

An Evaluation of the Leading with Compassion Recognition Scheme

Yvonne Sawbridge and Alistair Hewison.

University of Birmingham

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**“Educating the
mind without
educating the
heart is no
education at all”**

Aristotle

**(A Report for the Healthcare Community of Shropshire and
Staffordshire supported by Health Education England in the West
Midlands)**

Introduction

One of the values identified in the NHS Constitution is that *we ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care* (DH 2015, p5). Although the term compassion can be interpreted in different ways (Blomberg et al 2016, Strauss et al 2016), it is often used to mean 'good' patient care.

For example West and Dawson argue ... *that cultures of engagement, positivity, caring, compassion and respect for all - staff, patients and the public - provide the ideal environment within which to care for patients* (2011, p7). With the aim of creating such environments of care the *Leading with Compassion* programme was launched in Shropshire and Staffordshire in 2015. With support and sponsorship from Health Education England in the West Midlands, its purpose was to embed, recognise and research compassionate leadership.

A fundamental precept of this approach was to increase awareness that compassion is not solely a requirement in face to face clinical care, it is also an essential part of good leadership. This was based on the recognition that if patients are to experience kindness and compassionate care, then the staff who deliver the care must be treated with kindness and experience compassionate leadership (Kaur, <https://www.kingsfund.org.uk/about-us/whos-who/mandip-kaur>). The intention was to engage all staff in recognising and celebrating compassion irrespective of whether it was experienced by a patient, carer, or colleague. As part of this work a *Leading with Compassion Recognition scheme* was introduced in health and social care organisations in the West Midlands area in early 2016 (for a list of participating organisations see Appendix 1). The *Leading with Compassion* recognition scheme is designed to acknowledge and reward compassionate acts witnessed 'in the moment'. The process was designed to be straightforward, 'user friendly' and place no restrictions on who could nominate (staff or patients/service users) or be nominated. Nominations are made by completing a card and posting it in a box designated for the scheme located in the participating organisation or using the website to complete this form (Appendix 2). Nominees then receive a card explaining who nominated them along with the reasons for the nomination, and a badge which indicates they have been recognised for acting compassionately. All nominations are processed, and collated at a central point in one of participating organisations on behalf of the leadership leads group. This was seen as a way of recognising acts which were examples of compassionate leadership at all levels of the organisations.

"The healthcare community across Shropshire and Staffordshire has a shared vision and collective purpose to embed and recognise compassionate leadership across the region"

(<http://www.nhscompassion.org/compassion/purpose/>)

This report presents the findings of an evaluation project undertaken to capture the lessons learned from this innovation. It also makes a number of recommendations to inform the

development of the Good Practice Guide which is being produced to support the roll out of the Scheme.

National Context

It is evident that compassion is seen as an integral part of good healthcare (Royal College of Psychiatrists 2015, DH 2015, 2014, Nursing and Midwifery Council 2015) and it is one of the 6Cs in the National Nursing and Midwifery strategy (Compassion in Practice NHS England 2012). First identified in the Compassion in Practice strategy it was later emphasised that the 6Cs *belong to all health and care staff from nurses, midwives, doctors, porters, care staff, physiotherapists and managers both clinical and non-clinical, to executive Boards and commissioning Boards* (DH 2013, p24). Compassion has been defined “*as a sensitivity to suffering/distress in self and others with a commitment to try to alleviate and prevent it*” (Cole-King and Gilbert 2011 p 30) which means that to behave compassionately involves recognising a need in others, motivation to respond to that need and the knowledge and skills necessary to competently meet that need. This is not always easy to achieve in highly pressurised health and social care organisations. However the more compassionate the contexts people in work are, the more compassionately they can behave to others, and this requires compassionate leadership (Gilbert 2009).

The importance of compassionate leadership as a key requirement in the delivery of compassionate care is acknowledged in *Developing people - improving care* (NHS Improvement 2016), which states: *Compassionate leadership means paying close attention to all staff; really understanding the situations they face; responding empathetically; and taking thoughtful and appropriate action to help* (p2) This is reflected in the approach taken by the healthcare community in Shropshire and Staffordshire, supported by Health Education England West Midlands, who developed a shared vision to recognise and embed compassionate leadership across the region. This was initiated at a regional event- *Leading with Compassion* in September 2015 which was organised to share good practice and innovation across Staffordshire and Shropshire. This provided a forum for discussion which in turn resulted in the creation of a Shropshire & Staffordshire Community of Practice (S&SCOP) to spread compassionate leadership innovations and to help co-create a resource for sharing best practice. S&SCOP developed a *Leading with Compassion* recognition scheme for introduction to eleven health and social care organisations in the local health economy. The aim was that it would be a simple scheme used in each organisation, where staff patients and carers could nominate someone who they felt had demonstrated leading with compassion. In what follows a broad range of evidence has been combined in order to

answer the two key questions which guided the evaluation (see below) and to explore how compassion was defined by those making the nominations.

As part of the scheme the nominations of compassionate acts have been collated and organised into two distinct categories– actions and impact (see page 18). In this report these categories are considered alongside a number of existing analytical frameworks in order to inform the exploration of how compassion is understood and enacted by staff in the participating organisations. The aim is to provide ways of describing the enactment of compassionate leadership/ practice that are understood by staff and give organisations a means of purposefully directing attention to this sometimes intangible requirement, and to recognise and reward the many who practice compassionately in their work every day. Despite comments such as *kindness and compassion cost nothing* (CQC 2011- Overview, p4) the reality is that the pace and complexity of modern health and social care organisations can make it difficult to provide compassionate care in a consistent way (MacArthur et al 2017). This suggests it is important for organisations to develop ways of recognising and rewarding the enactment of compassionate behaviour and developing an understanding of how it can be best done.

Evaluation

This evaluation is a retrospective review of the programme, and addresses two main questions:

- What helped and/or hindered the roll out of the programme?
- How might a good practice guide support the spread and sustainability of this initiative?

Inevitably in the course of the project a wider range of related issues was identified and these were examined with reference to the emerging body of evidence in this area.

