

Compassion in Practice

Evidencing the impact



May 2016



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Evidencing the impact

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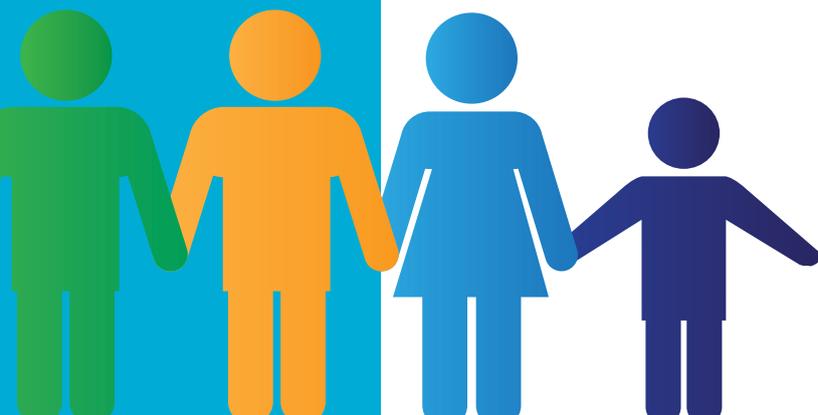
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1. Foreword

hello my name is... Jane Cummings

Chief Nursing Officer, England

Compassion in Practice - Nursing Midwifery and Care Staff - Our Vision and Strategy was launched in December 2012. It's hard to believe that over three years have passed since the strategy was published and addressed the issues relating to nursing and care that were subsequently published in the Francis Report in February 2013 and in 'Hard Truths: The Journey to Putting Patients First' January 2014.



Compassion in Practice was built on the values of the 6Cs (Care, Compassion, Communication, Courage, Competence, Commitment) and delivered improvement programmes through six work streams called Action Areas:

1. Helping people to stay independent, maximising well-being and improving health outcomes.
2. Working with people to provide a positive experience of care.
3. Delivering high quality care and measuring the impact of care.
4. Building and strengthening leadership.
5. Ensuring we have the right staff, with the right skills, in the right place.
6. Supporting positive staff experience.

There is no doubt that the world is different now to when we first launched the strategy. Over the last three years there have been many changes in the wider world as well as the health and care economy and this has influenced our understanding of health, wellbeing and the types of 'care' required by our diverse populations. Changes in health care demand, increasing global threats to civil liberties, the Ebola crisis, plus rising concerns about safeguarding children and vulnerable adults are only a few examples of the issues that have impacted on the work of nurses, midwives and care staff since 2012.

The third and final year of the strategy provided a good opportunity for us to take stock of what we as nurses, midwives and care staff have achieved through the strategy and how we have contributed to ensuring high quality, compassionate care. This means not only thinking about this final year, but also reflecting on the last three years as a whole.

I have been privileged to spend time with nurses, midwives, and care staff across the country and see for myself the opportunities, actions and efforts they have employed to make sure that individuals and communities receive



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the best care possible. This report can only give a snapshot of the hundreds of activities that have taken place and the wide range of locations involved - but it is important that we have a record of how the Compassion in Practice strategy and the values of the 6Cs have impacted on how care has been planned, delivered and experienced over the last few years.

A great strength of the Compassion in Practice strategy has been in its commitment to coproduction and co-delivery that lay the heart of the strategy from the outset. The wide-ranging requirements of a diverse care environment reflected in the Action Areas could not have been delivered by one organisation alone. Our successes were dependent on the way in which we devised and implemented the strategy in partnership across primary and secondary care, public health, education, midwifery, social care, community health, mental health, learning disability, children and young people. Indeed although originally driven by nurses, midwives and care staff, the Compassion in Practice strategy has been demonstrated over the years as having some relevance to all clinicians and professionals providing care.

It was impossible for us to know way back in 2012, what the actual outcomes or impact of the Compassion in Practice strategy would be. However, we recognised that by the end of the strategy, it was important for us to be able to not only evidence the contributions nurses, midwives and care staff have made to improving health and care quality, but also to consider the question

“Has the Compassion in Practice Strategy made a difference?”

This report, the third of three annual reports documenting our progress through the lifetime of the Compassion in Practice strategy addresses this question. It also sets out what we have learned from the challenges of the past in terms of both the experiences of people we care for; as well as the nurses, midwives and care staff delivering their care.

I remain immensely proud of our professions and the way in which we continue to strive to improve care experiences, adapting our approach as needed to ensure we do our very best in each situation. The Compassion in Practice Strategy provided a framework for our activities over the last three years, rebuilding public confidence and reaffirming pride in our profession. It also was important that during this final year we began to look to the future, and the direction of travel beyond the end of the strategy so that nurses, midwives and care staff could begin to frame their own agenda proactively from April 2016. To that end we also asked you during this year to tell us what hadn't worked so well during the last few years and how we could improve in future? Your responses and recommendations amounted to over 11,000 different types of data and information given at conferences, congress, online, social media, discussion groups, email and via live academic debates. I thank you for taking the time to comment, reflect and to challenge and the positive way in which you engaged with the future agenda for nursing, midwifery and care staff. Your contributions



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were invaluable in helping to create and shape the dialogue around whether we should have a follow-on strategy and what our approach should look like beyond Compassion in Practice. However, what has been most evident over the lifetime of the strategy, and is captured in this report, is how nurses, midwives and care staff continue to go above and beyond their duties to deliver high quality compassionate care and take very seriously their contributions to shaping the care agenda.

2016 sees the end of the Compassion in Practice strategy but with your help, its legacy and the learning gained from it has already helped to shape the new framework for nursing, midwifery and care staff in England which is called Leading Change - Adding Value. I am excited about what the new framework will help us to achieve in the coming years.

In the 21st century we live with constant change and challenge in health as well as other aspects of our lives. I want to sincerely thank all of you for your courage, strength and commitment to our profession through challenging times and the passion with which you continue to strive to make the experiences of staff, individuals and communities the best it can be. I look forward to facing the future together, one in which we can build on the value and contributions our profession made as part of Compassion in Practice and through compassionate leadership continue our efforts to improve the health and life chances of people and communities.





2. Introduction

The Compassion in Practice Strategy was first launched in 2012 by Jane Cummings, Chief Nursing Officer for England and Viv Bennett, Director of Nursing at the Department of Health. The strategy was framed around six action areas, with implementation of each action area being led by a senior responsible owner with some NHS regions taking the lead in operationalising the Compassion in Practice strategy.

Three years on, it is evident that a great deal of work has been completed to deliver the aims of the Compassion in Practice strategy and much of it has received recognition and support across regions. There have been many changes in healthcare practice and the wider health economy over the last three years and before we reach the end of the Compassion in Practice strategy, it is a good time to:

- embrace the opportunity to take stock, evaluate the impact and contributions that nurses, midwives and care staff have made to improving care quality and experience.
- share what we have learned in the process.
- think about future directions for the professions and ‘what happens next’.

