



Leadership in
Compassionate Care



Leadership in Compassionate Care Programme Executive Summary

June 2012

Enhancing Patient Care by promoting compassionate practice

Executive Summary June 2012



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Introduction and background



- 1.1 The Leadership in Compassionate Care Programme (LCCP) commenced in 2007 as a three year programme of work. Initial funding was received from a private benefactor and the two organisations involved in the programme (NHS Lothian and Edinburgh Napier University) were required to match this funding. The work of the programme developed beyond the initial funding. A Lead Nurse and four Senior Nurses were appointed to deliver the programme and a wide range of staff from both organisations were actively involved and participated with this team. The impetus for this programme arose from local and National concerns about care focussed on patients and their relatives experiencing a lack of empathy and compassion, acknowledging that it is often small acts of kindness and a human connection, alongside clinical competence that is appreciated by patients and relatives.
 - 1.2 Throughout the lifetime of the LCCP there has been an increasing focus, both national and international, on care and compassion within health services (Firth Cozens and Cornwell, 2009: Healthcare Commission, 2009: Maben, Cornwell and Sweeney, 2010: Parliamentary and Health Service Ombudsman, 2011). Maben (2008) identified that our current inability to consistently articulate and measure compassionate care, results in other aspects of practice, which are more easily defined and measured, taking precedence, for example rates of hospital acquired infection. It was evident that there was a significant need to focus on the area of compassion within the NHS, specifically ways to articulate what it is, develop measurement tools and techniques, and actively support staff to identify what is already good practice and actively develop further and enhance practice.
 - 1.3 A unique feature of this programme which was vital to its success was the forging of a strong partnership between Edinburgh Napier University and NHS Lothian with support and involvement from the highest level in both organisations. Individuals holding key positions within NHS Lothian, including the Executive Director of Nursing, Chief Nurse and a representative from Continuous Professional and Practice Development were invited to join the programme team and a broad aim was developed - to embed compassionate care as an integral aspect of all nursing.
- ### Purpose and objectives of the LCCP
- 1.4 The LCCP encompassed four key strands of work which deliberately spanned across nurse education and clinical practice and several points in a nursing career. The four strands included:
 - i. Establishing NHS centres of excellence in Compassionate Care (Beacon Wards, Development Sites, Development Units)
 - ii. Supporting development of leadership skills in Compassionate Care (The Leadership strand).
 - iii. Embedding the principles of Compassionate Care within the undergraduate curricula within nursing and midwifery.
 - iv. Supporting newly qualified nurses during their first year in practice to facilitate the transition from student to competent and compassionate staff nurse.

- 1.5 In regard to these four strands, the objectives of the LCCP were to:
- Develop and embed compassionate care in both clinical practice and nurse education
 - Develop a working framework for compassionate care that enables clear articulation of this approach, and measurement
 - Develop a transferable practice development programme that enables in-patient NHS staff to demonstrably develop and measure compassionate care practice.
 - Support the development of clinical leaders in compassionate care across NHS Lothian.

Strand 1

Leadership in
Compassionate Care 

*Establishing NHS centres of excellence in Compassionate Care
(Beacon Wards, Development Sites, Development Units)*

2

This strand involved three phases:

- 2.1 **Phase 1:** The Beacon Strand of the Leadership in Compassionate Care Programme (LCCP) aimed to establish NHS Lothian centres of excellence in compassionate care.
- 2.2 A robust selection process was devised. In total, eighteen wards submitted a portfolio, six wards were shortlisted and following assessment visits to these wards from senior staff from NHS Lothian and Edinburgh Napier University, four wards were chosen to become Beacon Wards¹. Those wards that were unsuccessful in their application were invited to select staff from their area to join the Leadership strand of the LCCP.
- 2.3 The purpose of this work was to understand what compassionate care looked like and develop key indicators and processes which identify and enable compassionate care to happen. The aim was to systematically discover the best of what is and what has been.

