

Title

Using Appreciative Inquiry to develop, implement and evaluate a multi-organisation 'Cultivating Compassion' programme for health professionals and support staff

Abstract

The 'Cultivating Compassion' project was developed in response to a research and innovation call relating to compassion training for National Health Service staff in the South East of England. The project aims included: the use of Appreciative Inquiry to develop, implement and evaluate a sustainable and evidence based programme of compassion awareness training through engaging with a diverse group of health professionals and support staff; an evaluation of a 'train the trainers' approach; and an evaluation of 'compassion lead' roles and a multi-modal compassion toolkit. The project team included academics from two universities and one medical school, NHS staff from three separate organisations, and service users. The participants recruited to the study included doctors, nurses, receptionists, chaplains and others working in close contact with service users from within four NHS organisations in the South East of England. The main findings from the project using thematic analysis from participant focus groups and interviews identified: project enablers and inhibitors; the value of project resources; and shifts in perspectives. Project conclusions highlighted the importance of effective senior level support and organisational leadership in cultivating compassion within a healthcare organisation and the importance of the integration of compassion-promoting resources within existing staff development initiatives.

Introduction

Compassion is not a new concept. It has been described and debated as a religious and secular value and virtue, as an emotion, a psychological process, a political phenomenon, a core value in health professional practice and as a topic of empirical research for some time. The word 'compassion' comes from the Latin 'co-suffering' or 'to suffer together with' (Austin et al. 2013). It captures two different ideas: recognition of and identification with the suffering of others; and a motivation to help, that is, to respond to relieve the suffering (Chockinov 2007).

The Cultivating Compassion Project was developed in response to a request from Health Education Kent Surrey & Sussex (HEKSS) to provide 'compassion awareness training'. The call document stated that: 'Compassion is an integral part of delivering good outcomes in healthcare' and relates to the values in the NHS Constitution (DH 2015):

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 2015:5)

The impetus for the call was in response to the Francis reports (Francis 2010, 2013) which detailed numerous care failures that resulted in the avoidable distress, neglect and deaths of patients. These reports indicate that the values of the NHS Constitution are not always enacted. In the call for bids, HEKSS highlighted the fact that the Secretary of State had issued a mandate to Health Education England (HEE) to deliver 'high quality, effective, compassionate care: Developing the right people with the right skills and the right values' (DH 2013).

A research team from two universities, one medical school, four NHS organisations and service users collaborated together to design, implement and evaluate the project. The project built on previous research, practice and educational expertise in the areas of professionalism and ethics in healthcare practice. The project had funding for one year and it aimed to develop a sustainable programme of 'compassion awareness training' that engaged with diverse healthcare staff within the partner organisations across the region, building on existing compassion initiatives. The nature and purpose of the research element of the project was to generate an evidence base for the implementation and evaluation of the compassion training programme.

Literature Review

Compassion is recognised as a core value within the NHS Constitution, in professional codes,

several policy documents relating to high quality service delivery, and in the Prime Minister's Commission Report on the Future of Nursing and Midwifery (NMC 2015, DH 2015, DH 2013, DH 2012, DH 2010). A significant number of empirical and philosophical studies on compassion have been published in the nursing, care and ethics literature. These papers were identified through online professional databases and included if they demonstrated rigour as well as relevance to the development and maintenance of compassion for people accessing healthcare services and for a variety of health professionals, students and support staff. Research from many countries and using different methodologies were included in the review. For example, Torjuul et al (2007) conducted a qualitative study of nurses and physicians regarding compassion and responsibility in surgical care in Norway. Van der Cingel (2011) investigated compassion in relationships between nurses and older people using in depth interviews in a variety of setting within the Netherlands. Curtis (2012, 2013) identified student nurses' socialisation in relation to compassionate care in the UK using Grounded Theory.

