriad ways to shape the work and care environment.

When we say 'patient' we really mean any recipient of care

In the interest of simplicity, we frequently say patient. The use of this term doesn't narrow the application of ideas and suggestions to only those with physical or mental health needs that require support. Nor does it override the need to see the person beyond the symptoms. The term can generally be used interchangeably with service user or any other recipient of care.

Creating cultures of compassion is a 'wicked' problem that demands 'clumsy' solutions

Wicked problems by definition involve complex, messy and stubborn challenges. They are continually evolving and have, at the core, many reasons; no single solution applies in all circumstances. Rather it's a question of solutions that can only be classified as better or worse, and not right or wrong. (Rittel and Webber, 1973; Grint, 2008)

- *Conventional processes can't resolve them* (for us: audit, performance management, stretch targets, standards and standardisation) – and not only that: they may exacerbate the situation by generating undesirable consequences, and provoke disengagement when it is needed most.
- *There are innumerable causes, acting cumulatively and systemically*: how we assess and categorise patient need and plan and organise care; what gets measured, rewarded and challenged, affecting perceptions of core purpose; how professionals are trained and 'institutionalised'; group thinking and responses to stress, to name a few.
- *What 'compassion' and 'leading with compassion' means is difficult to describe and doesn't have a right answer*. Equally, there isn't a defined end-point when we can say definitively "We have 'solved' this."
- *The nature of the problem is unlikely to be fully understood for each organisation, leader or team, until solutions have been developed and applied.*

So, there is no obvious remedy to creating climates that cause compassion to thrive. Rather, multiple incremental, partial solutions are de rigueur; the aim is to approach compassion from all sides, to tackle, address, and mitigate 'compassion-killers' and to bolster and pave the way for those things that cause it to thrive.

It requires stepping off the edge of the map.

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A few working assumptions (continued)

Engagement paves the way for compassion

There is no linear route for creating, shaping and challenging the work and care environment. Therefore, action and opportunities for engagement are needed at all levels.

Engagement at all levels and across all employee populations is essential: "When we care for staff, they can fulfil their calling of providing outstanding professional care for patients." (West & Dawson, 2012)

Engagement inspires personal initiative. It leads to better patient experience and a more positive working environment (West & Dawson, 2012). Its absence may lead to burn-out (cynicism, exhaustion or inefficacy) and ultimately poor experiences of care (Vahey et al., 2004).

Engagement, like compassion, is a result and not an input. Creating environments where compassion can thrive is inextricably linked to the ways in which individuals, leaders, teams and organisations engage collectively around their primary purpose.

Building capability happens inside-out; diagnosing, outside-in

Building capability usually happens from the inside out, starting with developing personal mastery, most often functional or technical.

The leader is usually the next step in the development chain, where they build their capability in managing others, usually doing classic management functions like staffing and managing budgets. Building true leadership capability – itself of course a crucial skill and one that can be developed – is often the last to be developed, if indeed it is developed at all.

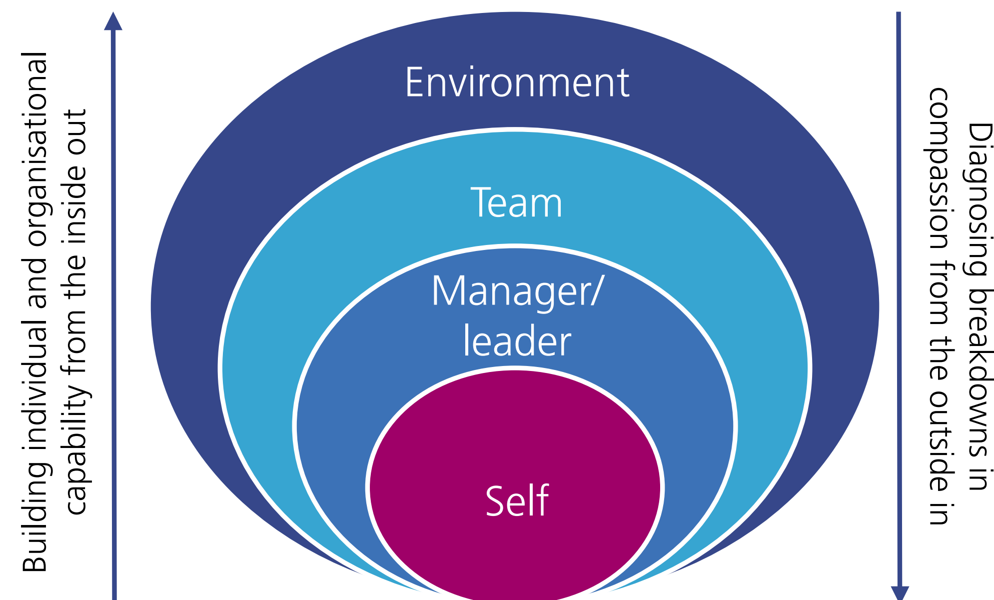
The environment – systems, processes and policies, which set boundaries for action – have a profound impact on people in their work, for example in recognising their contribution to creating a climate of care and compassion.

We believe that it is this last level which is usually the most potent in its impact on shaping the context and climate within which people and teams make decisions, both consciously and unconsciously.

Stated differently, organisations are seldom deliberate in focussing on creating the environment. It's usually a product of the aggregation of isolated decisions and workarounds. So cultures and norms emerge, and systems – often fragmented and not fully fit for purpose – can reinforce them.

The context then shapes and strongly influences individual choice of behaviour (e.g. Haney & Zimbardo, 1998) and conformity to group norms (e.g. Bond & Smith, 1996). One result: good people, in corrosive or toxic environments, have been known to do bad things – or have been known to stop behaving in 'good ways'. But it is not always easy to understand where things are going wrong – what can explain wholesale failures in humanity for example?

We have developed the following model as a useful construct for helping diagnose and explain behaviours and choices. Building capability usually happens from the inside-out. When diagnosing issues in the organisation, it is more useful to start with the environment and drill through successive layers to see where the 'breakdown' has occurred.



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:

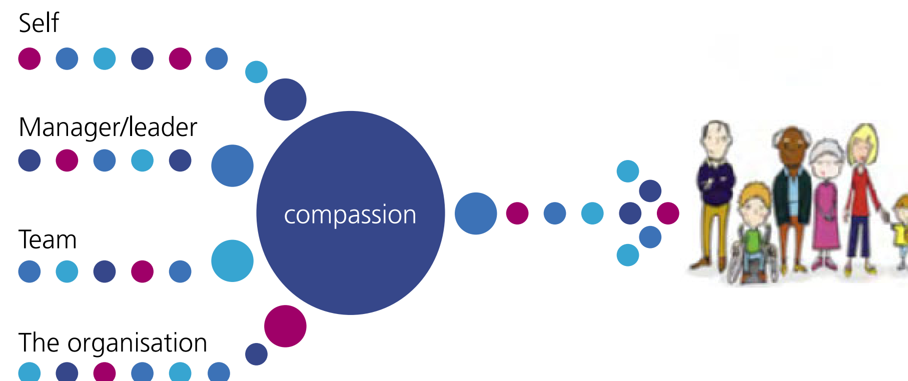
Self: the self-awareness, resilience, mindfulness and emotional intelligence that allows you to be present and available to the needs of others.

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.

* Quotes from our interviewees and survey respondents are shown throughout the report in a similar shaded box.



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.

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What compassion in practice looks like: the story of one man and the people who cared about his care

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Fran was mulling over the events from breakfast and the argument with Sam, her 16-year-old son. Door slammed, lingering regret over what she had said. He must know she hadn't meant it.

The call came in: male, 76, fall, suspected leg break. Fran shouted back to Jim to buckle up. She fired up the engine and flicked on the blue lights. Time to put thoughts of Sam away, made easier knowing she'd have time later to think further. She'd developed a habit of journaling at the end of the day.

The neighbour let Fran in, with Jim close behind. "He's in there." Stuart Mason was still on the floor where he'd fallen. He was frustrated for tripping over his own feet – not moving his legs fast enough. But he was also frightened, and in pain.

Fran saw Stuart was in distress. After an initial examination, having determined the technical components of his care, she offered the reassurance Stuart looked like he needed. "We'll take good care of you, Stuart. Don't you worry." Before Fran left the house, she fast forwarded to Stuart's likely admission and surgery, and how he looked like he would want a friendly face. "You said you have a daughter, Stuart. Do you know her number, or is it written down? Let me just get that before we go." Stuart, though in shock, relaxed a little. He felt a little safer. Fran was looking out for him.

*

It had just been one of those mornings. He was tired from squeezing in revision for the upcoming acute medicine exam, was four hours in to the shift without managing a toilet break, and still trying to process the look on the face of that girl with the severe spinal injury – dark terror.

Dr Ahsan Shah stepped into a side office and closed the door to block out the noise. He stood still, planted his feet shoulder-width apart, and turned attention to his breathing – one slow, deep inhale, a pause, and then a long, smooth exhale. "Ten seconds well spent," he thought, calmer and refocussed. A mental note to go to the next Schwartz Round.

The door opened, "Sorry Ahsan. I just need to use the phone. Is that ok?" "Of course." Back out into the white noise of a busy department.