We wanted to focus on what is working, rather than what the problems were. Four senior nurses worked with selected wards within NHS Lothian. These wards worked alongside the Senior Nurses for 9 months and 2 - 3 days a week to:

- Explore what was happening with regards to compassionate care;
 - Role model compassionate care;
 - Work with staff to identify development opportunities in delivering compassionate care;
 - Support staff to implement change;
 - Support staff in their development and learning beyond beacon ward.
- 2.2 **Phase 2:** Four development sites² were identified through a more streamlined yet robust process to test out the methods and processes understood from the Beacon phase and assisted staff to develop their relationship centred, compassionate care practice. The remit of this phase was to:
- Explore what is already understood from the beacon wards and look for this in the development sites;
 - Search for further evidence of compassionate care and how it is delivered within the development sites;
 - Enable the ward team to identify and try out ways of working that enhance compassionate, person - centred care;
 - Role model compassionate care;
 - Support staff to implement sustainable change;
 - Support staff to share their learning and development with other practitioners.

- 2.3 **Phase 3:** The aim of this phase was for the LCCP team to work with as many ward areas³ as possible to identify and develop strategies that would facilitate sustaining this theme over-time post the completion of the LCCP. The team worked with wards that were grouped together as part of a service and had the same line manager. In total throughout the 3 years of the programme 28 clinical areas were involved in the programme.
- 2.4 The work of this entire strand was underpinned by adherence to ethical considerations and appropriate permissions obtained. Three theoretical concepts were followed during this strand; relationship centred care, a participatory action research approach and appreciative inquiry.
- 2.5 To develop a shared purpose and vision, a Beliefs and Value Clarification practice development method was used. This created an early opportunity for the Senior Nurses to develop relationships with ward staff. Consistent with the Appreciative Inquiry approach, staff were able to envision their aspirations for the future, 319 staff participated in these sessions. The Royal College of Nursing's Dignity resources were also used as a resource in focus groups, enabling staff to explore issues of dignity and care, this involved 46 participants and 7 focus groups.
- 2.6 Formal and informal observation processes were used in order to uncover aspects of compassionate care and these were shared and reviewed with staff. In the initial stages of participation in the programme, staff found it difficult to articulate aspects of compassionate care, observation was helpful in uncovering compassion in the seemingly 'ordinary' elements of care. Fifty two episodes of formal observation were undertaken.
- 2.6 In addition, image work [photographs] were used as a quick and flexible tool to facilitate staff exploring their understanding of compassionate care and providing feedback about a range of issues, 269 staff participated in this. An output example is the use of a digital photo frame, relevant images were selected to form a background to a series of statements about positive care practices. This process linked images and words, the purpose was to make the positive care practice visually striking and more memorable. The positive care practices were used in this format to provide a basis for discussions with staff about compassionate care and reinforce positive ways of working. Images were also incorporated into feedback cards, these posed the questions: what have we got right for you in the ward, and what would help to make your experience better? These cards provided an opportunity for quick feedback from patients, relatives and staff and provided further evidence supporting positive care practices and identifying areas for development.
- 2.7 The use of Emotional Touchpoints was a particularly significant development in the LCCP. The process of using emotional touchpoints as a way of hearing the voices of patients, families and staff and the learning arising from these stories directly influenced change on the wards in the form of a range of action projects. The changes not only focused on practical solutions but provided a platform for discussing some of the more complex cultural and contextual aspects that contribute to the delivery of compassionate care. Seventy eight patients, forty nine relatives and one hundred and seven staff participated in this activity.
- 2.8 To support the Charge Nurses who were leading the programme in Beacon Wards action learning sets were employed. The inclusion of the process of action learning helped participants to explore challenges to developing compassionate caring practice in their areas. Action learning continued to be utilised as part of the leadership programme (strand 2) and staff from Development Wards and Units also participated in this process.
- 2.9 A principle of real time feedback was adopted throughout the processes identified above. This involved making a deliberate

attempt to feed back information to staff as soon as practicable after the data was collected. A range of feedback mechanisms were employed to make evidence accessible to ward staff giving consideration for example to large multidisciplinary teams and the shift patterns. Feedback took the form of group discussions, sharing information at handover sessions, meetings and information placed on ward notice boards and in folders.