Methodology

Individual interviews and a focus group were conducted using specific interview guides to frame the sessions (see Appendix 2 and Appendix 3) and consent to participate was recorded using a standard form (Appendix 3). Initially the intention was to interview participants from phases one and two of the project, to trace the progress of the scheme. However organisations launched their schemes at different times, to best suit local needs, and so an ordered approach to the evaluation following a phased programme of

introduction was not possible. This evaluation is based on semi-structured interviews with eight participants, some of whom were involved in the design and implementation of the scheme, and who had all nominated someone for recognition. This is a potential limitation as the views and experiences of those who have not used the scheme have not been accessed, and this may be an area individual organisations may wish to explore further. The respondents were drawn from the eleven organisations participating in the scheme (Appendix 1). Some of the interviewees were from organisations that were at the early phase of implementation, and others had been participating for some months. They were purposively sampled (Kuzel 1992, Teddlie and Yu, 2007) from the nomination forms, as this indicated they were both aware of, and had used the scheme. A small number of key stakeholders were also interviewed, (including a service user), and some participants who were unable to contribute in other ways, took the time to email their views about the scheme, and these data have also informed this report.

The use of semi structured interviews in exploratory work of this nature has an established provenance in research in health care organisations (King 1994) and they are particularly well suited to accessing the views and experiences people working in health care (Fontana & Frey 1994, Seale 1998).

The selection of a focus group as the means of collecting the views and experiences of people who had nominated colleagues was based on its suitability for gathering views in an efficient manner, whilst affording opportunities to explore the related issues in detail (Kitzinger, 1994, Wellings, Branigan, & Mitchell, 2000). The focus group request was sent by email to all those who had made a nomination inviting them to contact the researchers if they were able to attend. The aim was to recruit between six and eight participants, and the first recruitment round yielded one person, and so a second email was circulated and the focus group was also advertised in Trust newsletters. Despite the limited attendance, (three participants) the focus group enabled us to explore the key themes which had emerged from the interviews, supplemented the data from the individual interviews, and added depth to the findings

Data analysis

The aim of this analysis is to build understanding of the factors that support the roll out of a compassion recognition scheme in health and social care organisations and to generate a more nuanced and realistic account of how and why things have worked well in particular settings.

The thematic analysis of the participants' accounts was conducted in line with the principles of a cyclical approach involving

Key Themes:

Purpose
Communications
Progress
Tensions
Next Steps

identification of patterns, consideration of variations and limitations, explanation of patterns and building explanations (Porter 1996). In order to conduct this analysis the recorded interviews were listened to several times and detailed notes made of key phrases, along with verbatim transcripts of some statements. Full transcription was not possible because of budgetary constraints. However repeated listening, detailed contemporaneous notes and focussed, partial transcription provided a comprehensive record of the data for analysis. Codes were assigned to notable extracts that signified key issues in the data (Miles & Huberman 1994). These were then reviewed and grouped into categories reflecting the main areas addressed by the participants (Strauss & Corbin 1998, Charmaz 2006). These categories informed the development of five themes which characterise the introduction of the *Leading with Compassion* recognition scheme. Selected extracts from the data are included to indicate the nature of the themes. These themes were: Purpose; Communications; Progress; Tensions; and Next steps. The focus group findings are also incorporated in these themes as they encapsulated the key discussion points explored in the group. Secondary data was collected by S&SCOP as part of this programme, in parallel with this evaluation and includes the number of compassion recognition awards recorded in each organisation and the types of actions that prompted the nomination. Currently this amounts to 1500 nominations.

"I have both nominated and received a nomination for the Care and Compassion Award. I think it's a great idea and was really easy to do, ...my first nomination was made for a nurse at x to somebody who has been looking after me for a few years. I was really pleased to be able to do something to recognise the hard work she does for me. It was a great way to show my appreciation for all the help she does for me, without thinking, and I know she was shocked and surprised when she received it".

Themes from the interviews

The following section presents the findings from the interviews organised into the five themes. These data are also supplemented in places by extracts from the focus group.

1. Purpose

The purpose of the scheme to develop compassionate leadership, and organisations (as described in the introduction), was explored in the interviews. One interviewee described it as a tool to raise awareness and move compassion 'higher up the agenda'. It provided a focus on "*how you feel and how you make others feel*" and that this was at the heart of compassion. Others talked about it helping to provide a means of recognising that "*we are all human*" and as a way of fostering mutual support for each other. One interviewee summed it up by stating:

"It's the little things people remember- they don't remember the policies and strategies, but how they were treated."

Some interviewees had been nominated and nominated someone else, and valued both giving and receiving the recognition.

The extent to which the *Leading with Compassion* recognition scheme was associated with 'leaders' and approaches to leadership was a factor in the way it was rolled out in the organisations. For some it was integrated into an existing framework and for others it was a more prominent component of how leadership was viewed. This was related to the purpose of the scheme as envisaged in each organisation:

"Some organisations have incorporated it with their organisational values, I'm not sure how they've evaluated it. We've gone bigger on the leading with compassion rather than incorporating it into values."

"The Housekeeper was amazed and this seems to have really boosted her confidence-a noticeable change in behaviour. She put herself forward for the 'greater place to work' working group which has consultants, nurses etc and she wouldn't have seen it as her place to do this previously..."

Whereas elsewhere it was approached in a different way:

"It's a motivational scheme in our organisation so it's about having that recognition process without it being too formal to say thank you, which we're not always great at in terms of making sure people are recognised for something that might seem quite trivial, it can have a big impact on others, so we've done it for those reasons really."

and

"The idea was using the award winners as positive role models and promotion across the patch to say look at these acts of compassion to act as a catalyst for inspiration for more compassion."

One respondent felt that this scheme added value in ways that staff award schemes may not, because of its inclusivity:

"There is no need for big glitzy events- the informality and the human touch element of the recognition is important."

Most respondents viewed the openness of the scheme as hugely valuable, as compassion was often seen as being mainly in the domain of clinical staff. One described the impact her nomination had on the housekeeper she nominated (see text box above). However whilst there was overall agreement that the purpose of the scheme was to recognise and reward acts of compassion, there were some reservations expressed. One minor concern was that whilst some people liked being nominated and recognised, others were a little embarrassed by the recognition. Another concern was that compassionate care

should be the norm in the NHS and therefore rewarding people for delivering “*an everyday expectation*” invoked some disquiet. Indeed some felt there could be criticism for funding such a scheme in a period of austerity.

There was also a risk of ‘tokenism’ expressed with one respondent reporting that a colleague who was a nurse had stated “I don’t need a b****y badge to show I’m compassionate.” However most respondents felt that the balance could be struck, and whilst some talked about nominating people for exceptional acts- for example a housekeeper who went above and beyond her role to be compassionate- many noted that acts of compassion were becoming rarer in such pressurised environments, and so there was a need to continually raise this as an expectation. The participants agreed that recognition needed to be embedded in the everyday work of colleagues as part of ‘how we do things around here’, in this way it would be a useful reinforcement of required behaviours. The scheme was seen for the most part as a positive development in contributing to this.