A significant contribution to our knowledge of the impact of interventions on compassionate practice come from data collected as part of the Leadership in Compassionate Care Programme (Adamson et al 2012), a 3 year appreciative action research project run by NHS Lothian and Edinburgh Napier University which emphasises the centrality of developing leaders who can embed compassion within effective, relationship centred care.

The King's Fund report '*Seeing the person in the patient*' (Goodrich and Cornwell 2008) suggests that improvement in patients' experience of care requires the cooperation and effort of all staff who have direct contact with patients, with encouragement and support from the wider organisation. This operates at 4 levels: the individual, the team, the institution and the wider health system. Such improvement is a function of both organisational and human factors which interact in complex ways. Leadership for improvement at team and institutional levels becomes critically important in the support of compassionate care in the light of evidence which suggests that staff wellbeing is an antecedent to patient care performance (Maben et al 2012, West and Dawson 2012, Smith 2008).

Curtis (2013) identifies a new grounded theory of student socialization in compassionate practice, using in depth interviews and that the giving of compassionate care involves an emotional endeavor. Student nurses experience dissonance between the professional ideal of compassion and the practice reality they witness. Students manage this dissonance by balancing their intentions to uphold the compassionate practice ideal or relinquish it in order to survive reality. Essentially the student or carer must be:

able to understand another's suffering, empathise with their situation, think that suffering

is terrible and therefore want to relieve the suffering by doing what is best for that person. Curtis (2013:212)

Yet, in relating to and empathising with the patient, healthcare staff must also be professional - thus an emotional balance between utilising feelings of empathy with professionalism in the face of suffering is required. This involves emotional labour. Emotional labour is a term coined by Hochschild (1983) where the induction or suppression of emotion through deep or surface acting is required of the carer in order to ensure that the person being cared for feels comforted and safe.

There are some inherent difficulties and complexities involved in the emotional labour of compassionate care. First, in drawing on the self it requires the individual to relate to the suffering of others. In doing so they need to enter into that suffering.

Compassion asks us to go where it hurts, to enter into places of pain, to share brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion into the condition of being human. (Nouwen et al. 1982: 4, cited in Von Dietze & Orb 2000: 169)

Compassion fatigue and burnout are linked to high levels of surface acting (Erikson 2009; Mann 2004). Conversely, when deeper relationships are forged, the emotional labour results in a deep attachment, making it harder for the carer to hide their emotions when they deeply relate or to detach when the relationship comes to an end (Kelly et al 2000).

There is, however, a growing body of research (Weng et al 2014; Leiberg et al 2011) that suggests that the practice of compassion increases happiness and that training individuals in altruistic behaviour enables emotion regulation and results in emotional rewards such as increased satisfaction. Theodosius (2008) notes that emotional labour is based on reciprocal interaction – that is in entering into the suffering of the patient, the carer receives back from the patient gratitude and from a job well done, a sense of satisfaction. These emotions are important in sustaining emotional labour in the long term and in protecting against compassion fatigue. Others have identified the importance of self-compassion to protect against compassion fatigue.

Gilbert (2009) points to evidence that feeling love and compassion for ourselves is deeply healing and soothing. In their research, Hefferman et al (2010) found a positive correlation between high levels of self-compassion in nurses, and their ability to relate to the suffering of their patients. Self-compassion is therefore important to supporting and sustaining compassionate care (Gilbert 2009; Gilbert and Choden, 2013). To support self-compassion,

many authors are increasingly advocating mindfulness as a means of reducing stress and encouraging self-empathy (Gilbert 2009; Birnie et al 2010; Hefferman et al 2010). Kabat-Zinn defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally’ (cited in Black 2011:1).