At the beginning of year three of the strategy we began to think about what had been achieved and started to consider the legacy of the Compassion in Practice strategy for nurses, midwives and care staff that we could take forward. In this final year of the Compassion in Practice strategy it is important that we can evidence not just WHAT we did but also the impact it has had on our workforce and the people we care for.

To achieve this an evaluation of the Compassion in Practice strategy was undertaken during its final year. The aim was to address the question:

‘Has Compassion in Practice made a difference to the people we care for and our workforce?’

What counts as evidence?

To answer this question and demonstrate the impact of the activities and commissioned programmes undertaken as part of the Compassion in Practice strategy, it was important that there was a shared understanding as to what counts as evidence. This was particularly important as the need to ‘evidence’ work is not always a main influencing factor at the development stage of action planning for service improvement and delivery.

In relation to the evaluation of Compassion in Practice, evidence was identified as information which may help us to identify what impact, if any, that projects have had on outcomes for both patients and staff. This is more than simply information describing or reporting on all activities that may have taken place during the three years of the Compassion in Practice strategy. It really focusses reporting of specific activities/projects that were carried out to achieve the strategic objectives of action plans.



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These activities/projects usually included the following:

- They were designed to contribute/fulfil the goals/action plans of the Compassion in Practice strategy, 6Cs, Action Areas or other related health and social care policy.
- Directly linked to health and social care delivery or workforce development.
- Have a clear statement of aims and objectives.
- Are initially planned to be time limited (have start and end date) and resourced accordingly - although they may over time become part of the daily routine.
- Initiated to address an identified problem or issue in practice.
- May be focussed on service improvements, service developments, intervention development, toolkit development, service evaluations, scoping exercises or service redesign.
- Have measureable or demonstrable impact on the experience or wellbeing of the associated workforce and/or people we care for.

2.1 Evidencing the impact: The process

The process used to evaluate the impact of Compassion in Practice began in October 2014. It included three phases of activity.

Phase one (October 2014-April 2015) set out to evidence the impact of the first two years of the strategy in terms of programme outputs. Each Action Area was invited to submit a sample of up to three outputs from their programme activities during 2012-2015 that illustrated 'impact' on improving care quality. This was designed in the first instance, to get a clear view of the best evidence available from the first two years of the strategy, illustrating the impact of Compassion in Practice related actions and activities by Action Area. A scoping template adapted from one devised by the Midlands and East regional team was provided to Action Area leads to collate their examples.

A [Quality Assurance tool](#) previously developed by Professor Laura Serrant, formerly Compassion in Practice Research Lead at NHS England, and Dr Virginia Minogue, Research Lead, NHS England was used as a framework for evaluating the effectiveness of the submitted activity/programme in relation to:

- Clarity of purpose, aims and objectives.
- Level of involvement from staff and the people we care for the design/ implementation of activity.
- Whether aims had been achieved and outputs evaluated.
- Integration of existing evidence/research.
- Opportunities for wider application and sustainability.
- Implications for specific Action Area and Compassion in Practice strategy in general.



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In phase two (April 2015 - October 2015) an evaluation of staff experience of involvement with the Compassion in Practice strategy was conducted. This gathered information from staff working in a range of settings. It was independently analysed by researchers from Middlesex University.

In phase three (October 2015 - March 2016) the findings from the evaluation of programme activities and staff experience were combined with information from the programmes commissioned in year three of the Compassion in Practice strategy to inform this report.

2.2 Evidencing the impact: Report structure

The main body of this report begins with an overview of the commissioned programmes delivered in year three of the Compassion in Practice strategy. It then moves on to present a summary review of the evaluation of Compassion in Practice with reference to the activities delivered over the lifetime of the strategy and the experience of staff. It then moves on to reflect on what was learned from the process of delivering the strategy - recognising that contexts have changed over the lifetime of the strategy and are now in a different place to strategy was launched. The report highlighting some of the ways in have started to think pro-actively direction for nurses, midwives and Compassion in Practice and sets out in Practice strategy has informed plans for the future.





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3. Year three commissioned programmes

3.1 Introduction

In the year three of the Compassion in Practice strategy three programmes of work were commissioned to take place, building on some of the pilot projects that took place in the preceding year (2014/15). The programmes of work were led by regional teams as outlined below:

- Building and Strengthening Leadership NHS England (led by London region).
- Excellence in Continence Care NHS England (led by South Region).
- Always Events® (led by Patient Experience team, NHS England).

This section of the report contains summary reports for the three commissioned programmes identifying purpose, range and scope of actions undertaken and what has been delivered. Full details of each programme can be found online in the [Repository of Evidence](#).

3.2 Building and Strengthening Leadership NHS England (London Region)

The aim of this workstream is to build and strengthen leadership across the caring landscape. We know that there is a link between strong leadership, a caring and compassionate culture and high quality care. There is increasing evidence to support the hypothesis that when the right leadership is evident we get safe, high quality care and a positive experience for patients and staff. The Hard Truths report identified a need for healthcare providers to develop and deploy reliable and transparent measures of the cultural health of workplaces and teams. There is a need to facilitate system and organisation leaders to build capability and capacity, to measure and transform the culture of care across the system and in their organisations, taking account of the impact of diversity.

Our work on compassionate leadership is putting compassion at the centre of how care is delivered and led. Evidence shows that there is a strong link between patient and staff experience and the quality of care. There is a case that leadership for compassion makes good business sense and evidence is emerging that compassionate leadership can impact positively on performance objectives. So the challenge is to bring this to life for staff, teams, individual leaders and organisations so that compassion can thrive and people reconnect with the values and behaviours that brought them to work in health and care in the first place.



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To understand the qualities and characteristics that are needed to support an environment where compassionate leadership enhances patient and staff experience, we commissioned a piece of research to review the literature and interview role models identified by their peers as compassionate leaders. In November 2014 we published the findings of this research in a handbook and field guide 'Building and Strengthening Leadership: Leading with Compassion'.

Over the last year we held a series of bespoke regional roundtable events to share and discuss these findings. These were facilitated by the authors of the Building and Strengthening Leadership: Leading with Compassion Report handbook and field guide that were published in November 2014.

The aims of these regional roundtable events were to:

- Contextualise the compassionate leadership work in local issues.
- Help participants identify barriers and opportunities in leading compassionately.
- Identify what further support might be helpful.

Each regional event had a slightly different bespoke design but the common themes across them all included challenging assumptions, revisiting key messages, practical exploration of dilemmas, sharing stories, offering tools for constructive conversations and goal setting/next steps.





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In creating environments where compassion can thrive:

What do we already do?

- One-to-ones.
- Site visits and bringing in new perspectives.
- Mentoring in practice - on the job learning.
- Feedback - giving and inviting, affirming and learning feedback.
- Schwartz Rounds.
- Know-who, and know-how: defined roles, responsibilities and capabilities.
- Values-based recruitment and appraisals.
- Availability of frameworks and toolkits.

What can we do even more of?

- Celebrate and share what works - our successes.
- Celebrate ingenuity e.g. the importance of language: word amnesty - banning a word per month.
- Developing teams - resilience, honest conversations and emotional maturity, clear sense of purpose, growing self/team/climate awareness, fuel curiosity.
- Collaborative across boundaries on our wicked problems - locally/regionally/nationally.
- Protected time away from noise/pressure.
- Integration across boundaries - acute, community/professions.
- Think 'in the moment' as well as big picture - what behaviours get in the way of human-to-human connection e.g. email epidemic.