The 'jjjjj' as the sliding door opened, and the rattle of the trolley's wheels over the A&E entrance. Fran kept focussed on Stuart while Jim did the handover with Dr Shah. "Stuart, this is Dr Shah. He will be looking after you now. Are you happy if I ring your daughter to let her know where you are? You are in the right place. There's a good team here."

"So many people. The noise. And that hospital smell. It's a people factory," Stuart thought as he recoiled into himself. Ashan saw the look on Stuart's face, eyes wide and flicking around, and recalled a patient story he had heard of an elderly woman's experience of arriving at A&E and how disorientating she found it. "Stuart, I know there is a lot going on in our department. But things aren't as chaotic as they might appear. Let's talk about what's going to happen to you next, and I'll introduce you to Jane who will get your leg assessed. She'll also start the planning for helping to get you home again." Music to Stuart's ears – getting home again. "Thank you."

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"Hi Martin. It's Dr Shah. I'm phoning about Stuart Mason who has a confirmed fractured neck of femur." "Yep. I've given you a bed on Alexandra ward," he said curtly. "I know, Martin. And I want to hold off because elderly care isn't what this patient needs. He's fit. He'll mobilise quickly after surgery, and I want him home again soon. He needs to get on to Trauma & Orthopaedic. He's a way off breaching the four hours yet. I'd like to wait." A sigh came down the phone. Ahsan picked it up, "Martin, you've got a really tough job. And from your sigh, I suspect you feel I'm not making it any easier. But we are on the same team here. This is what is right for Stuart, yes?"

"These corridors are long! Lights are just flashing over me as I'm pushed along," thought Stuart, "but at least my nurse Jane, and this other man are treating me well."

Mike no longer saw himself as 'just' a porter. Things had been changing around here. He went to a 'Values, Standards and Behaviour' workshop, delivered by his boss's boss's boss – the chief operating officer – just inspirational! She really seemed to believe in how each person makes a difference and they talked about why they had joined the NHS, and what they cared about.

Mike volunteered as a porter representative, and got to work with a group of wards and their patients to find out what was already good, and what would improve the experience even more. "Never talk over patients; explain clearly where we are going, offer a friendly word; double check with the ward before coming, to make sure they are ready for us," were some of what Mike took back to his team. He recalled the thank you cards that his boss had shown the team.

He knew he still had to get better at getting to work on time. Every other week he had his daughter to get to school. Mike was working with the boss on things he could do differently, and also at the rota. They were, after all, on the same team.

*

Mike and Jane brought Stuart into the T&O ward. "Dr Shah had been right to hold out for a bed," Jane thought. "You can just tell – the ward space, the physios, the energy for getting people out of bed and mobile."

Stuart's trolley passed the door of the ward manager, Rehema, as she placed the phone in its cradle. She knew she felt flat following that request to find ways to reduce her use of agency staff. Fine normally, but this week she had three out on leave and another call in sick. How could she deliver great care? And role model what her team needed to be, in spite of the frustration? Rehema remembered the director of nursing explaining how the Trust needed to make savings, but it wasn't just the blunt instrument of a target. They needed to make their fixed resource go further and benefit more patients. She trusted her.

Regardless, it was a knotty problem. She would ultimately make time to think this through as a team, and put it on the agenda for the team huddle. But in the mean time, Rehema put out a note to her little group of colleagues who she met monthly – people who the Trust recognised had really pressured jobs and could benefit from a bit of peer-support and to help share ideas.

The door opened. "Rehema. Mr Mason is now on the ward, in bay 6. Do you want to meet him and review the care plan with us? Or are you busy?" "No, no. I'll come now." She briefly scribbled a reminder for herself to get in touch about the agency problem, and left the office.

*

Stuart had been given something for the pain throbbing in his outer thigh. He was also conscious that he was really hungry. Not long now until he'd be taken to theatre. He'd never been this nervous going to the theatre before, Stuart joked with himself, remembering fondly the plays he went to with his late wife.

He heard his name mentioned and looked up. "Jessica!" With huge relief, Stuart saw his daughter. That paramedic Fran, who said she'd contact his daughter, had turned up trumps. Stuart would make sure he filled in one of the 'complaints, concerns or compliments' cards that the care team actively promoted, a new Trust-wide initiative to make feedback core to protecting, promoting and recognising quality of care.

Stuart didn't remember much of his time in theatre. But his safety was protected nonetheless.

A scrub nurse earlier in the week had stopped a surgical procedure, pre-incision, as he had noticed the surgeon texting on his mobile phone whilst the team were reviewing the notes. Though nervous, he challenged the surgeon, stating clearly what he had noticed and that he felt it was necessary to revisit the review of the notes to make sure everyone was clear what needed to happen.

This act of courage would have previously been unheard of. But staff had recently been offered training involving simulations, to practice challenging conversations, how they could 'stop the line', and what they might say.

This piece of training was a direct result of a member of the local area team holding a 'Never Event' sharing session with senior clinical leaders, identifying the need and then designing an intervention to address such human factors in serious errors. Furthermore, incident reports are now followed up systematically to support staff to act preventively wherever possible, to avoid similar incidents entirely.

*

Stuart moved to recovery, and then back to the ward. He was tired, and really needed rest. His ward welcome pack thankfully had ear plugs and eye covers in, and he was grateful to be able to sleep: an idea that came from a health care assistant listening to a patient who couldn't sleep because it was noisy and light. She thought about how aeroplanes suffered the same problem and what airlines did about it. With the head of patient experience, they found a way of redesigning the welcome pack for the same cost as the old one.

Stuart was impressed how attentive the ward staff were, and that there seemed to be the right people there at the right time.

It wasn't always like that. In one of the team huddles, Rehema the ward manager heard how the ward got really stressful when it was at full occupancy with a fair number of high dependency patients. They suspected patient care suffered too. The audit department helped them to evaluate dependency levels, staff cover and patient experience.

With the results, Rehema helped the team find a way to keep a smooth running ward, even at peak times with high dependency patients. The general rule of thumb was to predict and be proactive in addressing likely patient needs – getting the ward on the front foot. And as soon as they knew they had the 'perfect storm' of high occupancy, high dependency and high agency cover, they would take a 5 minute huddle, including all ward staff, to re-prioritise tasks, reassign responsibilities if needed, and cease non-critical activities.

There seemed to be less conflict (and when there was, Rehema made sure the focus was on learning, not blame). The team was beginning to feel like a real team.

But Stuart didn't know any different. For him, it just worked.

*

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Stuart was ready to go home. He missed his routines, he missed the 'hellos' and chit-chat with the people in his local shops.

His discharge was planned days earlier, with the discharge coordinator listening carefully to both Stuart and Jessica, as well as the assessment by the rest of the care team. Rehema knew how long it was taking to get patients back home, and was accurate in estimating recovery times of her patients.

She still flushed with pride thinking about presenting a successful case to the Ops Board to get Trust-wide agreement to begin the planning process much earlier. It involved more of the multi-disciplinary team, and especially the patients and their families. The need for taking a rounded clinical and social judgement about when and how to discharge had been overwhelmed by the wide-spread anxiety around risk. But it was stopping patients getting back home, wasting resources, and meaning patients were being dotted around the hospital as the right beds weren't available at the right time.

Rehema couldn't have stood up and presented without the support of her line manager, who not only mentored her, but got her on a presentation skills course, and helped to get her confidence back. What really helped was bringing another patient with her, quite similar to Stuart Mason, to tell his story, and the real human costs of delayed discharge.

*

Stuart's final trip to be discharged from the hospital was not what he expected. Instead of a porter like Mike, Stuart was taken to the discharge lounge by Louise, who worked in the finance department. She explained how every Friday, non-clinically facing staff, who may not see patients, could volunteer for the morning and help out. Today, she was portering. The director of nursing asked them to go to an area they don't usually work in and with their fresh eyes, make a change by the end of the morning. "We come back at lunchtime and say what we've done."

"So what is your change going to be?" asked Stuart. "Well, I can see so many wards struggling with their rotas," said Louise. "It is taking a long time each week, and isn't making best use of the skilled people we have. I think I could create a business case to invest in a technology solution."

"Why do you do it? Do you have the spare time?" asked Stuart. "When you are not wearing a suit," explained Louise, "people talk to you differently. I get a better view of the hospital, what things are really like for patients, and the pressures on staff. And personally I think it is so important to really understand how financial decisions will affect patients like you, the services, and staff." She paused.

"Besides, if I can't spare three or so hours a week to care for patients, what am I here for?"

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Self

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The characteristics of a compassionate leader

While we aim to create and be part of organisations that provide compassionate care, acts of compassion are typically felt at a *personal* level. The work of bringing compassion into leadership is mediated by personal choice, bringing to bear personal beliefs, values and behaviours. In a survey of 140 alumni of the NHS Leadership Academy, respondents were asked to **identify the 10 most important characteristics of a compassionate leader**.

Forty potential characteristics were offered to respondents (a combination of mindsets, behaviours and personal characteristics), drawn from the literature on compassion and compassionate leadership. In the image below, the size of text represents the frequency with which the term was selected.