2.10 In response to the data collected and in partnership with staff a wide range of local action projects were identified, undertaken and reviewed. An iterative and collaborative process between the LCCP team and staff was essential, where possible patients and relatives were involved in these developments. Examples of action projects include:

- Developing information for visitors in response to a relative's story about the anxieties of visiting a hospital patient during the night.
- Establishing relatives rounds and relative clinics in response to evidence identifying a need for more effective communication and emotional support.
- Implementing monthly sessions where staff share positive caring stories from practice.
- Implementing the offer of toast rounds/ snack rounds in the early evening for ward patients.
- Learning more about patients and staff as people through implementation of a framework of questions integrated into the patient admission or staff recruitment process

2.11 Towards the end of the programme, 'exit interviews' were undertaken with staff and these facilitated gaining in-depth feedback including both positive and negative comments. These data gave an opportunity to identify areas for further development,

take another look at practice, generated new ways of working/thinking and reinforced staff's awareness of their ability to bring about change. Overall, staff were able to consider progress rather than seeing this as an end point. One hundred and forty staff participated in exit interviews.

2.12 During the three phases of working with Beacon Wards, Development Sites and Development Units, a continuous and iterative process of data analysis was undertaken by the team. A framework identifying key themes and sub themes in regard to the provision of compassionate care were developed. Six key themes were developed and these provide the focus for future practice development activity and research. The six key themes identified were;

- **Caring conversations**
Discussing, sharing, debating and learning how care is provided, amongst staff, patients and relatives and the way in which we talk about caring practice
- **Flexible, person centred risk taking**
Making and justifying decisions about care in respect of context and working creatively with patient choice, staff experience and best practice.
- **Feedback**
Staff, patients and families giving and receiving specific feedback about their experience of care
- **Knowing you knowing me**
Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done
- **Involving, valuing and transparency**
Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done
- **Creating spaces that work**
the environment: The need to consider the wider environment and where necessary be flexible and adapt the environment to provide compassionate care

Key Learning Points

Organisational

- Creation of dedicated opportunities for staff to have caring conversations, sharing perspectives about care and discussing practice. This needs encouragement and facilitation at local and organisational levels.
- Linking, aligning and integrating compassionate care activities to other organisational processes, targets, and quality initiatives would be imperative.
- The necessity of senior management support - e.g. local action groups, led and supported by senior staff, focused on quality improvement and taking forward compassionate action projects. Managers being proactive in their support, e.g. doing weekly 'walk-abouts' in the ward area, and asking staff about the outcomes of initiatives such as the implementation of relative rounds.
- Reflective forums such as action learning greatly enhanced staff's ability to learn from practice, take forward change and develop transformational leadership skills. (However due to service pressures, very few staff were able to continue with action learning following completion of the Leadership strand of the LCCP also few staff accessed clinical supervision).
- Committed senior staff in both organisations who are actively involved in supporting development of compassionate care and who have the authority to support changes to local practice.
- Expansion of the Leadership programme - in particular the opportunity this brings to increase and maintain capacity for leadership in compassionate care across the organisation.
- Patients and families involved in shaping service development and inform pre-registration curriculum delivery.
- Treating staff and students with dignity and respect as well as patients and families.

Interpersonal Communication at all levels

- The provision of emotional support for senior nurses and staff involved in taking forward compassionate care developments was important
- In using a relationship centred model this valued not just the perspectives and experiences of patients but of families and staff and students. Staff felt their voices were also heard.
- Recognition between staff of the complexity of this work and the emotional investment required. One manager stated that this was the hardest initiative she had ever been involved in taking forward.
- Working alongside people in their practice (both clinical and educational) helped to role model, question practices, and feedback about the less obvious or easy to articulate dimensions of compassionate care.