What makes it harder/gets in the way?

- Dispersed ownership - who owns the problem?
- Influencing the hard to influence (clinically, politically).
- Resistance to change/learned helplessness.
- A shared view of the 'truth' - meaningful data.
- Workforce and training - right skills at right time in right place and right quantity.
- Risk averse mentality - fear of 'getting it wrong'/permission-seeking and command and control!
- Heads down/narrowed horizons.
- Organisational structural changes.
- Relentless performance and finance focus.
- Time and timescales for system-wide change.
- Perverse incentives built into system design.
- Disconnected policies.

What would really help?

- Making it easier to add value e.g. infrastructure that worked.
- Time to cycle between reflection/planning/doing to find what works - with others.
- Seeing and shaping the bigger picture: an integrated strategy.
- Inter-professional/organisational working - not just nursing!
- More effective performance management, and compassionately holding to account.
- Opportunity to re-energise staff.
- Feeling safe enough to move beyond defensive positions.
- Better ways to reward initiative (personal and collective).
- Be able to answer are we making it better.
- Greater awareness of impact of system levers/design/climate.



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The Culture of Care Barometer

The Culture of Care Barometer was highlighted in The Francis Inquiry and the Government's response, Patients First and Foremost (2013). We commissioned King's College London to develop the barometer which has been piloted in acute, mental health and community settings. The barometer provides organisations with a tool to measure the culture of care in different parts of an organisation, and creates the opportunity for conversations between staff and managers to improve the environment in which staff work and to make it conducive to the delivery of compassionate, patient centred care.

The report was published in March 2015. A How to Guide has been developed and has been distributed nationally to all Directors of Nursing. It is also available on the [NHS England website](#). The Culture of Care Barometer online tool is being developed to provide live, real-time reporting, enabling and facilitating the conversations about culture to take place promptly.

Black, Minority and Ethnic (BME) career acceleration programme for our next generation of nurse and midwifery leaders

In September 2015 in partnership with NHS Leadership Academy a new programme for Black Minority and Ethnic (BME) nurses and midwives was launched. One in five NHS nursing staff are from BME backgrounds yet there is still an under representation of BME nursing and midwifery staff reaching senior executive posts.

The [Next Generation Career Acceleration Workshop](#) aims to support leaders from under-represented groups to have access to focused support to enable them to progress to become executive leaders in healthcare.

The difference between this and any other leadership development programme is that this is specifically focused on BME nursing and midwifery staff securing executive level posts. At the end of the workshop, participants should be in a position to more effectively and confidently navigate the senior recruitment search and selection process.

Evidence suggests that candidates from a BME background can lack confidence when applying for senior posts often because of past experience. This programme provides future senior leaders with the opportunity to gain the confidence and resilience to apply for senior roles and to ultimately become leaders in the world of nursing.

The programme involves group workshops, bespoke one-to-one career development, coaching as well as a link to an existing chief nurse sponsor who will help to guide each participant.



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“We know that BME nurses are widely underrepresented at board level and this new programme is a great opportunity to change this. The programme will benefit NHS staff throughout the country and in turn, it will really benefit patient care. We need to provide patients with the best possible outcomes and I believe we can do this with diverse, strong nurses leading the way”

Caroline Alexander, Chief Nurse at NHS England (London)

Eileen Bryant is Assistant Head of Quality and Regional Lead for Out of Hospital Care in NHS England (London) and was successful in securing a place on the programme.

Eileen said:

“I’m really excited about the programme because it’s a unique opportunity for me and other BME staff within the NHS to learn more about the transition into the next level of senior management. The great thing about the course is that the support doesn’t end after the two days are over; we are provided with on-going support and mentorship. This is a fantastic opportunity for me to realise my full potential and to be confident in applying for more senior leadership roles in the NHS.”





3.3 Excellence in Continence Care (South region)

The publication of a national Continence Commissioning Framework meets a number of priorities plan priorities including:

- Commissioning new models of care that are integrated, person centred and outcome focussed.
- Redesigning services including those commissioned from primary care.
- Prevention and early diagnosis.
- Improving health for people with a learning disability and people with dementia.
- Supporting patient and public participation.

The Excellence in Continence Care workstream arose following the publication of the Francis report and [Hard Truths - The Journey to Putting Patients First: the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry](#). This workstream focuses on remedying some failings uncovered in the inquiry by addressing how people's fundamental continence needs (bladder and bowel) must be met via a national approach.

The Five Year Forward View set us a challenge of refocusing healthcare to prevent ill health and provide people with greater control over their condition and care. It also encourages much greater collaboration between health and social care, working in partnership with the third sector (that includes voluntary and charity groups) and ensuring we maximise the value of resources we spend on healthcare.

This vision underpins what we want to achieve for people living with continence needs who, in the past, have often suffered in silence as higher profile conditions attracted attention and resource. Over the years, some excellent research and guidelines have been produced for best practice continence care but this work has often stalled as it has not translated into a clear commissioning plan for a local continence pathway.

The [Excellence in Continence Care guidance](#) provides a framework that enables commissioners to work in collaboration with providers and others to make a step change to address these shortfalls so that safe, dignified, efficient and effective continence care is consistently provided. This guidance could not have been produced without our diverse groups of patient and public advocates, clinicians and other partners. Their energy, commitment, expertise and determination to ensure that children, young people and adults of all ages, including the most vulnerable in our communities, can rightly rely on excellent continence care is commendable.

One of the most rewarding aspects of developing the guidance has been listening and responding to people using continence services and giving them the opportunity to rebalance power so people can have a greater role in the assessment and management of their continence condition and in service design.



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Properly used, the guidance provides a practical means for commissioners to understand the burden of continence needs within their local population. Also, to specify and contract for continence services, effectively measure outcomes and experience and work towards reducing health inequalities. Now is the opportunity to put into effect the best care and to guide people to the help they need to manage their bladder and bowel problems. Implementation of this framework can bring the beginning of system-wide improvements in the provision of continence care across the country.





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Case study

Name: Jacqueline Emkes

Location: Bedford

Occupation: Maths Teacher



Jacq began to have recurring bladder infections following a hysterectomy operation in 2009. In 2010 she was diagnosed with an obstructed ureter. Two major operations resulted in continued pain and infection and left her with no sensation in her bladder.

'Before this happened to me, the number of days I'd had off work probably amounted to a few hours a year. When I developed bladder problems and was subsequently given self-catheterisation as a means to manage the problem, it became a huge burden during working hours. I avoided using the catheter in school or public places, which meant I suffered more infections. It took me ages to find out how to get help locally. It would help so many people if GPs and nurses had more training and could direct people to the right place, so they could get help quickly.'

In 2013, Jacq found that she met the criteria for a Sacral Nerve Stimulator, which helped stimulate the bladder to empty better and meant that the need to self-catheterise reduced greatly during daytime hours.