How the scheme fitted with the longer term aims and aspirations of the different organisations varied depending on location. For some it was seen as something that was being done in the current year which would probably not continue in the same form next year:

“What we aim to do for this year, it’s been care and compassion, next year I don’t know what’s going to happen with this scheme but if it finishes we’ll probably pick another one of our values and do it around that, get recognised for that and keep it rolling”.

However for other respondents it was seen as a means of embedding compassionate behaviour as part of a longer term programme of development:

“We want to produce a best practice guide of examples that will inspire people across the whole patch but more importantly to create educational materials for each organisation that is a partner with us linked to case studies that have explicitly happened in their own organisations-so it is like this is what compassion looks like round here, it is happening in an organisation close to you and here are some the examples.

Similarly:

“What I would like to see from the scheme specifically is a combined data set that gives us a view of what people do think compassion is- gives us an opportunity to build into our existing programmes ‘this is what staff think compassion is, this is what patients think it is, it is an evidence base, its saleable to 10 organisations’. It makes sense that we’ve got a lot of data, between 1000-2000 entries now to give us a view of what compassion is.”

In summary, the respondents generally felt that this scheme did meet its purpose in terms of raising the profile of compassion, and also created a ‘feel good factor’ on the part of the nominees and nominators. If the purpose is to create a culture in which compassionate leadership can flourish, then application of Johnson’s (1992) model (see below) suggests that the symbols and stories being created as part of the operation of this scheme, could contribute to the changes in the other elements of the organisations that the model depicts

as being involved in the development of organisational cultures. In this case to foster one focussed on compassion.



(Johnson 1992)

2. Communications

Communication in healthcare organisations generally is often difficult because of the range of employees, teams, locations, span of managerial control and the complex nature of the work. Some of the Community Trusts have several staff bases, and access to computers can be limited, meaning use of emails for all staff communication is not always the most effective way to reach staff. Face to face contact is also challenging because of time constraints, and so each organisation had to develop its own approach with regard to publicising the scheme.

The participants became aware of the scheme in different ways, mainly through a corporate communication channel. For example in one organisation the CEO had heard about the scheme from a colleague at NHS England and wanted to start it in the organisation, and another learnt about the scheme at an annual open all staff event. The scheme was also implemented in a variety of ways with approaches ranging from formal launches to informal/personal 'spreading of the word'. Indeed one respondent had been invited to visit another Trust to talk about the scheme, as it was felt that word of mouth would be a more powerful and effective way to publicise the scheme and increase its uptake.

However continuing communication was reported to be limited and one participant thought the scheme had now 'closed'. It was also reported that after the initial launch it was difficult to find details without searching the website. Some Trusts had a number of different schemes already in place, including annual staff awards, and quality awards, and there was some concern that it would be confusing to launch yet another one and there was a need to emphasise that the *Leading with Compassion* recognition scheme was not an organisational award. Although it was felt that the scheme provided a suitable forum to:

“...have that conversation and the leading with compassion scheme is a voluntary scheme and the success of it in some organisations has encouraged others to adopt it”.

One mention was made of an organisation wide discussion of values, staff listening events, the introduction of a range of leadership development programmes, and a focus on coaching. This was in addition to the ‘normal’ work of the trust and so making the recognition scheme ‘visible’ in this environment was an achievement in itself. In other organisations there were concerns that the scheme would be ‘lost’ amongst existing awards and brands that were in place. Indeed some felt there was confusion concerning where the scheme fitted with the range of other awards made in the trusts and two participants thought it was a ‘one off’, indicating perhaps that more and clearer communication about the scheme is required.

Some Trusts started with executive ‘ownership’ and a top-down communication and support strategy. In another organisation it was reported that:

“The intention was always to have that soft approach, social movement as we had been advised that had worked really well in other organisations, if we had a number of initiatives that are all supporting a compassionate culture and leadership approach that would be the social movement element of that strategy really.”

In one Trust this ‘soft approach’ was accompanied by a ‘Flash communication’ which involved the distribution of 1000 leaflets explaining the *Leading with Compassion* recognition scheme by the OD team dressed as Queens of Hearts. In other examples some of those responsible for the roll out of the scheme added the award website link to their email signatures but acknowledged that not all operational staff access emails (as noted earlier) so this limited its spread. It was also reported that the scheme was highlighted in monthly meetings; team briefs; newsletters; health and well-being events and in Chief Executives’ blogs. Some organisations had posters made which were prominently and widely displayed, even on toilet doors. Yet despite this considerable effort devoted to publicising the scheme, the levels of awareness of its existence varied:

“I only knew how to nominate because I am an ex -employee and knew patients can nominate staff from this and it was only when I logged on to nominate my colleague I saw I could also nominate a member of staff”

“You’ve got to bear in mind that in terms of organisational priorities we have a lot going on at the moment and have always had really. You can meet a bit of resistance sometimes when introducing yet another initiative or scheme (my words) hence we aligned it very closely with what had previously been done, whilst we did big bang in terms of getting it out there and making sure everyone could have a go at nominating, we were quite soft in the launch and did not ram it down people’s throats. It sort of sits in the background”

Similarly

“I work within two roles in the trust and only know about the Care and Compassion Award from the one department as we were given the link with a video telling us about it at a group operations meeting, however in my other role I have received nothing to alert me to the scheme so maybe the word needs spreading a little bit more...”

Most interviewees who had some responsibility for implementing the scheme reported that when they had the opportunity to create their own compassion logo they ensured it reflected the organisation’s individual identity, and some had also explicitly linked it to their values and this was felt to be important.

For those with less formal or more ‘bottom up implementation plans, it was thought that future introductions of the scheme may require more visible executive endorsement. For example:

“One of the biggest barriers seems to be executive buy in and we haven’t as a centralised team wanted to impose our stance, we wanted to enable the nurse director or OD director to gain traction themselves, all of the branding is bespoke to each organisation, we did not want to force something on an organisation that doesn’t work, but there is definitely a connection between really strong executive buy in for the programme from the off, versus trying to do a soft launch in the absence of their real understanding of what the programme’s about.”

The interviewees believed that if full implementation was to be achieved the scheme needed more promotion and its introduction supported with more effort directed towards raising awareness. As one of the respondents commented: *“It doesn’t feel like it’s got a life yet”*. One suggestion of how this might be addressed was that it could be publicised on electronic bulletin boards to inform staff and the public it exists and to explain the process for making nominations. It was also suggested that the nominations could be used as a source of good news stories to counter-balance the current generally negative reports of NHS activity.