In descending order, accounting for 80% of responses, the most important characteristics were seen as:

1. Emotional intelligence
2. Integrity
3. Listening
4. Trust
5. Authentic
6. Openness
7. Caring
8. Reflective
9. Commitment
10. Genuineness
11. Empathy
12. Resilient
13. Balanced
14. Courage
15. Respectful
16. Kindness
17. Positive
18. Responsiveness
19. Responsibility
20. Motivation
21. Non-judgemental

These terms become useful in behavioural interviewing, values-based appraisal processes and engaging others in what compassionate leadership might look like to them.

From the results, it would appear the terms used have to:

i) resonate and have meaning (terms such as benevolent, camaraderie, equanimity, kinship, mutuality were never selected);

ii) feel appropriate to be used within the work and care environment ('gentleness', 'loving', 'sympathy' only had single responses – possibly being too awkward, 'soft', or culturally alien to use day-to-day); and

iii) use language accessible to a multi-faith and diverse workforce, given that care words can be associated with specific world religions.

Self: the field guide for improving self-mastery

What it means in this context

The personal attributes, practices and behaviours that keep the individual rooted to their core purpose and focussed 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, focussed 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).
- Desensitisation 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 lower incidence of post-traumatic stress disorder (Senge et al., 2005, Johnson et al., 2014).
- High self-efficacy – the belief inherent 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.

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Self: the field guide for improving self-mastery (continued)

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?

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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; and
  - monitoring 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; and
  - 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 around quality of listening, questioning, and being able to mentor others; and
  - 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 to 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.

Deep dive: core skills for self-mastery – mindfulness

Standing in the way of compassionate behaviour is the neurological response to threat and desire for self-protection, designed to attract attention, detect, process and respond to threats. The threat-based emotions such as anger, anxiety and disgust and defensive behaviours, such as fight, flight, submission, freeze – all can inhibit readiness to connect with others. In the moment, mindful activities can help still this with changing body posture, use of breath, tone of voice, or methods of stilling the 'internal chatter', bringing one back to the present, and the real.

Mindfulness is a way of paying attention to, and seeing clearly, whatever is happening in our lives and around it. It will not eliminate pressures that prevent us from behaving with compassion, but it can help us respond to them in a calmer manner that benefits our heart, head and body, and those around us. It helps us recognise and step away from habitual, often unconscious emotional and physiological reactions to everyday events. It provides us with a scientifically researched approach to cultivating clarity, insight and understanding.

Practicing mindfulness allows us to be fully present in our life and work, and improve our quality of life.

Mindfulness can be developed through meditation or other daily (or at least regular) practices, such as journaling, prayer, heart-to-heart discussions and solitary exercises like jogging, hiking and swimming. The important thing is to have some form of introspective practice that enables you to slow down your mind and 'be' rather than 'do'.

Like a muscle that gets stronger with practice, mindfulness can be brought to bear on situations, in the heat of the moment, which require presence and stillness of mind, not formulating a response as you are listening, but just genuinely listening.

"It's about being present for the person in front of you. The biggest challenge from patients is when they don't feel you are there for them. That you are not listening. It also creates more work downstream. It's the same for staff."

The ABCs of mindfulness – a tool for daily use

- **A is for awareness**. Becoming more aware of what you are thinking and doing – what is going on in your mind and body.
- **B is for just 'being' with your experience**. Avoiding the tendency to respond on auto-pilot and feed problems by creating your own story.
- **C is for 'seeing' things and responding more wisely**. By creating a gap between the experience and our reaction we can make wiser choices.

Source: Juliet Adams, Founder of Mindfulnet.org & Director, A Head for Work

"Meditation enables me to forget less important events and focus with clarity on significant issues. My most creative ideas come out of meditation. In addition, meditation increases my energy level and enables me to be more compassionate toward others." (George, 2013)

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Deep dive: core skills for self-mastery – emotional intelligence

> "Emotional intelligence is vital, and the ability to sense verbal and non-verbal patterns of behaviour – to see when people are with you, and when they are not, or when they have concerns."

Emotional intelligence (EQ) relates both to awareness of self and also of the other person or group.

Being aware of our own internal state, motivations and triggers, gives the opportunity to self-regulate. The skill is in slowing down the cascade from 'stimulus' to 'response':

1. Observe the situation and distinguish what things are known versus your perceptions based on *assumptions* (e.g. other people's intent).
2. What are the automatic thoughts that these perceptions provoke (including the 'inner critic')?
3. What feelings and emotions do these thoughts create?
4. How is your body reacting? What are the physical sensations (e.g. hot face, tensing of stomach etc.)?
5. What alternative ways of seeing the situation are there?
6. What choices do you now have in how you respond and behave?

The skill is in slowing this process down to be able to check out assumptions and consider alternative balanced thoughts, which opens up some potentially more constructive responses (Greenberger & Padesky, 1995).

The second aspect of EQ is recognising and understanding other people's emotions:

- Reading the verbal and non-verbal signs and testing out assumptions about what they might be saying (if appropriate).
- Being curious (and non-judgemental) about what else might be going on for that person – pressures, hopes, needs – that might affect their readiness to engage.
- Successfully managing relationships, recognising the give-and-take reciprocity integral to healthy relationships, making time to listen, as well as to share openly.

> "I pulled someone out of a team and we talked about care and compassion. They just couldn't recognise their own behaviours. It ended up with them shouting at me and storming off. I thought 'You are finding this harder than I am. I need to be kind to you.'"

> *"Between every action and reaction there is a space. And in that space is choice."* (Victor Frankl, 1985)

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Manager/leader

"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

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Manager/leader: the shepherds of clumsy solutions and collective intelligence

It is a bold and courageous person that takes on the role of a manager or leader in the NHS. In a shifting environment, with many moving parts, there is an expectation that they will:

- build solid, productive teams
- interpret and 'operationalise' the strategy, and help people understand how what they do connects with it
- set expectations for what must be done and delivered, and the standards of performance and behaviour
- help people develop their potential
- hold people to account for delivering results in a way that is consistent with organisational values
- model self-awareness, self-efficacy and self-regulation.

Health care, and Western society more generally, has tried and tested different approaches to leadership: leader as controller, leader as therapist, leader as messiah/hero (Western, 2008).

> "Heroic leadership just won't work here. It's not sustainable."

As this quote from an interviewee shows, in our increasingly complex world, the context demands a different set of skills and competencies.

Indeed, an underlying tenet of 'clumsy' solutions as a response to 'wicked problems' (see page 7) is the notion that the key leadership role is stepping back from reactive 'solutioning' to work out the right questions, encourage connectivity and create opportunities for new responses to emerge.

However, this is not an abdication of the leadership responsibility – quite the opposite. It is to orientate individuals and teams around a core purpose and about harnessing collective intelligence. For those who have been most successful in a performance management culture, this approach may feel quite alien – unless it is part of the organisational culture, and embedded in how it assesses 'success'.

Collective intelligence emerges from the collaboration of many individuals. New learning is created by people sharing their knowledge to solve problems, which supports the evidence that this is how novel solutions are developed to tackle wicked problems. The snag is that, as with all emergent phenomena, just as wicked problems can't be tackled using conventional management approaches, collective intelligence can't be managed that same way.

Harnessing collective intelligence requires a different set of skills of leaders and managers. They need to:

- be as skilled at finding the right questions as developing the 'right' solutions
- challenge the status quo, whilst being part of that system
- span boundaries, organisational and professional
- see failure as a necessary consequence of trying something new. The role of the manager/leader is not to prevent risks, but to make it safe to take them and to create learning from the failure.

Whilst leadership can be demonstrated by anyone who inspires others to act, in the coming section we are specifically focussing on those with a formal management or leadership role; those who have designated responsibility for enabling cohesive teams to respond to strategic and operational imperatives.

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.

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Manager/leader: the field guide for engaging and developing people (continued)

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."

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."

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?

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-to-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, eating much more or less. Use these 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.

Deep dive: core skills for manager/leaders – overcoming learned helplessness (the flip side of self-efficacy)

When people's efforts at taking control meet with resistance or even punishment, they often learn 'helplessness' and become passive. Organisations that have a rigid hierarchy and are highly bureaucratic can foster this passivity. Learned helplessness dulls awareness and innovation because people respond to a new situation with the assumption that they are incapable of doing anything to change events.

Learned helplessness is not just a feature of individuals. Teams can also learn to passively let managers direct them. So if the culture of an organisation makes it apparent that the authority of managers is absolute and that employees' concerns will not be investigated, employees learn not to complain, no matter how unreasonably others behave. In this way, the employee learns to feel helpless in the face of unacceptable behaviour.

Eventually, people can become desensitised to uncomfortable situations and therefore not act to change them (Martinko and Gardner, 1982).

It is perhaps through this context that the horrors of Mid Staffordshire can be explained, at least in part. Many can compellingly and legitimately explain away not changing the status quo i.e. budget constraints for not increasing nurse-to-patient ratios; staff shortages making cross-cover for training and development unpractical; the imperative of channelling resources to meet performance targets and relegating improvements in patient experience to something to be done later.