Processes used in LCCP

- Methods used within the programme (such as emotional touch points and observation) helped to get at the heart of what people felt and provided a powerful lever for development and learning. Staff needed skilled facilitation in order to take this forward.
- Appreciative inquiry - supported people to examine and learn about what worked well rather than focusing on problems.
- Action research helped staff to collaborate with the team, take forward and evaluate changes that were relevant to local practice and context.
- Opportunities to reflect, when staff were able to devote time to learning lessons from the experience of others worked well.

Strand 2

*Supporting development of leadership skills in Compassionate Care
(The Leadership strand)*

3

This theme was also underpinned by a relationship-centred approach with an explicit focus on appreciative inquiry and the Senses Framework (Nolan et al. 2006). It aimed to ensure that:

- Participants had an equal opportunity to participate in the programme and to have their voice heard;
- Participants' understanding of their own situation was enhanced;
- Participants' understanding of the situation of others in their work environment, especially their work colleagues, patients and family carers was enhanced;
- Participants were encouraged to take action and develop aspects of their practice/work situation in response to local evidence gathered during the programme.

The Leadership programme involved participants attending study days (n=10), receiving individual coaching and participating in action learning sets over a period of 11 months. In total 106 participants have participated in the leadership programme, the programme has run annually over three years. Participants have included nurses, allied health professionals and one doctor. During the programme participants were required to identify and develop an action project within their clinical area focussed on an aspect of compassionate care. Processes such as emotional touch point interviews, observation of care were presented at study days and participants were encouraged to utilise these processes within their clinical setting. Gathering evidence of experience in this way would provide the basis for their local action project. At the end of the programme

participants gave a short presentation to peers and managers about their experience of undertaking the leadership programme and their action project. Study days and action learning were evaluated; participants took part in focus groups where they reviewed their experience of the programme.

Whilst the programme itself would not provide participants with greater resources, the intention was that it would enable them to deal with competing demands more effectively and equip them with the skills to motivate their teams so that they were more supportive of change.

For most participants, the programme as a whole, and the 'Senses Framework' in particular, resulted in some quite profound changes, not only to their views on compassionate caring but also to their understanding of themselves. Several participants described improved confidence, assertiveness and the ability to delegate - all key leadership attributes. Moreover, participants' sense of purpose and achievement seemed to have been improved significantly and, for some, this had an almost 'existential' effect leading them to reflect on who they were, both professionally and personally.

The Leadership programme has empowered participants to initiate change, and in turn stimulate and lead others to think anew about 'the way things are done'. But having encouraged and enabled these practitioners to engage in 'courageous conversations' it is essential that they continue to enjoy the support they need to maintain, and indeed to extend, their dialogue.

Key Learning Points

- Enhancing personal skills within the Leadership in Compassionate Care Programme demonstrates that health professionals each possess the capability to deliver relationship-centred compassionate care more effectively when they recognise and utilise their leadership and influencing capacity.
- It is clear that focusing on the 'being' dimension of care produced positive effects for patients, their relatives and the multi-professional team.
- From active participation and leading projects which were centred on Compassionate Care raised participants' confidence and self-belief. We believe that participants have been empowered to optimize their leadership capability using autonomous motivation as a personal resource.
- Our findings support existing leadership research and extend our understanding of how personal leadership can be taught and nurtured through engagement, motivation, participation and support.

Strand 3

Leadership in
Compassionate Care



Embedding the principles of Compassionate Care within the undergraduate curricula within nursing and midwifery

4

This programme strand, focused on the undergraduate curriculum, and had two phases. The first phase involved conducting focus groups to explore lecturers' and students' views, values, attitudes and engagement in the principles of compassionate care within education and practice. The second phase used these findings to enhance the learning, teaching and assessment of compassionate care within the undergraduate programme through the development and delivery of a range of action projects.