Overall the importance of effective communication of the details and operation of the scheme was acknowledged, and it was felt there was a link between the approach taken and the take up rate of the scheme.

3. Progress

The number of nominations and participating organisations has risen steadily during the conduct of this evaluation, and continues to do so. This is evidence that further progress is being made in terms of implementation. Indeed those respondents with some responsibility for the scheme were generally pleased with the rate of adoption. For example:

“...the take up has been very high, higher than we anticipated and the feedback we get from those workshops is hugely positive.”

Although as noted above, this related directly to way it was launched/publicised in the organisations:

“given it’s been quite a soft comms launch, we’ve done a bit, we’ve done enough probably, alongside a lot of other things, it’s been steady, I wouldn’t say it’s been massive at all, but it hasn’t been our priority, it wasn’t one of our directorate or organisational priorities but it has done what it was designed to do”

Yet given the plethora of organisational initiatives, targets and other pressing concerns faced by the organisations involved, the 1500 nominations to date indicate that the scheme is taking hold, albeit at different rates. This is reflected in the fact that in one Trust 329 nominations were made in 6 months, whereas in another only four were received in the same period. Even allowing for differences in size and location this is quite a contrast.

“The recognition scheme has been taken up variably in the different organisations. Some have got it instantaneously and are motoring through their organisation because they had a culture that enabled it to land and take fire, whereas in other organisations there just hasn’t been the culture, ‘why would we?’ ‘we haven’t got permission to recognise each other’, so it has taken a longer lead in time”

In terms of the operation of the scheme it was reported to be straightforward. This was important because it was consistent with one of the driving principles for the scheme:

“What are we trying to spread here? All access, all areas anyone can nominate anyone else and there should be no barriers to that whatsoever, because it’s subjective, and that person’s reflection is their own so we shouldn’t try to interpret it, it is their own. “

also

“It’s been really positive. Easy to complete, put a few words down, get these cards and badges-a real value to it, really positive for us, it’s motivational. It’s worked for us. Its low maintenance in terms of administrative support, it’s been great. It’s motivational and that’s what it’s designed to do”

However, some respondents felt that the option of being anonymous would be helpful, particularly for service users, who might feel awkward meeting a staff member they had nominated. Indeed some of the staff making the nominations did not know they would be ‘named’ as the person making the recommendation when the recognition was conferred. It was suggested that an option to remain anonymous could be added to the proforma, as this may increase the number of nominations.

The participants suggested that it would be nice to know that the nomination had been received and also to have notification of when the notification was being given to the nominee. It was felt this would complete the process with nominators being made aware

that recognition had been given. In one organisation the Chair presented the first two awards, whereas in others there was no sense of an event, rather the certificate and badge were handed to the individual in the office. This generated some discussion within the focus group about how best to make the award. It was suggested that the badge and certificate be presented by the individual's manager so that there was awareness at that level that the individual had been recognised. However it was suggested by some respondents that this could foster dissatisfaction and possibly resentment on the part of people who had not received one. There was also concern, that this might confer a more 'formal' status on the recognition, detracting from its original purpose of recognising compassionate acts 'in the moment'.

In general the badges were seen as an important acknowledgment of the contribution made by the staff member, and also an opportunity to publicise the scheme more widely, as many staff wore them on their lanyards. For example:

"I have been in a couple of meetings where people have mentioned that they have the badge and showed it off proudly and that advertises the scheme really."

However one interviewee noted that the person she nominated, though pleased, was also embarrassed and had put her badge in her drawer rather than wear it, as she felt it was 'showing-off' (see tensions below).

Aside from the staff time necessary for the development and launch of the scheme, in terms of its operation it was relatively inexpensive-

"... each act of recognition costs about £2.00¹ (for the production of the badge and the certificate) so in terms of them being able to set that up it is fairly small beer in terms of the benefit it brings to the individual, morale and engagement"

When discussing the progress of the scheme one respondent expressed her appreciation of the central team who coordinated the scheme, developed the website, and managed the nominations. She felt her organisation would not have got to the stage it had reached without them. The value of having an external scheme, particularly one that could be adapted to fit with internal requirements was mentioned by others too. The sharing of the management of, and responsibility for the scheme by two counties was seen as positive as this fostered wider discussion about shared values and helped share the principles of leading compassion with eleven organisations.

As described earlier, the nomination process involves answering two questions (see Appendix 2) which can be done online or by using a paper nomination form. It is open for all staff and service users to access and can be completed in a short space of time. This was seen to be important in terms of generating engagement with the scheme.

Overall the participants were positive about the progress of the scheme although they agreed it needed to be managed differently, dependent on the setting (for example a more 'personal' approach to publicising the scheme could be taken in smaller organisations). However as with any initiative of this nature there were some inherent tensions which are discussed below.

¹ The actual cost is £1.48 for each badge, nomination form and card.

4. Tensions

There were a number of issues associated with the *Leading with Compassion* recognition scheme that generated some interesting insights on the part of the interviewees. These centred primarily on the extent to which the scheme could work counter to its original aims as a result of the way it was introduced, perceived and supported. For example one respondent felt there was a risk to consider if the scheme continued and awareness of it increased:

“The danger is as it grows is that if you haven’t got one (a badge) you are not very compassionate, so if the scheme grew beyond itself it could be counterproductive where some people are going ‘why haven’t I got a badge’ ‘why has no one seen this in me’ so that can be a fine balance as well”

One participant was aware that the scheme originated from the work of S&SCOP and their interest in well - being in the workplace, linked to leadership. This prompted some discussion about the association of the scheme with the term ‘leadership’ which was felt to be a bit ‘off putting’, although it was recognised that this was necessary because it was developed using the funding for the development of leadership. Uncertainty as to whether performance of a compassionate act could always be classified as ‘leadership’ was identified as an issue. Indeed the participants said they ‘sometimes had to tweak the nomination’ to ensure it fitted with the sections of the proforma. Whilst the nominations record compassionate acts by a wide range of staff in terms of roles, grades and groups, there was a sense that the title created a potential barrier in that some may feel that unless you hold a leadership role in an organisation, then you might not be eligible for this award. In some places the leadership element remains prominent, in others the emphasis has been more on compassion and less on its association with leadership. One interviewee suggested that calling it “*a moment of compassion*” might be more engaging and help make more staff/patients aware they can make nominations – “*it is not just a management tool or ‘gift’*”. Whilst some organisations had put posters in community clinics and public places to encourage nominations from patients/service users, some participants were not aware that patients/service users could make nominations. However, there was agreement about the importance of having a wider view of compassion and that it is not just for patients – “*it is about staff looking after each other*”, and that this scheme helps articulate this very clearly.