Managers unwittingly perpetuate the cycle by falling back on excuses that they themselves are helpless to influence things that fall outside their control and that absolve them of accountability for change or improvement.

So, instead of finding creative ways to deal with regulations or budget constraints, they accept the status quo and blame external conditions for the problems that exist.

Learned helpless is a contagion

Like a spreading infection, managers unwittingly pass on learned helplessness from group to group and level to level. Eventually the standard response to any initiative is some variation of, "We'd love to do that, but we really can't." And they cannot because they believe it.

The leader/manager's role in breaking the cycle of organisational learned helplessness

First, isolate and highlight the pattern

The first lever for changing a recurring cultural behaviour is to make people aware of it. Where there are persistent messages around an inability to effect change:

- Ask people to make an inventory of all the things that prevent compassion in practice from being the norm; the range of initiatives that would address the 'de-railers' that stop it getting off the ground.
- Put together a list of the 10 most common excuses for not taking action and start to unpick them. The more dialogue you can create around these issues, the more colleagues will become aware of largely unconscious behaviours.

Second, prove your organisational power to act

- Find one action or initiative that is within the individuals' or team's control, which can demonstrate, even on a small scale, that taking action is doable and will not result in reprisal or catastrophic failure and champion and support it to its successful implementation.

Everyone faces real constraints. The problem of learned helplessness can be worked out at an individual level through counselling, training, active listening, coaching and other forms of individual support. Organisationally, expectations are shaped by the overt and covert messages sent through how decisions get made, the way change is introduced, how jobs and reward systems are designed, and the other behaviours modelled down the line through organisational leaders.

Adapted from Ashkenas, 2012.

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The team

Teams: building functional and attentive teams

The high-performing team is now widely recognised as an essential tool for constructing a more patient-centred, compassionate, coordinated and effective health care delivery system. The research is compelling and includes study upon study to justify improving the quality and effectiveness of teams (West & Lyubovnikova, 2013):

- the body of research evidence suggests that effective teamwork in health care is associated with reduced medical errors. (Manser, 2009)
- increased patient safety (Firth-Cozens, 2001), as well as improved worker outcomes such as reduced stress (Carter and West, 1999)
- intent to stay at work (Abualrub et al., 2012)
- job satisfaction (Buttigieg et al., 2011)
- the quality of teamwork in health care is related to patient mortality in hospitals (West et al., 2001)
- lower staff absenteeism and turnover, more effective use of resources and greater patient satisfaction (West et al., 2011).

Teams in the NHS come in many shapes and sizes: e.g. disaster response teams; hospital teams caring for acutely ill patients; community based teams; teams that include the patient and loved ones, and a number of allied health professionals; arm's length bodies and other office-based, support or oversight teams – to name but a few. Many of them are dynamically formed or have a core team with others that come and go, such as agency staff to fulfil short-term resourcing needs.

So having a 'one size fits all' approach and field guide for building effective teams that demonstrate compassion in practice is somewhere between difficult and dangerous.

That notwithstanding, the research – both ours and the literature review – reveals some core themes, concepts and practices that are worth exploring as you, the reader, participate in or have stewardship for the formation, health and effective functioning of a team in the NHS. You will find a few of the essentials highlighted in this section.

Team diversity is good for the patient

> "Securing diversity in the NHS will be a sign of a compassionate leader. It is more than employment rights. If we have a diverse community, unless there is a diverse workforce who knows it and understands its different needs, it will be much harder to show compassion to those being cared for."

The literature and our research suggests that when health care recipients are treated by professionals whose ethnic backgrounds reflect their own, the resulting interactions lead to better understanding, improved patient experience and improved outcomes. It must be acknowledged that diversity, particularly of black and minority ethnic staff in senior leadership roles in the NHS, is proving to be a particularly wicked problem (Kline, 2014). We have included an example of one Trust that actively keeps diversity and inclusion on the agenda (see page 36).

Building diversity in teams can be tricky. By their very nature, diverse teams are made up of people who are different from one another: different skills, backgrounds, ethnicities, styles, preferences. These differences bring multiple perspectives, but can also introduce tension and undermine trust if teams are unable and unwilling to address the tension and resolve the spoken or unspoken conflict. Managers must be equipped, and organisations must provide the support structures to address the challenges of attracting and assimilating a diverse workforce and working in diverse teams.

Teams: building functional and attentive teams (continued)

West and Lyubovnikova (2013) outline what they consider to be the most important inputs and processes for predicting performance of health care teams.

The practice of reflexivity is particularly elemental in creating high functioning teams, available to work compassionately with each other and their patients and to demonstrate caring responses.

Aspect	What and why
Task	All teams require a team task. It must be sufficiently complex to demand some degree of task interdependence – in short, that require teamwork.
Team composition	Refers to the right skills with the right number of people to create the conditions for healthy decision making and dynamics.
Organisational support	At the organisational level, the context within which health care teams are embedded **must** support team-based working. Team, rather than individual, efforts should be acknowledged through a reward system which encourages team members to work collaboratively and recognises their task interdependence.
Shared, team objectives	Critical as they give team members the incentive to combine their efforts and collaborate closely.
Leadership	Leadership clarity was associated with high levels of participation, clear team objectives, commitment to excellence and support for innovation. But this is difficult in multi-disciplinary teams and more often conflict is present due to lack of clarity of who the leader is.
Reflexivity	The extent to which teams regularly take time out to define what it is they are trying to achieve, how well they are working together, what they need to change, and then making adjustments accordingly.

With so many potential team dynamics, it can be challenging to get a handle on where to start to develop effective teamwork. Lencioni (2006) identifies the five dysfunctions of a team (see the model above right), and by corollary, the five characteristics of a highly effective team – serving as both diagnostic and focal points for action.

Lencioni, The Five Dysfunctions of a Team, 2006

A model for diagnosing and addressing team dysfunction

Dysfunction 1: Absence of trust (leading to lack of vulnerability). Team members are reluctant to be vulnerable with one another and are unwilling to admit their mistakes, weaknesses or needs for help.

Dysfunction 2: Fear of conflict (leading to artificial harmony). Without trust, members won't openly share their opinions or debate key issues. As a result, the decisions will be poorer and the conflict is driven underground.

Dysfunction 3: Lack of commitment (leading to ambiguity) – without conflict being surfaced and addressed, it is difficult to commit to decisions and set direction, disheartening staff, particularly high performers.

Dysfunction 4: Avoidance of accountability (leading to low standards) – without commitment to a clear plan of action, even the most performance-focussed individuals will be reluctant to challenge behaviours and actions that may seem detrimental to the good of the team, non-bureaucratic reporting arrangements and opportunity to reformulate action plans are needed.

Dysfunction 5: Inattention to team results (leading to poor results) – when individuals aren't held accountable, team members are likely to pursue their own needs (e.g. recognition, career development). If the team has lost sight of the need for achievement, the organisation will ultimately suffer.

NHS England

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 (Borrils 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.

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."

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?

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 26).

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."

Deep dive: diversity and inclusion in action – a case study on how one Trust got traction

The organisation

The 5 Boroughs Partnership NHS Foundation Trust provides treatment, support and guidance for people affected by mental ill health and learning disabilities. With 2,200 staff, covering a population of over 900,000, it provides services for people of all ages, living in the catchment area. They offer day care, in-patient care and community services.

What they did and why – in their own words

The trust started with a stated commitment to:

- build a diverse workforce which reflects the communities it serves; and
- promote an environment characterised by dignity and mutual respect both within its workforce and the service it delivers.

The unit supports the development of good practice by ensuring that equality, diversity and inclusion lies at the centre of all policy-making, employment practice, service delivery and public and patient involvement. The development of the unit stems from the recognition that the culture of institutional discrimination, due mainly to the lack of awareness and understanding, has no place in today's NHS. The unit's main aim is to promote the value of the unique contribution made not only by all of the trust's employees, through their diverse experience, knowledge and skills, but also to promote the recognition of the unique experiences of service users and carers.

How they did it

To their disability and equality agenda, they added an equality and diversity advisor to address race and ethnicity. The Trust transferred its equality and diversity functions to the nursing, governance and performance directorate to mainstream equality and diversity as a governance issue.

They developed a positive action employment scheme and the recruitment of a coordinator. The post was later extended to encompass the growing social inclusion agenda and appropriately re-titled as social inclusion coordinator. This placed the equality, diversity and social inclusion agenda firmly within the core business and day-to-day activities of the Trust.

In 2008 the unit developed an involvement scheme, coordinating a wide range of opportunities and involvement initiatives across the Trust. This led to the development of an additional post of involvement scheme coordinator, whose role is to provide administration and day-to-day support to managers who coordinate their involvement in business activities.

The results

The unit continues to provide a full range of equality diversity and inclusion focussed services which include (not exhaustive) the following:

- strategic direction and support on all aspects of patient and public involvement, equality and diversity and social inclusion
- guidance on ensuring legal compliance with equality legislation
- development of culturally sensitive services through staff training
- engagement with staff, service users, carers and the public
- supporting alternative communication needs (interpreters and translation)
- information and advice to staff
- partnership working with voluntary and community groups, private and statutory agencies
- disability advice and support to access and facilities; support to disabled members of staff through the trust's occupational health and employment services.