Today, Jacq is recovering from further bladder reconstruction surgery, which took place in August 2015. She is also attending a pain clinic, as back problems and many infections have left her with almost constant pain. She is also on a waiting list to receive a stimulator in the spine to help reduce pain.

'My life and that of my family has been greatly affected by my illness. I am left with limited working capacity and feel very disappointed to have had to reduce my career in such a way. To have a social life and do normal day-to-day tasks has been very challenging at times. However, I am grateful for the support I have had. My GP, urological surgeons, the nurses and a specialist bladder and bowel physiotherapist have helped me enormously through the last few years. I have also found great strength through support networks for one use Clean Intermittent Self Catheterisation (CISC). I am now looking forward to better health and trust that my recent operation will prove successful.'

What Jacq would like us to understand: 'I'd urge anyone with early signs of bladder and / or bowel problems to seek help without delay: literally thousands of people suffer in silence. Although it hasn't been straight forward for me, the support and expertise I have had from the health professionals that have looked after me has had an enormously positive impact on me.'



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3.4 Always Events® (Patient Experience team, NHS England)

This area of work linked with Action Area two - Working with People to Provide a Positive Experience of Care. Clinicians and staff in all clinical settings seek to understand and provide compassionate care to meet the comprehensive needs, values and preferences of the patients they serve. Yet, in the busy world of clinical care, there are too many situations where what really matters to patients and their family members is not understood or adequately addressed. NHS England, Picker Institute Europe and the Institute for Healthcare Improvement have been working together to develop a joint programme to create a learning community to develop, implement and spread an approach for reliably implementing Always Events® since mid-2014.

The Always Events initiative provided an opportunity to:

- Better understand the concept of, and development process for Always Events.
- Develop a support framework for Always Events, which can be used in their independent implementation at local provider and commissioner organisations.
- Share experiences with peers and colleagues to better understand what already exists.
- Come together as a learning community to share and develop ideas and concepts for co-design, implementation and measures of success.

What are Always Events?

Always Events were first developed in the USA by The Picker Institute; they are an improvement programme that aims to support the delivery of person and family centred care by putting patients, service users and families at the heart of co-designing the care process in partnership with the professionals delivering care.

Always Events give organisations the opportunity to reframe their discussions of person centred care in a positive intention-based manner that builds relationships between and among patients, families and staff. The approach highlights what is working well and determines how to learn from and expand upon that success to promote consistent performance of the Always Events with every patient, every time.

Always Events are defined as those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system. Over 2015/16 the Always Events programme developed to take in a further eight organisations from across England to co-produce and co-create Always Events specific to that organisation, having a pilot group of 10 provider organisations, with differing backgrounds across a wide spread within England.



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The 10 pilot sites:

Pilot sites in NHS England Always Events® Programme	Pilot sites and area of focus for the Always Events®
Blackpool Teaching Hospitals NHS FT (phase 1)	Stroke Ward: Patients always know what to do when they get home or, if not, they know who to contact
Lancashire Care NHS Trust (phase 1)	Learning Disability Services: We will always support you in moving on in care
Aintree University Hospital NHS FT	Medicine Ward and Major Trauma Ward: Open visiting for family members
Ashford and St Peters NHS FT	Dementia-Friendly Medical Ward: What matters to you and your carer?
Calderdale and Huddersfield NHS FT	Outpatient Orthopaedic Clinic: Patients understand clinical condition and treatment plans; Clinical team understands what matters to patients
East Kent Community Trust	Community Nursing Teams in Ashford, Faversham & Whitstable: Safer Administration of Medicines
The Royal Marsden NHS FT	Haematology Clinic: Patients get the right information at the right time
Southampton NHS FT	Medical Ward: Involvement of patients and family members in planning for discharge
Taunton and Somerset NHS FT	Pre-natal Care by Community Midwives: Information being available when mothers need to access it
University Hospitals Morecambe Bay NHS FT	Post-partum Ward: Customise immediate post-natal care for the entire family and prepare for discharge

These 10 sites were supported throughout the development of their Always Event, with coaching telephone calls and face to face visits from the three partner organisations (NHS England, Picker (Europe) and Institute for Healthcare Improvement). The sites were also involved in the design and testing of an Always Event Development toolkit, which will be available for organisations to use in Autumn 2016. [You can find out more about Always Events on the NHS England website.](#)

Measuring Always Events was essential to guide the sites in understanding how the changes they have made are improving care and help them make adaptations to the interventions they have co-designed with patients. This data also helps pilot units develop a strong case for sustaining and spreading the Always Events process.



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As well as using these measures as part of the study phase of the Plan-Do-Study-Act cycles which form the foundation of the Always Events model, this data has also been used to evaluate the pilot overall. Each pilot organisation has investigated the impact and effectiveness of changes made in pursuit of their Always Event on improving people's experiences of care.

At each site, a range of measures are being used to explore:

- How well patients and families were engaged in the improvement process.
- The changes that were made based on the partnership with patients and families.
- Successes and barriers to implementing those changes, including contextual factors (time, resources, culture).
- Whether the intended outcomes were met - optimal patient experience and improved outcomes.
- Whether any unintended outcomes were observed, including the impact of the changes on staff experience.
- How sustainable the changes are, any barriers to sustaining the change and opportunities for spread.

Each pilot organisation continues to work to gain a deeper understanding of the impact of their Always Event, to ensure they are meeting the needs of patients and families who access the service, and ensuring continuous improvement to the patient and staff experience.





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4. Evidencing the impact of Compassion in Practice

4.1 Introduction

In the first two years of the Compassion in Practice strategy, activities were delivered in line with the six action areas. Reporting on progress and focus of activities in these early years were reported in the two reports: [Compassion in Practice Nursing, Midwifery and Care Staff Our Vision and Strategy \(2012\)](#) and [Compassion in Practice: Two years on \(2014\)](#). This section of the report summarises some of the key outputs delivered in year 1-2 of the Compassion in Practice strategy, the contribution made by the 6Cs and presents the main findings from the evaluation of staff experience.

4.2 What was delivered as part of Compassion in Practice?

The examples given below relate to the first two years of the Compassion in Practice strategy when programmatic actions were related to Action Areas. The outputs summarised below from each Action Area are not exhaustive, but provide a snapshot of the range and scope of activities delivered either by or with strong links to The Compassion in Practice strategy. It must also be noted that while presented by lead Action Area, many of the activities are linked to more than one Action Area, than the one listed as lead. In addition, some of the activities/projects (particularly in community/social care settings) were not necessarily led by NHS organisations but were contracted through NHS processes.

Nursing Directorate - Commissioning and Health Improvement

- Development of Caremaker role and enrolment of 855 caremakers.
- Delivery of a National Leadership Programme with 10,843 frontline staff attending.
- Establishing safe staffing guidance in the NHS Contract.
- Identifying nature of clinical leadership required to support behaviour change.
- Promoting and supporting commissioning within the prevention agenda.