Another tension was concern about what the scheme should be seen to be recognising:

“...we shouldn’t get too enthusiastic about recognising people going above and beyond, because in this organisation we have many, many, many people who go way above and beyond and we do not want to create a culture where that is expected, we want to create a culture where people can and are able, and willing to go above and beyond where they choose to do that, but not having a recognition scheme that only recognises when people are working extra hours.”

There was also discussion of the extent to which behaviours and actions which would be expected as part of normal practice/behaviour should require recognition. However it was

felt that these were issues for the future as in most of the organisations participation in the scheme was far from being at 'saturation point'.

There was some variability in how the scheme was envisioned in the different organisations. For example:

"Initial conversations around the table were that there was variable interest in developing a common approach, the community trust had already established compassionate leadership as one of its philosophical drivers so it was already established there. Some of the acute trusts were less happy to go with this approach because they had already done work in their own organisations around their own leadership development programmes and had a different approach."

"What is going above and beyond and should you be thanking people for the day job?"

Despite the tensions of introducing this scheme alongside a number of other initiatives, the respondents felt it was important to model compassion at all levels, and this scheme enhanced rather than detracted from this overall cultural aspiration. However it was felt there was a risk in 'separating it out' (the recognition of compassion)-with one participant stating *"Will it really change the culture? No. Will it have any massive impact in the long term? No."*

However others were more positive about its impact stating:

"It has exceeded my expectations. I thought it might go flat- but it hasn't Staff say they get a lovely warm feeling when nominated"

An interesting tension in terms of measuring impact emerged in the discussions. There was a recognition that the NHS culture required a measurement element but there were real concerns about how this could be done. How can the impact of the scheme be reported to Boards? Can it be quantified? Should impact be measured by the number of nominations made or by collating evidence of less tangible elements? Precisely how should the 'feel good factor' be captured? The respondents did not provide answers for these questions they posed, however they indicate a number of what may be unanticipated issues that have emerged from the introduction of the scheme. There was also some concern expressed about the potential for a competitive element to develop, for example *"how many badges have you got...?"* This led to suggestions that perhaps the number of certificates of recognition individuals were able to receive should be capped. However one of the features of the scheme is that each individual nominated only receives a badge once, any further nominations trigger receipt of another card. Even so although there were no clear conclusions reached concerning these the issue of multiple episodes of recognition it may be an area of concern becomes more pressing if the scheme expands.

One potentially contentious issue had been discussed at an early stage in the development of the scheme. It was felt by some that a nomination of a member of staff who was subject to disciplinary proceedings or being 'performance managed' because of complaints about their attitude, for example should not be possible. However it was resolved that no-one

was to be excluded, because it is not a value judgement about the individual, but recognition of a 'moment in time' from another individual. If the individual concerned performed a compassionate act, then this moment of compassion existed and could be recognised as part of the scheme. It may be that some of the issues reported here, which have emerged since the scheme was introduced, may require similar resolution in due course.

Whilst concerns were expressed about rewarding behaviour that could and should be reasonably expected by NHS staff, it was acknowledged overall that the scheme was necessary in the current environment of the NHS as the lack of compassion for colleagues in particular, was of concern, and so any organisational effort to address it was welcome. This is particularly important when it is considered that 25% of all NHS staff in report they have been bullied in some way (NHS England 2016). Indeed, the opportunity to reward staff for being compassionate to colleagues does seem to distinguish this award from other initiatives, which tend to focus on compassion for patients. Given the links between staff well-being and compassionate care, this would seem an important component which is often overlooked.

5. Next Steps

Although there were differences in the way the scheme was introduced in the different organisations, and that this difference was important in terms of 'organisational fit', there was a general consensus amongst the interviewees that further work was needed to embed the scheme fully. It was reported that this would involve devising a way to measure impact more accurately, in order to inform future decisions about supporting the scheme financially, once the central funding expired. To this end some were planning to access the NHS Staff Survey to try and determine the impact of the scheme by examining the responses to particular questions. In addition one trust had completed an internal survey focussing on engagement, leadership and compassion which had provided 'a baseline of where we are at'. This survey had a very high response rate of 60% and although the data were yet to be analysed at the time of the interview it was anticipated that the *Leading with Compassion* initiative and the associated recognition scheme would 'score highly'. This in turn would signal areas requiring action in the future.

Similarly in another organisation a follow up survey was planned for 12 months following the introduction of the scheme as it was recognised data was needed concerning the 'personal impact':

"We also want to do an anonymised survey of those that have been touched by the scheme to find out what the personal benefits of them receiving a nomination was when organisations have a groundswell of numbers."

There was also a desire to collect some more detailed and fine grained evidence concerning the experience of people making and receiving nominations.

Whilst commitment to pick up the funding necessary to support the further roll out of the scheme 'in house' had not been agreed for many when the evaluation was being conducted,

most participants thought the scheme should continue. Those responsible for the introduction of the scheme also had plans to integrate it with other activities. For example in one organisation a plan had been developed to link the scheme with a photography competition. The theme for the first part of the competition being compassion, with the aim of producing a calendar for the following year made up of 12 photographs depicting how compassion is enacted in the organisation. Another had plans to produce a 'heat map' of their organisation over time and trace the source of nominations and examine the reasons for this. Another respondent described their idea to link it to the appraisal process by encouraging staff to take their nominations along to their appraisal meeting as evidence that they were acting in accordance with the Trust values. It was also suggested nominations could be included as evidence by professional staff for the purposes of revalidation. This was in direct contrast to the concerns others expressed about being able to persuade their Boards to invest in this scheme, given how difficult it is to evaluate impact in concrete terms, when the NHS, along with the wider public sector, is experiencing a period of austerity.

In terms of the overall roll out of the scheme the next key milestone was the conference organised for 14th February 2017 (see pages 24 & 35). This was referred to several times in the interviews and seen as a point for reflection and consideration of planning the future of the scheme.

Framework Comparison

Considerable work was invested by the *Leading with Compassion* recognition scheme team and the wider Community of Practice to distil the content of the 1500 nominations into a smaller number of descriptors to help make the scheme more manageable and accessible. The framework was developed inductively and at the time of writing is in its ninth iteration and identifies seven 'action themes' and 'impact themes' derived from analysis of the nominations (1500 at the time of writing this report).