The Trust has employed additional staff including:

- one full-time and one part-time equality and diversity advisor
- three part-time equality and diversity trainers.

In addition, staff from the unit provide administrative support to the North West's NHS equality and diversity forum, which involves nearly 100 equality and diversity officers from trusts across the North West.

The forum meets bi-monthly and receives regular contact via an e-network.

NHS England

The organisation

Bringing it all together: an organisation and system-wide approach to shaping cultures of compassion

The 'organisation' establishes the infrastructure, the systems and mechanisms to support (or thwart) managers to enact desired values and behaviours, such as compassion, as they in turn support and guide teams and individuals.

"It is good to see words like *compassion* appearing in recent health policy […]. In the current climate, however, there is a danger of the development of yet more standards, specifications and procedures to promote such behaviour. This process is unlikely to reap the benefits hoped for unless ways of promoting and supporting *attentive kindness in everyday practice* are brought to bear on the daily lives of staff." (Ballatt & Campling, 2011)

Some (e.g. Illes, 2011, Seddon, 2008) argue that the industrialisation of health care, with its reliance on audit, inspection, protocols and targets has alienated carers from the cared-for, distorted purpose and reduced ability and confidence to improve services: contributing factors to the degradation of compassion.

Therefore care will be needed in establishing the means of creating the systems of incentives, measurement and control when organisationally determining how to engender systemic change.

Our premise is that compassion in practice is an outcome: the result of all the leadership and environmental factors that create the conditions within which compassion either thrives or withers.

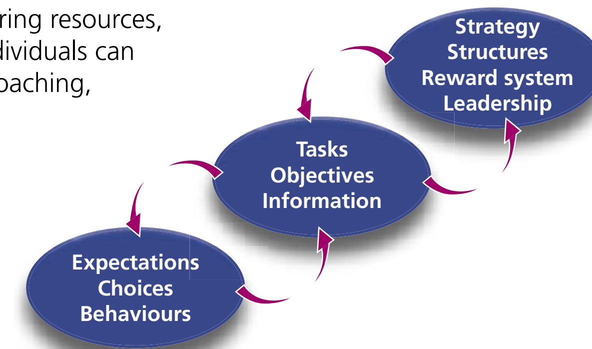
Individual resolve certainly plays a role, but as the research and history demonstrate, when faced with difficult environmental factors, good people with solid values have been known to do bad things, reverting to tactics that allow them to survive dysfunctional and even toxic environments (Zimbardo, 2007).

The repeated theme throughout the report is the importance of engagement. To achieve this, some aspects will be firmly rooted in the creative and relational: whole system engagement – telling stories of compassionate care; agreeing what it looks like and how we will know if we are delivering compassionate care, engendering skill and will to do 'the right thing'.

This approach is certainly necessary to reawaken humanity in our institutions. However to be sustainable, it needs to become incorporated in the DNA of each organisation, and health system.

Organisational approaches to engendering values-driven work will also need to create the infrastructure that supports and balances push and pull interventions:

- the push of mandated approaches to how the work is done and processes through which people are managed (e.g. cascading strategic imperatives as goals and objectives); and
- sometimes the pull of offering resources, support, options which individuals can draw on as needed (e.g. coaching, 360s, Schwartz Rounds).



NHS England

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 when it out-ranks 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 the 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 et al., 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 getting to the story behind the numbers: "I held a 'Never Event' sharing evening. I invited the Director of Nursing and Medical Director 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 frontline.
- 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?

Achieving Excellence: revolutionising patient experience to put it back at the heart of the organisation. The story from Professor Nancy Fontaine, Director of Nursing and Quality at Princess Alexandra Hospital NHS Trust

NHS England

I started as Director of Nursing and Quality in 2012, picking up a beleaguered organisation, with evidence of underinvestment, a poor estate and lack of leadership. It had been in the bottom 20% for all of the patient surveys for some years but, despite this, the Princess Alexandra Hospital (PAH) staff had not lost their determination to focus on patients and to look after each other.

Six weeks into the job, the CEO, the medical director and I were required to attend a risk summit to give account of all of the quality and safety issues and detail the quality improvements. This was an opportunity for me to galvanise my vision: for quality, safety and to revolutionise patient experience to put it back it at the heart of the organisation; to implement a whole governance structure which would allow shared learning and a staff culture honed to patient safety.

I launched an organisation-wide development for safety and a social movement: 'Achieving Excellence' – to improve and promote patient experience. It embraced the 6Cs, but we use 7Cs, as we include chaplaincy.

Creating a phased sustainable approach to improving both patient and staff experience, the first phase was to listen. We ran focus groups 'In Your Shoes' for over 400 patients, carers and staff together, which allows the sharing of experience and takes the participants through their journey. It also involves them in the improvement priorities for change. This is a continuing approach for the organisation as improved patient experience is not possible unless you work in partnership with staff.

We engender listening, responding, acting for patients, and also between staff. **People had stopped listening to each other internally. It had been broken for so long. We balanced the equation by providing space to make listening possible.**

Words that kept arising were: respectful, caring, responsible and committed. Staff want to be perceived like this and be treated by each other that way. It is what patients expect and the feedback from staff and patients reflects the NHS values.

We have distilled all the outputs from all the focus groups with patients, carers and staff and the behaviours they wanted to see. All of the stories, expectations and improvements are as the patients and staff told them.

Behind all this are the behaviours – committing what we will do and won't do as staff. We have *Values, Standards and Behaviours* training for all staff matched to the objectives.

Prior to the 'In Your Shoes', we trained groups of listeners and facilitators which was the precursor for developing staff competency. In the actual workshops, a trained listener supports the family and they stay with them for the duration.

There is a cathartic opportunity for the patients to share their experience and then we move the journey onto the partnership development which asks: "What part of the journey do you want to make better?". The patients told us they are reassured that we will do something about the issues they raised; it moves people from lack of confidence, to being hopeful, and ultimately being helpful.

NHS England

Achieving Excellence: revolutionising patient experience to put it back at the heart of the organisation (continued)

At the end of every workshop we write to everyone involved detailing the headlines and committing "This is what we will do". We then write again at six months and a year to keep them involved and assured things are changing. We are also working with patients on specific services e.g. day surgery, using their experiences to design services and patient information.

All 3000 of our people are going through *Values, Standards and Behaviours* training. We have also developed staff so they can run 'In Your Shoes' sessions for their service annually. The social movement continues, now distilling down to service level.

Our values, standards and behaviours are written into *all* appraisal documents and staff must provide evidence they are upholding them. Our intelligent recruiting means that adverts, job descriptions and job plans now reflect the values, standards and behaviours. Our workforce strategy develops staff and leadership in line with the values. They are included in our complaint and compliments forms. If someone is specifically named in a compliment, they receive a congratulations and thank you card from the CEO and director of nursing. It links into staff awards – those people are our role models and change agents.

We use video stories of patient, carer and staff experiences, both positive and negative. They extract where we did and didn't meet values and behaviours, like "I expect my family to be treated with kindness and compassion", "In my whole care, every member of staff genuinely cared for me."

We run 'train the trainer'. Getting doctors on board is one of the toughest but most rewarding challenges. The medical director and clinical directors are trainers in *Values, Standards and Behaviours* in their service areas, who in turn hold staff to account. This is the strength of changing from within to be sustainable and capture hearts and minds of staff.

We have dedicated particular standards to specific patients, and bring in the personal reason behind why we do this. These have often been stories we have presented to the Trust Board.

We bring patients back all the time to feed back, to revisit their stories with the staff, so they can feel what it is like to be in 'the skin' of the patient. I speak with many families who have had care from us after previous poor experiences; they report it's like a different organisation.

We involve student nurses and midwives in our values training as they are the future leaders; this has a long-term impact. They take those values and behaviours with them across the NHS. We've done the same with junior doctors, with the medical director leading from the front.

We are clear however, that if, despite training and working with patients, this is not for you and you cannot uphold the values and behaviours, then maybe it is time to 'step off at the next station'. The behaviours and values are non-negotiable. Everyone who joins needs to get it, live it and refresh it.

Heroic leadership just won't work here. It's not sustainable. You can't stop leading and cascading and developing the workforce.

We are now into the third phase of developing a communication programme for all staff as this is our biggest area requiring improvement. Poor communication is a common failing and the programme will build on the *Values, Standards and Behaviours* foundation. We witnessed a small improvement in the 2013 Inpatient Survey, only six months after our Achieving Excellence launch. I'm hoping we will see more improvement in the 2014 survey. There was a 50% reduction in complaints in 2013/14. We were bottom in the Midlands and East when it came to friends and family. Now we are 75–80% most of the year.

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.

Deep dive: re-framing and re-badging 'whistle blowing' to effect positive change

At the time this report was written in July 2014, the Department for Business Innovation & Skills had just published the Government Response to the Whistleblowing Framework Call for Evidence of July 2013. The Call for Evidence required further exploration of the law governing whistle blowing which the Government acknowledges has not always achieved its intended outcome – namely to reduce malpractice in organisations and to ensure individuals can report malpractice without fear of reprisal.