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Action Area 1

- Developed and promoted a health equality framework to help commissioners, providers, people with learning disabilities, their families and carers to determine the impact and effectiveness of services for people with learning disabilities.
- Worked to support compassionate care in addressing the dementia challenge, including e-learning resources.
- Production of the framework for personalised care and population health.
- Health Visitor programme (implementation plan): Appointment of an additional 4,065 Health Visitors to narrow skills gap and respond to increase service needs.
- Project which expands the role of the District Nurse, enabling physical assessment, diagnosis, prescription and evaluation of patients in care homes and preventing admission to hospital, whilst enhancing the healthcare experience for patients.

Action Area 2

- Rolled out Friends and Family Test (FFT) as indicator of service satisfaction levels across primary, acute, in-patients and maternity.
- Formative evaluation project across the NHS England Midlands and East region to understand storytelling programmes in action and their associated outcomes and to provide a catalyst for further storytelling action.

Action Area 3

- Agreed a set of metrics and information that acute trusts and the public would find useful in decision making such as NHS Safety Thermometer, pressure ulcers, FFT, falls, patient and improvement stories.
- Developed an Open and Honest Care programme for maternity services, and a care bundle to help reduce stillbirth and early neonatal death.
- NHS England North used Insights Discovery (Investing in Behaviours) approaches with staff to facilitate the focus of change/improvement to behavioural. Ideas then triangulated with existing indicators to determine measures for improvement. Each participating organisation identified their own improvement plan with the view of then sharing their learning.

Action Area 4

- Published the Cultural Care Barometer, providing organisations with a pathway and a process for self-assessment of organisational culture and putting actions in place to address any issues.
- Building and Strengthening Leadership - Leading with Compassion Field Guide bringing to life what compassionate leadership looks like and feels like in practice, to yield pragmatic, prioritised and actionable recommendations.



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Action Area 5

- Commissioned an overview of nursing and midwifery shift patterns with particular focus on the impact of 12 hour shifts on patients and staff.
- Prepared a guide to safe nursing, midwifery and care staffing capacity and capability using evidence based tools to ensure the right people with the right skills are in the right place at the right time, which was published by the National Quality Board.

Action Area 6

- Established a staff recognition scheme to celebrate contributions to improving care in line with the Action Areas (debuted at the CNO Summit 2014).
- Launched the Draw the Line campaign, providing resources and guidance for managers on supporting people to raise frontline care concerns.

4.3 The 6Cs

The 6Cs (Care, Competence, Courage, Communication, Compassion and Commitment) were identified in the Compassion in Practice strategy as the values and behaviour underpinning high quality care delivered by nurses, midwives and care staff.

Through the lifetime of the strategy, the 6Cs became more prominent in discussions and programmatic activities related to the strategy. By the end of year two the expanded use of social media and online platforms by the health care workforce, academics and service providers fuelled what was labelled as a 'social movement' around the 6Cs. This was partly due to the greater visibility of the 6Cs in the media and partly due to the relative ease with which people were able to remember and pass on the message the 6Cs set out to convey.

The values and behaviours associated with the 6Cs were not new in themselves; few values underpinning strategies or policies in the 21st century are. Research shows that similar values have been cited over the years, the earliest being from Sister M. Simone Roach, in her theory of caring published in 1933. Roach's 5Cs included three of the values cited in the 6Cs. She presented a theoretical discussion of these as moral virtues which guide and individual's inner motivation to care. As with all theoretical frameworks, they are developed and moulded by others over time. Roach's work was previously extended, for example into 8Cs to underpin care in terminally ill patients by Pusari in 1998. The 6Cs therefore continued a tradition of adapting frameworks around care values to fit with current drivers for practice improvement.

To some extent their popularity bought challenge and critical debate - which is a good test for any values based strategy. Critical debate invites a range of views which whether positive or negative have the effect of making us reflect, think and give an opportunity to further improve or sharpen our thinking.



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There was also evidence that the 6Cs have currency and application beyond nursing, midwifery and care staff, e.g. exploration of 6Cs for medical and paramedic staff have been explored by Clinical Leaders Network, and integrated into student paramedic training through the #makeadifference and #studentparamedic campaigns.

In addition, there has been interest shown internationally in developing culturally appropriate nursing strategies in other countries utilising the values base of the 6Cs to initiate discussions e.g. Malta (nurse education), Brazil (public health and health inequalities) and Australia (nursing practice)

Overall in the evaluation of Compassion in Practice as a whole there was a feeling that the 6Cs had done much to re-establish confidence in the workforce in England and began to heal some of the negative feelings expressed after the publication of the Francis Report.

4.4 Staff experience of engaging with Compassion in Practice

At the start of year three an evaluation was carried out to review staff experience of engagement with Compassion in Practice as a whole in order to inform the overall evaluation of the strategy. The purpose of the evaluation was to identify areas and programmes of work which have improved staff experience and supported staff in providing high quality care. The evaluation also makes recommendations on how future programmes of work can be built to provide continued support to staff.

The evaluation was conducted across a random sample of trusts in England. The sample was selected from all acute, community and mental health NHS trusts in England as listed on the NHS Choices website (n= 235). A 25.5 percent sample (n=60) was randomly selected stratified by speciality. The evaluation was registered on Integrated Research Application System (IRAS) and completion of the Health Research Authority (HRA) tool confirmed that the evaluation was not classed as research and did not require ethical approval.

Permission to take part was sought in each of the identified trusts prior to proceeding with the evaluation. Approval was given in 37 (62 percent) of the 60 Trusts which were approached to participate in the evaluation. The 37 Trusts participating in the research represent 15.74 percent of 235 NHS Trusts nationally. Permission was given from the director of nursing and/or the Research & Development departments and/or research and innovation departments in each of the trusts.

4.4.1 Approach to evaluation

A case study approach was used with each trust being defined as a 'case'. The data included in the evaluation was both qualitative and quantitative. It was made up of telephone interviews, an online questionnaire, a survey exploring staff experience of engaging with the strategy and existing secondary data - Friends and Family Test (FFT), Staff Family and Friends data (Staff FFT); NHS Staff Survey data (NHSSS).



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There were four phases of data collection used in the evaluation:

Phase 1

Analysis of the Compassion in Practice survey in 37 NHS Trusts. 36 (97.29 percent) Trusts actively participated in the survey and 2,267 responses were obtained.

Phase 2

- Literature scoping to inform online forms and telephone interview schedule.
- Qualitative telephone interviews from a sample of staff sample in the selected case study sites (n=10).
- Completion of online questionnaire by self-selected sample in 10 case study sites (n=11).

Phase 3

- Collection of Friends and Family Test (FFT), and Staff Friends and Family Test (Staff FFT) data for the period 2013-2014 Q3 to 2015-2016 Q1 and NHS Staff Survey (NHSSS) data 2011 to 2014.

Phase 4

- Integrated analysis of all data.

4.4.2 Findings from the survey

There was difference in awareness of Compassion in Practice and whether staff felt this had been discussed in their trust by region, seniority of staff taking part and by size of Trust. Awareness was highest amongst respondents from trusts in Midland and East region (64.1 percent); followed by North (59.4 percent) and London (57.9 percent). Respondents in the South region had a lower level of awareness of the Compassion in Practice strategy than the other regions, with just over half (51.6 percent) of respondents saying that they were aware of the Compassion in Practice strategy.