Action themes

1. Supporting through distress
2. Role Modelling
3. Recognition of staff
4. Kindness
5. Listening and Assurance
6. Discretionary Effort
7. Maintaining morale through change

Impact themes

1. Feeling Secure
2. Feeling Valued
3. Feeling proud
4. Feeling empowered
5. Direct Improvement in Patient Care
6. Creating or maintaining a positive culture
7. Improved emotional resilience

This framework has been developed inductively from the details of the nominations compiled on the central database. There are a number of models and frameworks of compassion which exist and these are explored here briefly. This is both to locate this important work in a wider theoretical and empirical context and also to identify how this pioneering approach can be further developed if required.

Many of the nominations depict behaviour which could be described as caring. In work to develop a means of measuring compassion, caring was cited as the enactment of compassion and it was found that patients identified compassion as their greatest need (Burnell et al 2013). Therefore recognising caring behaviours, as was evident in the *Leading with Compassion* recognition scheme, is a route to defining and observing compassion. Whilst Burnell et al's work approached the concept of compassion from the patients' perspective, and focused on nursing care rather than the recognition of compassion as enacted for all staff and patients, there are similarities between the frameworks (see below). Burnell et al also report that the ability to exhibit caring behaviours to patients routinely, has benefits for staff in terms of job satisfaction because it is the work they wish to do and in that sense is self fulfilling. Whilst their survey focused only on patients in hospital, and the compassion recognition scheme encompasses a wider range of services (community; commissioning; mental health services), the framework shares some common ground with the analysis of the recognition scheme nominations.

The four elements of compassion identified are:

- 1. Meaningful connection** – establishing personal connections; focusing on the most relevant needs for the patient and acting accordingly.
- 2. Patient expectations** – pain control; careful listening; being respectful; offering clear explanations and giving timely assistance.
- 3. Caring attributes** – provide hope, kindness and understanding; being empathetic; appreciating family /carers needs.
- 4. Capable practitioner** – competence, confidence and requisite knowledge and skill set for role.

(Burnell et al 2013)

It can be seen that the action themes 1 and 5 derived from the analysis of the nominations made as part of the recognition scheme are consistent with the Meaningful connection element of Burrell et al's framework. Similarly 4 'maps' across to Caring attributes, and 6- discretionary effort as identified in the analysis of nominations relates to patient expectations and being a capable practitioner elements found by Burrell et al (2013). In an integrative review of six papers which examined studies of how compassion is measured in nurses and other healthcare professionals, Papadopolous and Ali (2015) identified eight themes which emerged from the appraisal of the papers. These were:

1. Being empathetic,
2. Recognising and ending suffering,
3. Being caring,
4. Communicating with patients,
5. Connecting to and relating with patients,
6. Being competent,
7. Attending to patients' needs/going the extra mile,
8. Involving the patient.

Again there are some commonalities here in that 'Being empathetic' (Papadopolous and Ali 2015) and 'Supporting through distress' (Action Theme) are almost the same. Similarly 'Recognising and ending suffering' (Papadopolous and Ali 2015) and 'Listening and Assurance' (Action Theme) seem to be matched, and indeed are common with Burnell et al's (2013) 'caring attributes'. This indicates a broadly shared understanding of the nature of compassion. However this does not necessarily lend itself to accurate measurement.

The challenges this presents are further demonstrated in two other projects focussed on compassion. In a focus group study, forty five academic staff, health care students, clinicians and service users in nine groups were asked to define compassion in the context of health care (Kneafsey et al 2015). One theme developed from the participants' responses was 'Compassion: 'A big word that you can't summarise in one', which although may be accurate, highlights the difficulties when seeking to study and/or recognise acts of compassion. The other themes were positive communication and consistency, losing compassion: when the system takes over, and supporting compassionate practice (Kneafsey 2015). The latter two themes indicate the importance of the organisational context with

regard to compassion, which was also a focus in a large Cultivating Compassion Project (2015). The project was conducted by a team with members from three universities, four NHS organisations, and service user representatives in the Brighton area. The aim of this project was to develop an awareness of compassion and investigate how compassion can be recognised, promoted and sustained in the healthcare workforce. It had a training element, involved the development of a 'toolkit'- described as a set of resources that enable people to do their work more effectively- and followed a broadly appreciative inquiry approach. In the course of this work a 'menu' of indicators for the multiple and diverse ways in which compassion has been expressed by health service staff in practice was produced. The items were presented as intentionally aspirational in order to generate discussion and think about what could be done differently (Cultivating Compassion 2015).

There were sixty five items identified, organised into themes which are:

1. Towards ourselves;
2. Self -compassion;
3. Supporting each other;
4. Leadership;
5. Organisational culture;
6. Balancing competing demands;
7. Person centred care;
8. Being non-judgemental;
9. Holistic approach to our work;
10. Relating to people.

This framework, whilst including the 'common' elements of support and relating to others, has a much more distinct organisational component-particularly the identification of leadership which resonates with some of the themes arising from the recognition scheme nominations. However this adds further to the emerging picture conveying the complexity of compassion and the difficulties of measuring it.

Based on the premise that without an agreed definition and adequate measures, it is not possible to study compassion, measure compassion or evaluate whether interventions designed to enhance compassion are effective Strauss et al (2016) conducted a review of nine psychometric compassion measurement scales. In this detailed and comprehensive review they found there was poor internal consistency for the subscales of the measures they reviewed, insufficient evidence for factor structure and/or failure to examine floor/ceiling effects, test-retest reliability, and discriminant validity, and concluded a suitable robust scale for the measurement of compassion has not yet been developed (Strauss et al 2016). In response they present a definition drawn from a consideration of a range of definitions from Buddhist and Western psychological perspectives and five components of compassion were identified:

1. Recognition of suffering;
2. Understanding its universality;
3. Feeling sympathy, empathy, or concern for those who are suffering (emotional resonance);
4. Tolerating the distress associated with the witnessing of suffering;
5. Motivation to act or acting to alleviate the suffering.

(Strauss et al 2016)

Again there are parallels here with the Action Themes drawn from the nominations, for example 1 and 1, 1 and 3, and 6 and 4. However as Strauss et al (2016) conclude their review provides a foundation for progressing research into compassion, and more work is needed to investigate the nature of compassion. Further analysis of compassion, as identified through the operation of the recognition scheme, could provide a rich source of data to contribute to the development of knowledge and practice in this area.