Phase one

Ethical Approval was obtained from Edinburgh Napier University's Ethics Committee. Eight focus group discussions were held with Lecturers and students. Twenty eight lecturers (all 5 branch programmes were represented) and fifteen students participated.

The questions discussed at the groups focussed on:

- What does compassionate care look like;
- Values about providing compassionate care;
- Experiences of teaching and learning about compassion in both the university context and clinical practice.

With permission, the focus groups were audio taped then transcribed. Data from transcriptions and notes (from an observer) were analysed using constant comparative analysis. All researchers were collectively involved in the analysis process. Each analysed their own group then a comparative analysis between focus groups was conducted.

Findings

Following the analysis of all the focus groups three key themes emerged.

1. Understanding and demonstrating compassion
2. Is there a cost to being compassionate?
3. Can compassionate care be learned?

Understanding and demonstrating compassion

Providing compassionate care involved demonstrating behaviours that were described as ordinary and subtle, however despite their subtlety, they were identified as having a significantly positive impact on care. Developing an understanding of compassion requires careful observation, reflection and development of insights that impact on the practitioner's ways of working.

The importance of positive role modelling of compassion from clinical staff to patients, and academic staff to students was highlighted as an important feature of experiential learning and instilling a culture of compassionate care.

Is there a cost to being compassionate?

The costs of providing compassionate care were identified as financial, emotional and related to time. These three factors were identified as interrelated. Financial pressures within the NHS result in an increasing focus upon efficiency and fast throughput of patients through our healthcare systems. Healthcare is an important but limited resource that requires robust management. Focus group discussions highlighted a tension between this situation and the time it takes to provide compassionate care, but also the emotional frustration of wanting to provide a level of compassionate person centred care within the parameters of this current system. Polarised views were expressed in discussions about the time required to give compassionate care: compassionate care takes a long time, to views that it does not take any additional time.

Can compassionate care be learned?

There was a consensus that an objective of the undergraduate curriculum is to nurture compassionate caring attributes amongst student nurses and midwives. The term nurture was positively acknowledged in preference to the terms, teach and learn. This is related to building upon and developing existing caring attributes. Participants highlighted the recruitment process for student nurses and midwives and the importance of identifying compassionate caring attributes in the selection process.

Phase 2:

In the second phase six action projects were undertaken to use the findings from phase 1 to enhance the learning, teaching and assessment of compassionate care within the undergraduate programme. The action projects were:

1. Use of Patient Stories derived from clinical practice integrated across the undergraduate curriculum to enable an understanding of compassionate care;
2. Feedback to Placement Areas involved consideration of how students alongside their Mentors and Practice Education Facilitators could provide feedback about their experiences of compassion and caring;
3. Developing relationships in busy environments and assessing compassion skills;
4. Supporting Lecturers involved the consideration of developing proactive ways of dealing with the emotional costs associated with the provision of compassionate care to students and practice staff;
5. Enabling candidates to demonstrate their compassionate and caring attributes during recruitment and selection.
6. Including compassionate care as a component of a student's personal development planning process.