The Government has announced that it will take a number of legislative and non-legislative steps to address what it sees as deficiencies in the current regime in order to drive behavioural change.

The list reads like the legal document that it is: complex, full of conditional clauses of what will and will not change. The legislative changes will not come into effect until April 2015.

Once an individual or an organisation falls back on legal proceedings to protect or pursue, the ability to effect swift, effective and meaningful changes to ineffective people or processes is lost.

Those who demonstrate the courage to stand up and challenge the system are often vilified and censured. At worst, they lose their livelihood and ability to earn a living. Their relationships suffer and they suffer untold stress and anxiety. All in the cause of doing the right thing. Who would *want* to be a whistle blower? It takes a rare, courageous person willing to risk all to take on 'the system'. Often the stories are of the horrors that followed blowing the whistle. The term 'whistle blowing' by its very nature conjures up images of vilified, sacrificial lambs and creates fear – fear of reprisal, of being censured, ostracised.

Whistle blowing is a reaction to what has become an impossible situation, when actions have already reached untenable proportions. It signals that disaster has already struck. And 'reporting systems' don't fix the problem. Or at least not immediately. They are a way to register and track problems, for the purpose of isolating them and remedying them. But there is the lag between reporting and remedying.

"We celebrate whistle blowers. It's hard for people to complain, with the perception there is a lot to lose. We also involve them in bringing about improvements."

At least 10 years ago, Virginia Mason Medical Centre in Seattle, Washington, adopted from the automotive industry a more immediate way of dealing with breakdowns: JIDOKA, or more simply: **Don't accept defects – Don't make defects – Don't pass defects on.** It involves one-by-one detection. But to err is human, so defects do happen. So they have also embraced the notion that also comes from the automotive industry about dealing with defects or breakdown: **Detect defects – Stop – Call for help – Problem solve.** The important thing is to raise the alarm while the defect is before you. And to reward the person who 'stopped the line', thereby preventing more serious harm.

This could easily be applied when compassion is under threat.

Is it time to create new language, practices and norms around rewarding good behaviour to encourage and support people to speak up when compassion in the workplace is threatened?[1]

[1] Since Robert Francis's report into the failings at the Mid Staffordshire NHS Foundation Trust was published in February 2013, the Friends and Family Test was introduced, with the intention of encouraging a cultural shift in the NHS where staff have further opportunity and confidence to speak up and where the views of staff are increasingly heard and acted upon. The Whistleblowing Helpline, an independent, confidential, free phone service for staff and organisations working within the NHS and social care sector was introduced following the publishing in March 2014 of Raising Concerns at Work, guidance aimed at NHS and social care staff and employers.

Deep dive: mutual support and learning

Schwartz Center Rounds® (www.theschwartzcenter.org)

Schwartz Rounds are a one-hour per month voluntary multi-disciplinary meeting, providing opportunity to openly and honestly discuss the social and emotional issues carers face in caring for patients and families – the human dimension of care.

A pre-selected multi-disciplinary panel spend 10–15 minutes presenting a case story and describing their role, the issues the case raised for them and how this made them feel. With a skilled facilitator, discussion then opens up to the larger group of participants, who ask questions, share experiences and reflect on the challenges of care. Participants are encouraged not to problem-solve but to consider the implications of the case for staff.

With American origins, UK organisers said: "There was some anxiety about whether it would translate from the US to the UK, i.e. would people talk openly about their emotions? They did!"

A UK pilot, whilst small, has evaluated positively (Goodrich, 2012).

Reported benefits include:

- Attending more to the emotional aspects of care ("You hear words used you don't normally hear such as anger, guilt, shame and frustration. They are obviously there, but there is no outlet for them.") and renewed belief in the importance of empathy, reconnecting people with why they entered their profession.
- Improved team work, increasing respect, empathy and understanding between staff, levelling power differentials.
- A positive impact on institutional culture – a symbolic act of valuing staff and their well-being: "It generates pride in our identity. We need to re-emphasize that we are here to care for patients, so we need to look after staff."

Other approaches for mutual support and learning

Consistently across those who were interviewed, people brought their teams together, whether opportunistically or planned.

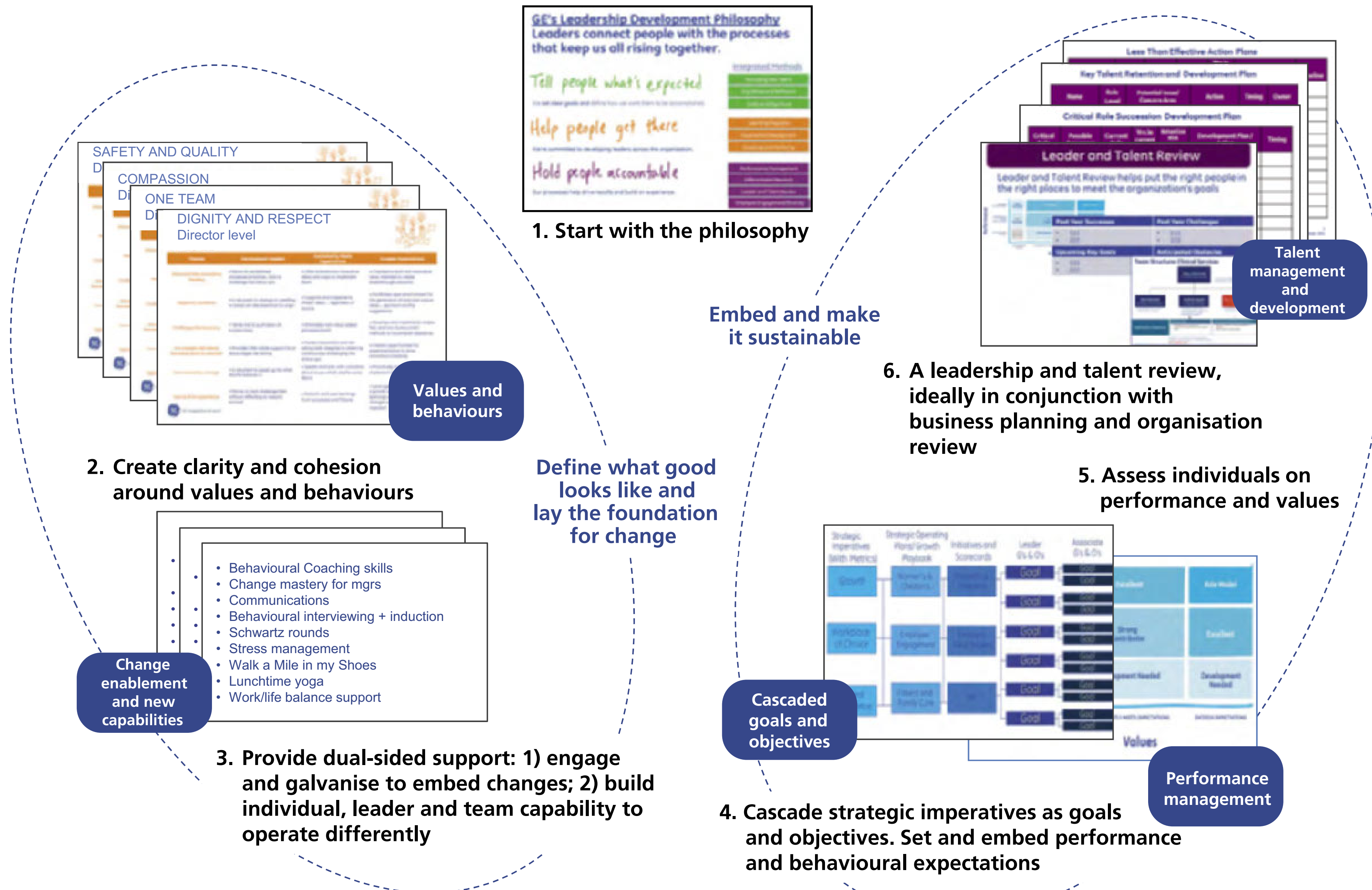
> "I know what it's like to have a busy shift, and go home with my head buzzing. If you have the opportunity to discuss and reflect with people who have been with you, it helps build personal resilience. And it builds mutual support: 'How was it for you?' We discuss feelings (whether good or bad)."

Another popular approach is the action learning sets, often as part of a structured development programme. It brings the following benefits:

- There is an immediate peer-support group, for group coaching, sharing ideas and good practice.
- The individual's professional network expands, potentially spanning organisational and professional boundaries. With such diversity, it increases the likelihood of new ideas, approaches and opportunities.
- As with the Schwartz Rounds, a multi-disciplinary membership promotes a more empathetic understanding between teams and individuals: "Anecdotally, nursing staff, physios, all staff really, say they have a greater sympathy for doctors, who seem less cold and hard. And doctors have greater respect for the rest of the team as you appreciate what they do and what they are having to take home with them." (Goodrich, 2012)

> "I run a 'communication cell' each week. It reduces the opportunity for things to get out of control: 'What's gone well or was difficult that you need time from the group on?', 'What are your challenges coming up?'. There are some operational bits but the majority is task-related mutual support."