Discussion

It is clear that defining and measuring compassion is a complex task, which has been the subject of considerable academic endeavour. This in turn makes it difficult to evaluate the impact of such a scheme on the culture of organisations and to identify precisely where it fits with regard to creating compassionate leadership. However this scheme appears to have intrinsic value in terms of providing data which can be used to stimulate strategic discussions about how compassion is enacted, and in that it can also be used in a number of ways to help raise the profile and the enactment of compassion in organisations. These include:

- Providing information at induction and training sessions about what is expected with regard to compassion and how it is recognised in the organisation(s) involved in the scheme- ‘the way we do things around here’.
- Generating a sense of well-being in both those nominating and nominated. Patients and service users also valued this process.
- Starting the conversation about how organisations can enable or hinder this culture.

Whilst it is difficult to conclusively demonstrate value for money, the running costs are relatively minor and given the nature of the nominations made and the reports from staff in the interviews and focus group, there is the beneficial impact of a noticeable ‘*feel good factor*’ experienced by both nominees and nominators. This is an important cultural aspect for organisations, and the scheme also helps render compassionate acts more visible and helps increase the understanding of their complex nature, as witnessed in many forms.

“People are definitely talking about it so it has had an impact and is good for morale at a difficult time. It is a bit of a tonic to all the mess that is going on”

However a formal recognition scheme will only be effective if it is part of an overall approach to people management and staff engagement (NHS Employers 2015). The way this aspect of the introduction and operation of the scheme was managed varied between organisations and

was dependent on context. For example in some it was closely aligned with the leadership development programme in the organisation, for others it was more explicitly linked to broader organisational values. This was reflected in the experience of staff seeking to make nominations in that they were not always clear how a compassionate act related to leadership, so some clarification of this may be beneficial in the future development of the scheme. There is also a balance to be struck in terms of recognising compassion yet not characterising it as something 'over and above' what would be expected of staff. Again as the scheme enters its next phase some wider discussion of this potential tension may be helpful.

The commitment and effort of the team responsible for the scheme has been crucial to its success, and this is particularly evident in the analysis and development of the action themes that has been undertaken. This moves beyond broad characterisations of compassion arising as it does from the identification of the specific compassionate acts of staff in their interactions with each other and patients/service users. Several of the themes emerging from this can also be identified in other related work, however what is perhaps distinctive about the approach taken in the recognition scheme is the link made between compassion and leadership. Whilst this caused some issues with regards to the nominations, it gives the scheme a clear identity and provides an opportunity to give due emphasis to compassion so that it is seen as central to all activity for both patients and staff.

It was noted in the interviews and the focus group that there is a plethora of award schemes and initiatives in the trusts, and so emphasising that leadership and compassion are synonymous at all levels would be a way of capitalising on this distinctiveness. Schemes which are linked to locally developed values and overall patient care appear to have most support among staff and have the most impact (NHS Employers 2015). In addition, the detail concerning the nominations made as part of the scheme provide a rich source of data for continuing analysis to further and deepen understanding of the nature of compassion. As Blomberg et al (2016) found, although many interventions to improve compassionate care have been investigated (25 in their review) none of the studies they examined presented sufficiently strong evidence of effectiveness to merit routine implementation of any of the interventions into practice (Blomberg et al 2016), however they did conclude that some positive outcomes suggest that further investigation of some interventions may be merited. The practical difficulties of assessing or measuring impact may affect decisions about the longer term funding of this scheme, given that Boards are required to demonstrate value for money prior to making any investment- however small. In view of this it is likely that sustaining this scheme will require a different understanding of what represents value and that the narratives in this report may enable different conversations about impact to begin. The sharing event held in February 2017 (see pages 24 & 35) was arranged to begin the further exploration of these issues.

It is only appropriate to end this evaluation report with the words from one interviewee who described the scheme as a "*roaring success*". She felt that this had raised the notion that compassion is important in the management of staff as well as being crucial in building resilience characterising it (the scheme) as "*a brick in the wall*". She described the scheme as "*a healing balm- you can rub a bit of cream on it!*" and that it "*tells everyone that this is*

what the organisation is really like.” This comment summarises a strong and compelling narrative about the positive impact of this scheme.

Recommendations

The recommendations below are based on a combination of learning from the interviews, focus group and the wider literature. They are intended to support the production of the ‘Good Practice Guide’, to help others to learn from this project. However, as is often the case, the views of those who have yet to experience the scheme may provide further learning and provide a valuable perspective on how to enhance its continuing development.

- Review the relationship of compassion and leadership inherent in the Scheme and consider how this might be developed.
- Review the nomination process and nomination form to ensure the link with leadership is not preventing nominations; and consider if the process could include both a link back to the nominator to let her/him know the award has been sent and include an option to tick a box for anonymity.
- Consider the ‘fit’ of the scheme with wider organisational priorities to inform its future development, and identify a ‘hook’ within the organisation to enable the roll out of this scheme as part of the overall organisational approach to staff well-being.
- Evaluate the range of communication approaches used when launching the scheme to share best practice.
- In addition to the sharing event in February consider the merits of a larger National event. It has been noted that Trusts can learn from each other in this area (NHS Employers 2015), and this could be extended to encompass those who have worked on similar projects nationally.
- Continue to collate and analyse the nomination information as this is a rich source of data for the study and investigation of compassion, however, this will require a sustained resource and funding opportunities may be limited.

Postscript

Compassion Celebration Event-Tuesday 14th February 2017 (See appendix 6 for the programme)

The compassion celebration event had been organised to report on the progress of the *Leading with Compassion* recognition scheme and to consider how it could be developed further. The event was hosted by the George Eliot Training and Education Centre and Sixteen people attended.

It was reported that as of 14th February 2017 a total of 1500 nominations had been received as part of the scheme. It was announced that the George Eliot Hospital was the eleventh organisation to join the scheme and its launch in the Trust was timed to coincide with the celebration event. The first nomination from the George Eliot Hospital was received during the course of the day.

The activities in the morning focussed on updating those present on progress and revisiting the purpose of the scheme. This was followed by a series of sessions designed to explore the potential of the *Your Journey of Compassion* booklet, and different educational exercises, to support learning about compassion based on discussion of, and reflection on a number of the nominations that had been received. Consideration of the action themes was used as a means of examining what may be effective approaches to explaining the nature and impact of the scheme.

In the afternoon there was a session which examined the Psychology of Compassion and its importance in Leadership followed by a report of the evaluation of the scheme. The combination of these presentations generated a wide ranging discussion during which the following issues were addressed:

- Compassion among staff. Staff supporting each other;
- Links of compassion to emotional well-being;
- The relationship of leadership to compassion;
- The potential for measurement/classification of compassion arising from the scheme-useful contribution to knowledge; useful to trusts/organisations as characterising what compassion 'looks like' in different organisations; promotes clarity concerning the meaning of compassion;
- How compassion relates to other organisational values;
- Consideration of an 'honour roll' of acts of compassion on line that could be continually updated;
- Need to embed the scheme in the wider organisational strategies for staff well-being-challenges involved when the range of initiatives/projects underway in organisations is considered;
- The link between recognising compassion and increasing staff resilience.