Although a majority of respondents across all types of trusts were aware of Compassion in Practice, there were clear differences by specialty (see Chart 1), with community trusts having the highest level of awareness of Compassion in Practice (63.5 percent), followed by acute trusts (59.3 percent) and mental health trusts (51.2 percent) The differences were significant (chi-square test, $p < .001$).



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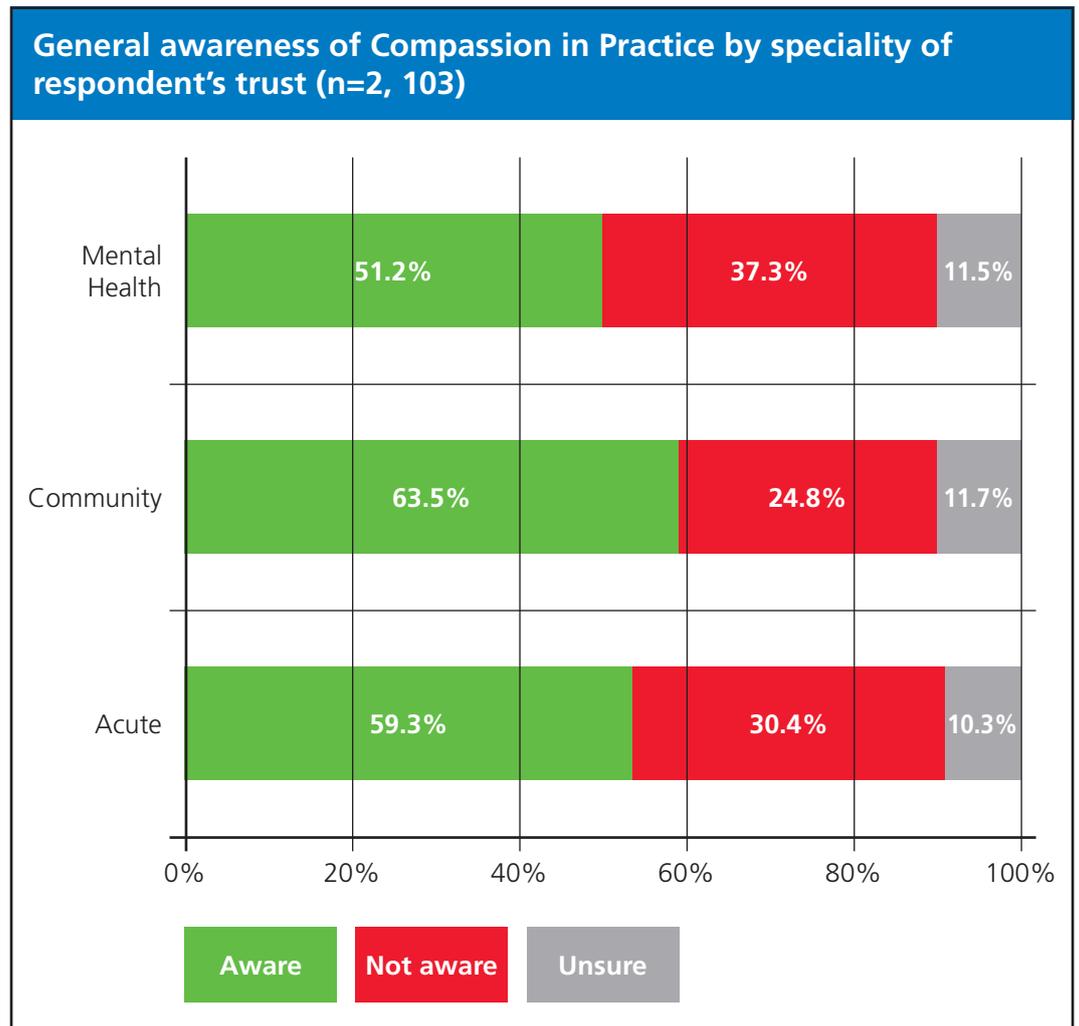
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Chart 1: General awareness of Compassion in Practice by specialty of trust



Reported levels of involvement in any aspect of Compassion in Practice varied by the same factor. The greatest barrier to involvement in related programmes of activity reported by staff was that they were either unaware of Compassion in Practice or were unaware how to become involved in their trust. This lack of awareness meant that they were then unsure of which actions were related to the strategy and could not describe any associated impact of Compassion in Practice. The highest levels of involvement by staff was reported in the FFT and Staff FFT. These were followed in terms of involvement levels by Making Every Contact Count; 6Cs Live; Dementia Challenge; NHS Leadership Academy and the Safer Nursing Care Tool.

The most common source of learning about Compassion in Practice was through email (57.5 percent); followed by meetings (35.2 percent); newsletters (31 percent); journals (26.9 percent) and notice boards (24.7 percent). 14.8 percent of respondents had heard about Compassion in Practice through social media and 7.6 percent had heard about it through other means (the main other channels were internet, induction and colleagues). It is clear that various forms of online or electronic communication (email, social media, internet)



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have been extremely important in raising awareness about Compassion in Practice. The vast majority of senior managers felt that Compassion in Practice had been discussed or highlighted but little more than a quarter of ward level staff agreed. This is significant when trying to understand the extent to which information is effectively cascaded down from senior management to middle management and then to ward level. The majority (56.1 percent) of those aware of Compassion in Practice did feel it supported nurses and midwives, although this varied by seniority and role significantly.

The Friends and Family Test (74.8 percent), Six Cs Live (62.9 percent), Making Every Contact Count (58.4 percent), Staff Friends and Family Test 56.7 percent and Dementia Challenge (53.2 percent) were the workstreams which respondents were most likely to be aware of (more than half of respondents were aware of all of these). More than a third of respondents were aware of NHS Leadership Academy, Raising Concerns Campaign and Open and Honest Care. Less than a quarter of respondents were aware of Overview of Shift Patterns, Investing in Behaviours, Caremakers, Culture of Care Barometer and Call to Action to Reduce Stillbirth.

Overall, the quantitative results suggest that although there were a large proportion of staff who are unaware of Compassion in Practice, most felt that they are delivering care in ways which are consistent with Compassion in Practice.

Staff taking part saw considerable potential in Compassion in Practice to improve patient care. However through the open ended questions there also seemed to be a perception amongst some that it has had limited impact due to other issues.

The open ended question responses indicated that:

- Structural issues (high workload, lack of resources, paperwork) influence/shape the delivery of compassionate care.
- Cultural change (preventing bullying, supporting ward level staff) is required to support compassionate care delivery.
- There are varying levels of awareness of Compassion in Practice which is largely influenced by level of seniority in nursing and midwifery roles (i.e. more awareness among senior roles).
- Trust leadership teams need to build into the next strategy a plan for top-down change (role modelling compassionate care for staff) to support the embedding of compassionate care delivery at ward level.

4.4.3 Friends and Family Test (FFT) and Staff Friends and Family Test (SFFT) findings

The FFT survey asks patients and their friends and family about their likelihood of recommending the trusts they have just received care at. FFT data was only available for four of the trusts which participated in this research. The data was available under the work areas of inpatient, A&E and maternity for the period 2013/14 (quarter three) to 2015/16 (quarter one).