Deep dive: one approach to creating the organisational infrastructure to sustainable, transformational change*



*Taken from the GE approach to shaping, embedding and sustaining transformational change.

NHS England

Concluding thoughts

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Concluding thoughts: where is a sensible place to start?

We have not attempted to offer a standardised means of closing a 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)

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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.

> "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."

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.

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 of 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 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.

Appendices

NHS England

Appendix 1 References

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Appendix 2 Survey and interview results

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Design of survey

The principal purpose was to answer key questions:

1. The extent to which respondents believe that compassionate leadership has the capacity to transform service-user and staff experience.
2. The characteristics respondents consider to be the most important for a compassionate leader.
3. Who are the known examples of compassionate leaders (with the intent of inviting them to interview).
4. How do their role models demonstrate compassionate leadership.

A weblink to the survey was distributed via email and this was kept open for the intentionally short period of one week, to enable project milestones to be met and given that response rates drop off considerably after the initial invite, with diminishing returns.

Respondents

- Survey sent to 140 attendees from NHS Leadership Academy programmes: 70 executive leaders (Top Leaders Programme); 70 nurse leaders (Senior Operational Leaders and Frontline Leaders Programmes).
- Response rate 25% (n=35).
- Organisation type given below:

Organisation types	Roles
Acute Trusts (x7)	Chair (x2)
NHS England, Area Team (x2)	Director of Nursing (x4)
Mental Health and Community Trusts (x2)	Joint Deputy GM and Head of Nursing (x1)
	Ward Manager (x1)
	Matron (x1)
	Lead Nurse (x1)
	Director (x1)

- Respondents split as 55% managerial, 34% clinical and 11% who describe themselves as both.

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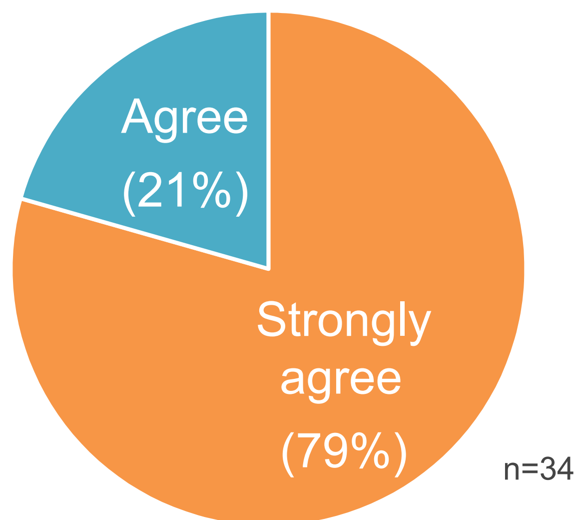
“Compassionate leadership has the capacity to transform service-user and staff experience”



“If compassion is shown from the top, it provides a benchmark for all to follow.”

“Lead by example and embed compassion as a cherished value, not a weakness.”

“It will bring out the best in people, which leads to sustainable change and better ways of working.”

Themes

Responders were invited to explain their response, with 10 doing so.

- There is direct follow-through: being led in a compassionate way will follow through to the care patients receive.
- It is vital that compassion in leadership is seen as a strength to be valued, not a weakness.
- On the one hand, it is seen as a foundation upon which the NHS is built: compassion and caring for people is central to why many choose to work for the NHS. The focus on targets, financial balance and efficiency have led to a collective loss of moral compass.
- On the other hand, it represents something new: it is at the core of a different set of leadership attributes that are now needed for the NHS. We cannot fix the quality issues or achieve sustainability without it.
- Compassion in leadership will bring out the best in people, unlocking and valuing creative, sustainable solutions. Its thoughtfulness is likely to consider both staff needs as well as being more person-centred.
- It needs to be modelled from the top to flow through the organisation.
- It also needs to be understood and demonstrated at every level.

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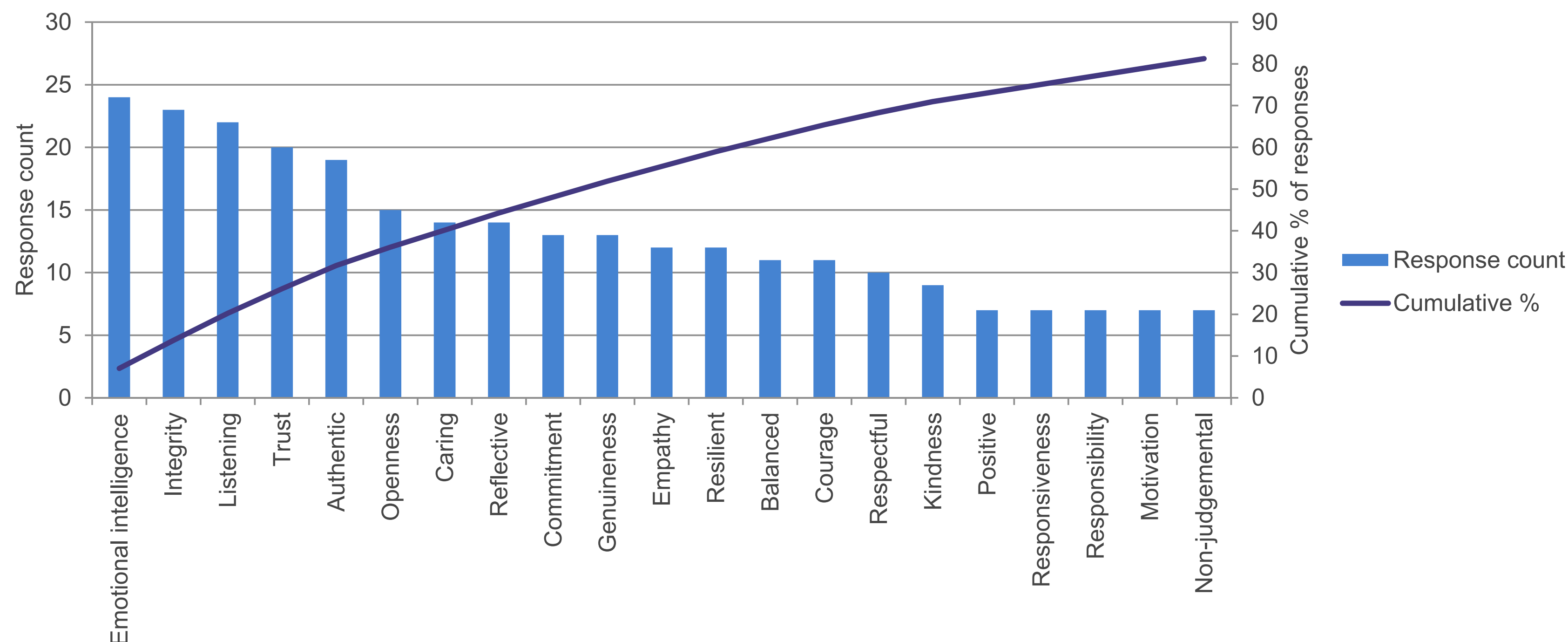
The most important characteristics of a compassionate leader

Frequency of characteristic (% of all responses)



- Forty potential characteristics were offered to respondents (a combination of mindsets, behaviours and personal characteristics), drawn from the literature on compassion and compassionate leadership.
- Whilst there was a lengthy tail to the above graph, the characteristics that account for 80% of responses are shown.
- Respondents were free to suggest others that were not included on the list. Whilst only single answers, they included:
  - value driven
  - approachable
  - positively challenging
  - belief in possibility
  - forgiveness
  - holds themselves and others to account.
- Terms from the pick list that were selected by one respondent:
  - gentleness, generosity, loving
  - a hypothesis: culturally, they appear too ‘soft’ or inappropriate/awkward in a work setting.
- What wasn’t selected from the pick list:
  - benevolent, camaraderie, equanimity, kinship, mutuality, sympathy.

NHS England

How do role models demonstrate compassion in their leadership?

"She gives you **100% of her attention** and **puts patients at the heart** of every decision."

"She leads a huge team whilst still having time for individuals **ensuring their development** and worth within the team. [She] **inspires** me to want to be a good leader as she role models and has a genuine interest in developing her team. [She] leads with utter compassion whilst achieving her role as both Deputy General Manager & Head of Nursing."

"Is **mindful of the pressures** others are under, sets out a clear strategy and the required approach. **Holds people to account**. Is respectful."

"**Cares deeply about staff commitment and experience** and recognises that if the staff feel good then there is much greater chance that patients will have good quality care and a positive experience of services."

"She truly keeps the focus on individuals and facilitates ways of resolving issues, **without providing direct answers**."

"**Authenticity and integrity** in their approach. Completely trustworthy."

Responses

Nineteen of 35 respondents identified role models: 12 female, six male.

Fourteen of the role models cited pointed towards those occupying senior leadership roles (e.g. medical director, director of nursing, chair, CEO, area director, deputy general manager).

Five role models identified had strong operational roles, all nursing (e.g. ward manager, staff nurse, triage matron). Leading with compassion is not the sole province of those who occupy formal and senior leadership roles.

However, the majority of those identified (13) were senior leaders and are were more readily noticed for the behaviours and qualities they exhibit.