Key Learning Points and future development

- **Project 1 Using stories within the curriculum:** The stories derived from clinical practice as part of the LCCP provided valuable insight into the patient, relative, staff and student experience. Stories have been made available as podcasts. A range of activities, such as story week were undertaken to highlight this resource to academic staff, further work is required to raise awareness and use of these stories within the school. Stories are being used in a number of forms in teaching, learning and assessment activities and evaluation is ongoing.
- **Project 2 Feedback to placement areas:** Lead mentorship forums will provide the appropriate focus for the dissemination of good practice in compassionate care. It has been agreed that an Appreciative Inquiry approach will be used to provide feedback to placement areas. The successful Edinburgh Napier University WebCT based 'mentor-centre' provides the focus for highlighting and exploring student and mentor stories. The Mentorship training programme is the vehicle to target learning related to compassionate care: what it is, how it is experienced and how this is demonstrated and valued in busy working environments.
- **Project 3 Developing relationships and assessing compassion:** An existing Year 3 module 'Recognising Acute Illness and Deterioration' was used as a vehicle to explore the teaching, learning and assessment of compassionate care. The process of change used to make compassionate care more explicit within this module has been shared with colleagues as one example of how stories can be used successfully to influence teaching learning and assessment within the nursing and midwifery programmes.
- **Project 4 Supporting lecturers:** The supporting lecturers' action project provided a restorative space through a series of four facilitated three-hour workshops over a period of nine months. Through the development of a collaborative supportive network within the group and utilising creative approaches such as collage, participants were able to provide support to each other and to identify and participate in actions which could lead to positive change within the School.
- **Project 5 Identifying compassion at recruitment:** From the data a list of values-based personal attributes was derived which will be used to create a person-specification for prospective nursing and midwifery students. It is aimed that this will focus future candidates' awareness of the importance of compassionate care in preparation for their interview whilst providing those involved in recruitment a benchmark for selection.
- **Project 6 Incorporating compassionate care within Personal development planning process:** Interviews with students identified value in the role of the Personal Development Tutor (PDT) in regard to provision of academic support, the personal qualities of the tutor and the demonstration of compassion towards students. Lecturers identified the PDT role as providing academic support for example guidance with assessment, providing a professional relationship, namely a constant point for contact and a sense of belonging. Positive and challenging elements of the PDT role were identified such as finding a balance between academic and pastoral support. Lecturers also identified support needs for this role, e.g. a form of supervision. The next stage of this action project will be to explore the potential for an adapted version of the Senses Framework to further analyse data and consider this to be utilised within the actual PDT processes. On the basis of this recommendations will be made in terms of enhancing compassionate care within the PDT role.

Strand 4

Supporting newly qualified nurses during their first year in practice to facilitate the transition from student to competent and compassionate staff nurse.

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This theme involved newly qualified nurses during their first year in practice, taking part in a number of specifically tailored study days. Within the study days a range of teaching and learning activities were undertaken. Five study days were held each year and newly qualified practitioners were invited to each. Study days included a motivational presentation from an experienced health care provider, interactive sessions focussed on compassionate care, small group activities that linked to the NES Flying Start™ programme for registered health care practitioners. Participants were able to complete an aspect of their portfolio as a result of this activity. Participants also took part in small reflective groups where they shared their experiences and supported one another, this was highly valued. Creative activities were incorporated into the study days, these were focused on key themes from the LCCP, for example the Clown Doctors ran sessions on communication and feedback. Evaluation of the study days involved participants completing study-day evaluation questionnaires, comments indicated that the relaxed atmosphere of the study days, in conjunction with their content, made these a positive and thought-provoking experience with the potential to enhance participants' practice.

Participants in the study day had the opportunity to take part in qualitative research, the research question was: To explore newly qualified staff nurses' perceptions of compassionate care and factors that facilitate and inhibit its delivery

A constructivist grounded theory approach was adopted and the study was carried out with participants during their first year following registration. Data collection was by focus group interviews (n=7, total participants =42), small group interviews (n=1, participants = 2) and individual interviews (n=2), using a flexible agenda to guide discussion but which ensured

that participants were able to address issues relevant to them within the remit of the research questions.

Findings of the study identified that support for newly qualified staff was eclectic rather than systematic with participants stating that they did not realise at the time how supported they had been during their undergraduate practice placements. Some participants considered that the undergraduate curriculum should focus in final theory and placements on the realities of practice rather than providing what they considered to be an idealised view. Participants felt that they were 'flung in at the deep end' and 'left to sink or swim'. Some staff were perceived as being 'in with the bricks' and resistant to change of even a minor nature, creating an environment described by one participant as 'institutionalised negativity'. Clinical supervision was perceived as a very positive support in areas where it was used and a 'buddy' system was suggested by one focus group.