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The analysis shows that, of the four trusts for which data is available, all have seen sizeable increases in the proportion of respondents who would recommend or strongly recommend their trust as a place to receive care and have seen sizeable increases in the proportion of respondents who would recommend or strongly recommend their trust as a place to receive care. While caution should be exercised in making links between FFT results and the Compassion in Practice strategy, as there are a number of other factors which could potentially account for the change other than Compassion in Practice (e.g. changes in resourcing, staff challenges, local organisational change, policy or practice initiatives other than Compassion in Practice) - the data does show an overall increase in patient likelihood to recommend (at four of the trusts in the research) during the timeframe of the strategy.

The Staff FFT has been carried out with staff, quarterly, from 2014 (apart from quarter three). This asks two questions;

- The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care.
- The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work.

Staff FFT data was available for ten of the trusts included in this research, for quarter one (2014/15) to quarter four (2014/15) (i.e. one year) but not including quarter three data which is collected separately in the annual NHS staff survey.

Analysis of the results show overall there was very little change in staff responses over the period. However, it is interesting to note that recommendations on each trust as a place to work appear to be related to recommendations as a place to receive care. This suggests that in the view of staff, a good place to work is also a good place to receive care and vice versa. Although this is a limited sample and Staff FFT does not use a standardised methodology, the implications of this relationship are potentially quite deep, since it suggests that ultimately the delivery of care cannot be improved without considering the quality of the work experience and work environment for staff.

4.4.4 NHS Staff Survey (NHSSS) data

The NHS Staff Survey has been carried out each year since 2003. It covers a range of topics regarding staff experiences at work, satisfaction with their job and satisfaction with the standard of care which they deliver. In the period 2011-2014 (one year prior to introduction of Compassion in Practice and two subsequent years) there is a majority agreement, with an upward trend, on the NHSSS questionnaire items 'I am able to do my job to a standard I am personally pleased with'; 'I am satisfied with the quality of care I give to patients / service user' and 'I am able to deliver the patient care I aspire to'.

Key finding 21 (KF21) in NHSSS 2014 reports that just 30.4 percent of respondents felt that there was good communication between senior



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management and staff. This may suggest that the apparently limited cascading of information about Compassion in Practice from management to ward level staff regarding Compassion in Practice may be symptomatic of a much bigger issue around good communication between management and ward level staff.

4.4.5 Qualitative findings

The interview findings confirmed to a large extent the results from the survey, namely that:

- Compassion is valued in nursing although there are differing opinions as to whether it can be taught or is innate (as in the open ended responses).
- There are significant barriers to delivering compassionate care and at the same time, examples of excellent responses to the need for change to embed the Compassion in Practice Vision and Strategy.

Overall staff felt the 6Cs had helped to focus and highlight their work.

"It's something I feel is very important. The 6Cs encapsulated everything, but it's something I've been concerned about for a while, that nurses are becoming very technically proficient in many ways, but that the fundamental essentials of being a nurse and coming across as a nurse who can be approached, relied upon, friendly, knowledgeable - if they don't know, they'll put you in touch with someone who can - is perhaps beginning to be missed a little bit, not just within this Trust, I feel nationally" (Site 5)

The staff responses also included a wide range of examples of good practice relating to; embedding of the 6Cs, dissemination of good practice in response to the strategy, How staff had applied the strategy and how staff had actively listened to patients. For example, in one Trust, the process of explaining the strategy to staff had led to greater engagement more widely with the 'safety and quality agenda':

"They were valuable in the sense of actually getting - the ground level staff engaged, not only with the 6Cs, but actually the safety and quality agenda that was aligned to it" (Site 2)

For several of the staff, the strategy had helped them respond to the criticisms of nursing contained within the Francis Report (2013). Responding meant in some case taking responsibility. Responsibility in this sense meant that some participants contextualized the Compassion in Practice strategy within a long timeframe, i.e. a career spent delivering care; within a historical context based on many years of experience in the NHS:

"When I read the Francis report and it was one of those that I had to go back to and read in bite-sized chunks because a lot of it didn't make pleasant reading as you know - and then when the compassion in action document came out; it's so obvious isn't it? that something sometimes goes wrong, and I think most people come into the profession for all the right reasons; when they're doing it, day in day out, with all the challenges, all the resources, they sometimes get desensitised" (Site 2).



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4.4.6 Conclusions

The evaluation of staff experience of the Compassion in Practice strategy demonstrates that compassion and the 6Cs are valued as a focus for care work although opinions differed as to whether it can be taught or is innate. Staff felt that significant work was in place to embed and deliver compassionate care and there was some resentment, even anger that this appears unrecognised.

The findings show that having an awareness of the strategy and having a meaningful approach to developing it is key. A suggestion for future strategy is to embed a co-production model of development and policy implementation.

Staff highlighted some significant barriers to delivering compassionate care and at the same time gave examples of excellent responses to the need for change to embed the 6Cs and Compassion in Practice strategy.

4.4.7 Recommendations

In summary, staff felt that the NHS and their own employers should recognise the work of nurses, midwives and care staff to provide compassionate care and the challenges around delivering it by working to:

- i. Improve staff morale and supporting on-going cultural change.
- ii. Address the need for cultural change taking account of possible sector challenges including policy fatigue, bullying, and targets which at times might seem overwhelming.
- iii. Add a seventh C - co-production for change i.
- iv. Support nurses and managers so they can continue to provide compassionate care.





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5. What the review of the evidence is telling us in relation to the impact of Compassion in Practice, including the 6Cs

5.1 Introduction

Review of evidence from the first two years of Compassion in Practice strategy, the outputs from the commissioned programmes in year three and the evaluation of staff experience combine to give us a detailed picture of the impact and contribution made by the Compassion in Practice strategy. The evidence is useful in helping us to reflect on not just the outputs of the programmatic activities but also the overall processes involved in developing the strategy and our experiences of implementing it in order to inform approaches for developing the follow on strategy from April 2016.

5.2 Evidence from evaluation of impact tells us that

- A range of outputs were produced and implemented over the lifetime of the Compassion in Practice strategy through programme activities including evaluation project reports, case studies illustrating good practice, toolkit development and sharing of innovative ideas e.g. The 'Open and Honest Care' programme from Action Area 3 - includes support tools for Boards, Acute, community as well as maternity Trusts. In the [evaluation report by Edge Hill University](#), staff overwhelmingly felt that the strategy had helped them to identify areas for improvement, energising and empowering them to act and contributed to a culture of learning across their organisations.
- Piloting smaller programmes in the early years is a good way of identifying 'scale and spread' potential of activities. Some of the regional programme outputs were identified in year two as, subject to further trialing, potentially being used more widely e.g. Action Area 4 building and strengthening leadership with focus on supporting BME leadership development, now being expanded as part of year three commissioned work on compassionate leadership.
- The 6Cs were widely recognised by the profession as representing the values and behaviours underpinning the Compassion in Practice strategy and staff felt that on the whole they had a positive impact on reaffirming the positive identity of nurses, midwives and care staff in the public domain - highlighted in the evaluation of staff experience and feedback collated from over 400 free text comments from delegates at the RCN Congress 2015.