Themes

- Keeps patients, carers and the quality of patient care central to operational and strategic decision-making.
- Mindful of the working environment and pressures their colleagues and teams experience.
- Interest in developing individuals and teams.
- Readiness to hold others (individuals/groups) to account.
- Doesn't 'rescue' individuals but supports others in resolving their own problem.
- Ability and desire to engage fully with others e.g. making time for listening, staying in touch with the workforce, constant desire to understand others.
- Personal qualities of integrity, authenticity, balance, trustworthiness.

Additional comments on compassionate leadership from respondents

It's more than being 'nice'

"It isn't just about being nice! It is about a leader who works to get the best out of a situation. And helping their staff to do that. It creates sustainable change and improvement as it works for the people. It is like servant leadership."

"Compassionate leadership is not soft which I think is a common misconception. It is tough, relentless and brave as well as caring about staff and patents."

Views about its application

"The NHS needs to completely rethink the leadership style it values and promotes and needs to take brave action to not tolerate leadership that falls below the required standard."

"Can it help us to recruit more effectively and develop and support staff to show compassion?"

"Giving leaders the encouragement and space to develop enhances them to become compassionate leaders. An appreciative enquiry approach across an organisation enhances this further."

"Caring for staff is very important in terms of patient experience and the staff survey is the only good lead factor in terms of outcomes."

"Although communications have been sent from our chief executive with regards to the goal of compassionate leadership, experience at grass roots is that our organisation is driven by financial goals in order to become a foundation trust, rather than improving patient care."

Its organisational value

"Caring for staff is very important in terms of patient experience and the staff survey is the only good lead factor in terms of outcomes."

"Although communications have been sent from our chief executive with regards to the goal of compassionate leadership, experience at grass roots is that our organisation is driven by financial goals in order to become a foundation trust, rather than improving patient care."

How it gets reinforced or undermined

"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?"

"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 frontline or significantly undermine it."

NHS England

Design of interviews

The purpose of the semi-structured interviews was to:

1. Understand how leaders in different health care settings are influencing their environments to enable compassion to flourish.
2. Gain concrete examples of individual, team, leader and organisational practices that develop the centrality of patient and staff care and welfare.
3. Identify what situations arise that compromise the possibility for compassionate leadership, and what was done about it.
4. Gauge whether diversity across leadership has an impact on the prevalence of compassion.
5. Test whether the lenses of individual, team, leader or organisation have a greater influence or relative importance on compassion in practice.

Interviewees were identified through a survey sent to 140 alumni of the NHS Leadership Academy, plus recommendations from the programme sponsor.

There were 22 individuals proposed as good examples of compassionate leaders, identified by individuals working in:

- national bodies (x9)
- Clinical Commissioning Groups (CCGs) (x5)
- Acute Trusts (x4)
- community and mental health providers (x2)
- 'other' organisations (x2).

Interviewees

- Fifteen individuals were traceable and invited to interview. Eleven interviews have been carried out.
- Interviewees represented a cross section of organisations and levels of seniority.

Organisation types	**Roles**
Acute Trusts (x7)	Chair (x2)
NHS England, Area Team (x2)	Director of Nursing (x4)
Mental Health and Community Trusts (x2)	Joint Deputy GM and Head of Nursing (x1)
	Ward Manager (x1)
	Matron (x1)
	Lead Nurse (x1)
	Director (x1)

The outputs from the interviews were thematically analysed and the ideas and quotes were incorporated within the body of this paper.

Additional useful quotes, not included in the main body of the paper, are included over.

NHS England

Self: extended quotes

Strengthening one's sense of core purpose

"I'm a bit tired now! The enormity of it. The job is the best in the world, and the hardest. Because I believe this could be my children, mum or dad. It is a mark of quality when patients say they have been treated with care, compassion and kindness."

Acting on 'practical wisdom' to take a reasoned approach to assessing risk

"One day I was working on the ward with a less-experienced member of bank staff. When confused, the dementia patient might follow you. We went into kitchen and the patient wanted to follow. The bank staff member said: 'You can't come in here', concerned for their safety. But I said: 'If you say this, they may feel rejected, or become angry and distressed. Let them come in and make sure they don't come to any harm.' You have made sure they are safe. A nurse might think any 'risk' is against the rules. But it's not a risk if you are going with them. But staff often don't see it that way, bogged down with risk and rules, but forgetting the patient."

Personal time for reflection

"I tend to be very reflective. I have a coach, bouncing ideas off somebody, who is also reflective. I develop strategies to deal with issues that arise and use my coach to work out solutions for addressing my response to issues."

Team: extended quotes

Creating space for team learning

"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. Like, why a band 5 nurse didn't stop the line, when a consultant was on their mobile phone, seeing everyone was not on the same page. They didn't feel part of team, or put their hand up due to fear of consultant shouting. How do you give someone confidence to do that? They might not have seen someone else do it. How do you train, when it's not a common occurrence? How do we engender doing the right thing and feeling confident to do that?"

Helping teams who need support to remain functional

"We actively manage the emotional temperature when things go wrong. Staff often know they could have done things differently. So I check in with individuals and teams to say: 'Are you ok? What could be improved next time? How could we support you more?' Sometimes things will go wrong. We need to help them get back to the reason why they are here, and quickly, so people reconnect. With whistle blowing, the identified person might have feeling of betrayal, so we need to help that team become balanced again, and support team learning."

"The CCG Directors of Nursing were new but dealing with established Directors of Nursing in the Trusts. The CCG Directors wanted to win respect from them in the new commissioning landscape. So we heightened their political awareness, the ability to read body language, key items to address on the agenda, what questions to ask and issues to challenge. Commissioners advocate on patients' behalf, so it is best for the patient to get the best out of everyone in meeting."

"The level of professional dissociation needs keeping in check. We had really bad services historically for older people and hadn't achieved much on it. In the end we put the total staff-team on a professional development programme off-site, to help them form as a team and understand what they were there to do. Teams need investment to ensure a strong sense that we are 'all in together' and the patient remains the focus."

Generating group norms through a clear purpose, and clear expectations

"I reinforce patient benefit. It is the main reason we are here. I offer clarity of expectations and hold the team to account. I acknowledge good work and am clear when it is not. It is important to create shared behaviours and norms built on a clear sense of what is professional behaviour, which includes compassion."

Manager/leader: extended quotes

Inspire and show what compassion means

"You can say in the class room what you should do, but for all the theory in the world, none of it is relevant unless it is happening in practice. Bridging the gap is role modelling at the point of care, when it's needed, to really see what it looks like and the impact it has."

Putting people before procedures

"Rules and regs 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 is not about do we have procedures in place, but why are we doing this. For example, why do we have information governance in place? How will this make a difference to patient care and patient outcomes? I begin key meetings with these questions to be clear on our focus, and make sure that we are putting the people before the procedures."

Committing to honesty, authenticity and action

"Our new CEO had the courage to give up her power. She knew on coming in that she needed to reinvigorate the team. She engaged in open and frank dialogue with staff. She talked about what she felt and wanted to know what others felt. She led by saying we need to rewrite our values and through the process, renewed their sense of hope. And then followed up with: 'How do we turn our values into action?' There has to be action."

Building capability and confidence for decisions to be made at the right level, and carried out with respect

"We had a major Care Quality Commission report on the Trust which showed a lot of bullying, like with other trusts. Unpacking that, really we are talking about clumsy management: requests coming across as dictats and 'better do this or else'. In governing big bureaucracies, you have to have decisions made at the right level. And making sure that those who have decisions to make do it in a creative and positive way."

"It's about building a network of leaders and encouraging them to build their teams."

NHS England

Organisation: extended quotes

Celebrating action that takes the organisation in the right direction, even the tough parts

"We celebrate whistle blowers. It's hard for people to complain, with the perception there is a lot to lose. We also involve them in bringing about improvements."

"Celebrating successes, and identifying areas of improvement, there is a duty of candour. People have permission and the means to say what's not right."

Acting on data

"We identified a high number of falls across the patch leading to patient harm. We looked into it further and picked up some common threads. By collectively sharing this, collectively we have put in a falls bundle and agreed how to collect and present the data to track progress."

"In the Trust there was a small service with three consultants. They weren't leading. They had just been doing the same old thing for 30 years. We showed them thematic analysis of complaint themes. We triangulated the data and confronted the team. 'Surgery don't get the level you get on attitude and behaviour. Why is that?' Just be honest, if quality is not good enough, you just need to say it. And then help them come up with solutions."

"There were 60+ complaints a month. They were never properly responded or used to improve and learn from as an organisation. If it had carried on we may have been a Mid Staffs."

Remaining alert to subversion of purpose

"We have to be incredibly careful we don't collude with bad behaviour, for example losing focus on what we are trying to deliver, where organisations are focussing on how to sustain themselves as an organisation but possibly at the expense of what is best for the population. We challenged a business case that proposed expanding research, as the drive appeared to be attracting more money, more than how would improve care for the patients."

NHS England commissioned GE Healthcare Finnamore to carry out this research and report on their findings. GE Healthcare Finnamore is a leading specialist health and social care consultancy.

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