It was agreed that further discussion of these matters would be required as the scheme enters its next phase.

Summary

Bev Ingram, Regional Clinical Lead for Workforce, Transformation and Innovation at Health Education England drew the event to a close stating that the funding provided for the development of the scheme was 'money well spent'. She recommended that the scheme should be developed and extended further. There were some challenges to overcome and the scheme needed to be aligned with organisational board strategies more closely, however its benefits in recognising the compassionate acts of staff were clear and work should continue to develop the supporting evidence base and best practice guidelines for implementation.

Organisations Participating in the Leading with Compassion recognition Scheme

- University Hospitals of North Midlands (UHNM) NHS Trusts (Acute Hospital)
- Staffordshire and Stoke-on-Trent Partnership (SSOTP)
- NHS Trust (Community and Social Care) Shrewsbury and Telford Hospitals (SATH)
- NHS Trust (Acute Hospital) South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Mental Health)
- North Staffs Combined NHS Health Trust
- Birmingham South Central CCG
- Coventry and Warwickshire Partnership NHS Trust (Mental Health and Community Care)
- Royal Orthopaedic Hospital (Specialist Orthopaedic Trust)
- Robert Jones and Agnes Hunt Orthopaedic Hospital (Specialist Orthopaedic Trust)
- NEB/MCP (Primary care)
- George Eliot Hospital (District General Hospital)

Leading with Compassion Recognition Scheme Nomination form

This is your chance to show your appreciation for an act of compassion, please complete the simple form below to send the individual a leading compassion badge and card within a fortnight.

Thank you for caring.

Your Name (required)

Your Email (required)

Your Phone Number

Nominee Name

Nominee Job title

What team does this person work for?

Where do they work?

Which organisation do they work for?

Reason for Nomination

How did this person lead with Compassion?



What was the impact on you? And/or others?



- Are you happy to be contacted about this nomination.
- Information stored and transmitted from this form is not encrypted, please confirm that you have not included any personal or patient information (required)

Evaluating the Leading with Compassion Recognition scheme across Staffordshire and Shropshire LETC

Semi-structured interview schedule:

1. Introductions, restatement of purpose of the interview. Confirm consent.
2. How did you first become aware of the Leading with Compassion Recognition scheme?
3. What do you understand to be the purpose of the Leading with Compassion Recognition scheme?
4. Could you tell me a little about how it was introduced?
Was there board support? How was this demonstrated?

Were workshops held to explain it?

Were certain wards/units selected (if yes why)?

Was there an overall plan?

5. What were your specific responsibilities with regard to the Scheme?
6. How was it received by staff?
7. Were there any particular challenges?
8. What has been the take up?
9. Have there been any noticeable benefits?
10. What advice would you give to colleagues wanting to introduce the scheme to their organisation?
11. What are the plans for the next stage of the development of the scheme?
12. Overall how would you rate the success of the scheme
Key indicators?

Impact?

Evidence?

Thank you

Evaluating the Leading with Compassion Recognition Scheme in Staffordshire and Shropshire LETC

Focus Group Interview schedule

1. Introductions, restatement of purpose of the interview. Confirm consent.
2. Can you recall how you became aware of the leading with compassion recognition scheme?
3. What do you understand to be the purpose of the leading with Compassion recognition scheme?
4. Could you tell us a little about your experience of the scheme?
 - how/why were you nominated?
 - how/why you nominated someone?
 - was it a straightforward process?
 - how was compassionate care defined/identified in your case?
5. What has been the reaction from colleagues/patients?
6. Has it had an impact on how you view your trust?
7. Have there been any noticeable benefits?
8. Has getting the award affected your work?
9. What are your overall views of the scheme?
10. Do you think it should continue?
11. What are the advantages of the scheme?
12. What are the disadvantages of the scheme?
13. Are there other ways compassionate care could be recognised?
14. How can compassionate care be supported?
15. Is there anything else you think it would be helpful for us to know about the scheme?

Thank You

Evaluating the Leading with Compassion Recognition scheme

Oral consent script

Hello, my name is ___ ___ from University of Birmingham. Thank you for agreeing to take part in an interview for this study [briefly explain the study]. The interview will take approximately 45 minutes of your time.

Your participation is entirely voluntary, and you can stop the interview at any stage if you wish. The potential risks of this study are minimal and your anonymity will be guaranteed.

Do you have any questions about the evaluation or what taking part will involve [refer to information sheet if necessary when answering questions]? If you have any questions about the evaluation after the interview has finished, please contact Yvonne Sawbridge who is leading the study. Yvonne's details are on the information sheet that you were given.

Before we get underway with the interview, do you give your permission for me to record our conversation? [If participant does not agree to recording] I will take some notes during the interview as a record of the conversation.

I am now turning on the recorder and we will start the interview.

Participant name :....

Date of interview:

Researcher signature:.....
(Researcher to sign to confirm that consent script has been followed)

Appendix 6

COMPASSION CELEBRATION EVENT AGENDA & TABLE OF CONTENTS

A Day to celebrate compassion		
10:00	Welcome and introductions	Rob Cragg – Deputy Director People and Strategy. North Staffordshire Combined Healthcare NHS Trust
10.15	Our journey of compassion	Laura Rogers, Shropshire and Staffordshire Leadership Lead
Sharing the themes of compassion		
10.45	Bringing our learning to life	Jane Rook, Shropshire and Staffordshire Leadership Lead
10.50	Coffee Break	All
11.05	Experiencing real life case studies	All
Reflections		
12.35	How has that experience changed your opinion of compassion?	All
12.45	“The Psychology of Compassion and its importance in Leadership”	Dr Sarah Lehmann - Assistant Director of Human Resources/Head of Organisational Development. University Hospitals North Midlands.
1.15	Your feedback on the West Midlands model and themes of compassion	All
1.25	LUNCH	All
Impact and evaluation		
1.55	Impact on individuals, teams and organisations – University of Birmingham formal evaluation feedback	Alistair Hewison, Senior Lecturer, Birmingham University
Pulling it all together – so what?		
2.25pm	Next Steps – how can we progress this model of recognition?	Rob Cragg
2.45pm	Individual pledges	Jane Rook
3.00pm	Summary and reflections	Bev Ingram - Regional Clinical Lead Workforce Transformation & Innovation
3.15pm	Finish and close	

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