Compassionate care was a tautology for most participants i.e. care would not be care in the absence of compassion. The concept was frequently described by examples of situations in which compassion was not present. Nursing was described as 'more than just a job' and an occupation in which 'emotional engagement' is not only desirable but is a prerequisite for provision of high quality care.

The findings indicated a tension between 'agency' i.e. the ability of individuals to act and 'structure' i.e. the physical, social, managerial and cultural environments within which care takes place. Supportive environments facilitate provision of compassionate care although individuals are accountable for their own practice regardless of the structures within which they operate.

Key Learning Points

- There are implications for the undergraduate programme in preparing students for the reality of practice i.e. providing strategies to deal with the transition and advice about support mechanisms that will be available to them e.g. clinical supervision.
- There are implications for managers of care settings in ensuring that support systems are in place to reduce the feelings of initial inadequacy and eclectic support described by staff nurses in this study. Support systems need to be formalised rather than ad hoc.

Recommendations

Leadership in
Compassionate Care 

*Future recommendations from the LCCP for NHS Lothian
and Edinburgh Napier University*

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Organisational

- Recognition that compassionate care requires high levels of skill and ongoing training and support. An example from practice where staff need ongoing support: altering patient documentation to ensure we ask people about what matters to them when they are in hospital. Working with patient responses to these questions can be hard and challenging for staff;
- Staff and students should continue to be encouraged, supported and trained to understand from the patient and family perspective how care is experienced and how this can lead to developments in practice;
- Recognition of the emotional intelligence required to do this type of work. Consideration given to how we value and support this more, for example staff participating in action learning, clinical supervision;
- Consideration given to how to develop measures of people's experiences of giving and receiving compassionate care and embed this routinely into organisational learning, development and governance processes;
- Consideration given to how to develop measures of compassionate care that matter to people;
- Co-ordinate and integrate the work of the LCCP with other quality initiatives.
- Pull together existing resources across NHS Lothian that seek feedback about experiences of care, make access to these easier, minimise duplication and maximise organisational learning and development;
- Examine the extent to which appreciative approaches may inform quality activity across the organisation.
- Identify how staff challenge evidence of conflicting values about compassionate care within the organisation;
- The approach of relationship centred care, appreciation and principles of compassionate care could be made more explicit across a range of organisational processes and activity e.g. induction, mandatory online learning modules, complaints process;
- Consider how can we identify and share positive care practices and the processes that enable these to happen in a more systematic way across both organisations;
- More opportunities to include a wider group of leaders in compassionate care (to date

have attracted nurses, AHP's, Medical staff, Educators and support staff - however recruitment of wide group could be developed further);

- Share and embed compassionate care leadership skills across existing development and training programmes;
- Continue to develop capacity of leaders in compassionate care - including senior management;
- Consider greater scope for senior management to support, encourage, value and inquire about compassionate caring;
- Debate how can we truly value and incentivise compassionate care;
- Consider how to promote day-to-day activities that demonstrate organisation wide

commitment to compassion, actions such as reading patient stories and resultant actions at board meetings; incorporating or highlighting aspects of compassion within existing audit activity; celebrating student learning and achievement in compassionate care.

- Find ways in which compassionate care is identified as an organisational priority in line with other aspects of care e.g. infection control and prevention of falls.
- Consider a range of ways in which to communicate and share compassionate caring evidence e.g. intranet, raising awareness sessions etc.;
- Consider communication of more explicit messages to indicate organisations value and commitment and prioritisation of compassionate care.

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¹ Beacon Wards were: acute medicine for older people, older people with enduring mental health conditions, respiratory and stroke care.

² Development sites were: Rehabilitation in mental health, older peoples and palliative care, combined assessment area and a national unit for neuro-rehabilitation of brain injury.

³ Phase 3 Ward areas: 3 areas within maternity services across two sites, 3 discharge lounges/medical day care areas across three sites, 3 surgical wards, 5 inpatient community services across three sites and Clinical Neurology 3 areas on one site.

Wordle™ result of entire final report