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- It is important for staff to feel included as drivers of change at a regional level or within their own areas of practice. Successful implementation of actions within programme areas to improve local processes and address concerns was more likely to occur when staff had high level of local ownership in setting actions and determining activities with programmes.
- In challenging times of reduced resources, staff found inclusive and innovative ways to deliver programme objectives and share the message of compassion at the heart of the strategy, e.g. North Tees and Hartlepool NHS Foundation Trust used Insights discovery approach to implement nurse led 6Cs promotion programme to ensure compassionate care delivered to all patients and staff recognise value of everyone's contribution to care in the trust - they reported improvement in staff and patient satisfaction, FFT/audit compliance and student placement experience as a result.
- Involving the experiences of people we care for in reviewing the services we provide to inform service improvement increased levels of satisfaction amongst staff as well as service users themselves, for example, evaluation of using patient stories in Midlands & East region (Action Area 5) to help understand how processes impact on patient experiences; patients/carers/ staff report being able to 'feel' the difference in the organisation and feeling 'well supported' through sharing stories.
- People we care for report they are proud of the NHS and feel their care has improved over the last few years. Backed by information from the [staff experience evaluation](#) and Ipsos MORI poll of 1,016 adults (published 2014) - overall satisfaction remains high and majority feel the NHS is one of best in the world, providing good value for money and they are treated with dignity and respect.
- While Action Areas were predominantly led by one partner or regionally coordinated- some programmes illustrated opportunities for successful implementation or further development beyond one group or pilot site e.g. The extra 4,000 health visitors recruited through the programme in improving child health, will positively impact on population health and reducing health inequalities in future. The equalities framework providing support and guidance for people with learning disabilities and their families - linked with the framework for personalised care and population health - highlighted the impact on families and their carers of the prevention agenda using sound evidence, personal experiences and interprofessional approach.
- The organisational culture around compassion for both staff and people we care for are key factors in successful implementation and future sustainability of compassionate care. This was repeatedly raised by staff during the evaluation survey. In addition, the Culture of Care Barometer developed by Action Area 4 in partnership with Kings College London's National Nursing Research Unit at the Florence Nightingale Faculty of Nursing and Midwifery, builds on existing tools, such as staff surveys, but is much shorter so can be used more frequently as a 'dip-stick' test of the culture of care at different times and in different parts of an organisation.



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6. Towards Leading Change, Adding Value: a framework for nursing, midwifery and care staff

6.1 Introduction: Engaging to transform

The impact of a strategy lies in more than the programmatic activities delivered and the outputs developed as a result of those programmes. The process of developing and implementing strategic priorities and the experiences of those involved over the lifetime of the strategy are equally important in guiding our thinking. This is particularly important for informing future processes and approaches to our work.

The final sections of this report summarises our learning from the process - what worked/didn't work or needs to be adapted so that it is fit for purpose in future.

6.2 What worked well?

- At a wide range of professional events the majority of nurses, midwives and care staff at different stages of registration and experience (included students) reported that the Compassion in Practice strategy went a long way in re-establishing trust and pride in the profession.
- There was general recognition by senior nurses and midwives at national, regional, commissioning and provider levels that this strategy was needed by the profession post-Francis and a need to take a new approach and move from 'responsive' mode to future planning.
- Over the first two years programme focus has seen a gradual shift from re-establishing confidence and quality to ensuring future sustainability and effectiveness' (from never events to Always Events).

6.3 What/needs to be done differently next time?

While staff overwhelmingly demonstrated support for the Compassion in Practice strategy itself, they indicated throughout the evaluation areas that needed further work or which should be approached differently in future. This was valuable in demonstrating nurses, midwives and care staff's commitment to reflecting on actions and suggesting positive ways forward to guide the professions. Some of the issues raised and suggestions made included:

- A call for sustained and strategic work around leadership and particularly supporting leaders in making transition from operational management as well as improving the diversity of professional leaders at national and



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regional level. This arose in early years of the strategy and was focused on as part of commissioned work in year three.

- Research/evaluation and evidencing practice became increasingly recognised as important aspects of improving services in year two. Further support and development is needed for frontline staff to increase confidence and skill in planning for creating as well as utilising evidence. A clear commitment to evidencing the impact and contribution of funded programmes moving forward and should be integrated into future strategy development.
- A growing recognition that social media played an important role in the second year of the strategy in communicating outputs as well as ongoing strategic and programme developments. Social media was the key arena that initiated the beginning of social awareness of the 6Cs and an optimising of positive professional identity. It was suggested that earlier implementation and wider use of social media in future could provide positive benefits in communicating or developing future strategy.
- The Action Areas provided a clear strategic framework for identifying lead responsibilities, action planning and guiding programme delivery but were not always well understood by frontline practice and academic nurses. There was a lack of understanding for some staff of the relationship between 6Cs, Action Areas and the strategy itself led to some believing the 6Cs were the strategy itself and over time the identity of the Action Areas and purpose became blurred. In the future, use of a detailed engagement plan beginning with frontline staff and people we care for to articulate why we are developing strategy and processes involved, could help to minimise confusion.
- The strategy was perceived as having a predominantly 'acute hospital' focus. In some areas of practice e.g. midwifery, community, mental health, children and young people, academics felt their professional roles were less well articulated or publicised. It was suggested that in future strategic developments utilising a stakeholder engagement plan to ensure inclusion, reflecting the range and scope of professional practice including other health and social care organisations, would help mitigate against this.





CNO Welcome

Introduction

Year 3 Commissioned Programmes

Evidencing the impact of Compassion in Practice

What the review of the evidence is telling us in relation to the impact of Compassion in Practice, including the 6Cs

Towards Leading Change, Adding Value: a framework for nursing, midwifery and care staff

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7. Summary Statement

Evaluating the impact of Compassion in Practice, a strategy for nursing, midwifery and care staff, set out to answer the question: “Has Compassion in Practice made a difference to the people we care for and our workforce?”.

The evidence presented here illustrates the wide range of programmes delivered, the contributions made to service delivery. Perhaps more importantly the experiences of staff and the people we care for suggests that overall the answer to the above question is “yes”. In addition, the evaluation of impact as a whole has also given us the opportunity to reflect on what happens next and to consider how we may improve in future.

During the evaluation nurses, midwives and care staff expressed a strong desire for a follow-up strategy to give clear direction, developed with as much staff input as possible. To this end, the latter part of year three included a development phase (called Our Vision). In this phase, taking on board the learning and experience from Compassion in Practice, engagement with a wide range of stakeholders began using a co-production approach to inform, design and develop the next strategy to follow on from Compassion in Practice.

This report has demonstrated that nurses, midwives and care staff can be the primary agents of transformation but must be helped to prepare for the future - strategically setting out how we can create the right culture for change, explaining the need for change and providing the tools to achieve it. Now is the time to be proactive in progressing the strategic focus for nurses, midwives and care staff.