Resource constraints also significantly impact on the quality of care provided by health care staff. Research on emotional labour suggests that low resources negatively impact on the quality of emotional labour given (Bone 2002). The lower the staff to patient ratio, the more likely staff will use surface acting, which is directly linked to compassion fatigue and burnout (Ball and Catton 2011; Erickson 2009; Rafferty et al 2007). The organisational context in which compassionate care is practiced is fundamental to cultivating compassion (Paley 2014; Goodman 2014; Rynes et al 2012, Gallagher 2015). Greenhalgh (2013) points out that, despite the Francis Report identifying a lack of compassion as the root source of the neglect encountered at Mid-Staffordshire Hospital Trust, almost all the recommendations relate to documents or procedures. Youngson (2011) contends that compassion must be defined in relation to ethical leadership as it is the leaders who provide the role modeling of an organisation’s values in the way they behave towards their employees.

The health service has seen major scientific, medical and technological advance but it is the human element – compassion and basic values and behaviours – that have never been more important. Cummings (2014:1)

It is also important to consider the evidence base for compassion ‘training’. Weng et al’s (2014) research ascertained that compassion training does increase altruistic behaviour. Their participants were divided into two groups: those who received compassion training and those who received re-appraisal training. The results showed a significant increase in altruistic behaviour in the compassion training group demonstrating that cultivating feelings of compassion for different groups of people, does work.

However, the concept of cultivating compassion across a diverse workforce poses educational questions concerning the best means of achieving this. There is little evidence to suggest that delivering training using one off lectures by outsourced educationists has the desired effect. Indeed, Levine et al (2007) found that traditional lecture style training was not effective so introduced the ‘train the trainer’ model. Their aim was to change physician behaviour in the management of common conditions. The University Faculty trained 60 peer-educators and these peer-educators then trained their fellow physicians in the practice setting using a purposefully designed Toolkit. Follow up research on the impact of this method showed statistically significant increases in self-reported knowledge and attitudes six months after the peer sessions. Levine et al (2007:1281) also found that the toolkits were important factors in

enabling their peer-educators to facilitate learning. This Levine et al finding are supported by Barac et al (2014), however, they found that many of the reports in their scoping review on the use of toolkits lacked robust evaluation of their impact.

From published literature, it can be seen therefore that the nature of compassion and enabling the development and provision of sustainable compassionate care is complex. Compassion requires the care giver to relate to another's suffering and to empathise with those they care for in a constructive way, using emotional labour, so as to alleviate suffering. Compassion needs to be embedded within organisations as a whole and be visible in leadership behaviours. Also, cultivating compassion requires senior role models who are compassionate in their acts as well as words, to get the message across. In order to cultivate compassion within a diverse workforce, these complexities need to be taken into account.

The primary aims of the Cultivating Compassion project were to:

- Develop a sustainable and evidence based programme of compassion awareness training that enhances patient safety and experience and promotes ethical healthcare practice;
- Engage effectively with healthcare staff building on existing organisation initiatives to promote compassionate care
- Evaluate the 'train the trainers' approach, the use of compassion leads and the compassion toolkit

Methodology

Appreciative Inquiry (AI) was identified as an appropriate underpinning for a programme of compassion 'training' that could engage with a diverse group of health professionals and support workers and to implement and evaluate the programme. This is an effective means to locate best practice and to bring about change. AI requires a move from a problem-orientation to an appreciative stance and involves exploring and actively seeking out the best and focusing on what works well and is being achieved within organisations (Carter 2006). The approach was conceived and developed by Cooperrider and colleagues (Watkins and Cooperrider 2000) as an evaluation approach. AI engages with and appreciates the perspectives of all stakeholders, identifies best practice and provides the opportunity to further enhance services and organisations. The project team selected an AI approach because of its potential to identify, develop and enhance compassion within diverse groups and organisations, and because of its potential for meaningful collaboration with staff rather than identifying failings and blame. AI was also seen as having the potential to contribute to the development of an appreciative

learning culture, so highly suitable for a project team working collaboratively with participants taking on the role of 'compassion lead' within their organisation.

Barrett (1995 p.48) describes appreciative learning cultures as those that 'nurture innovative thinking by fostering an affirmative focus, expansive thinking, a generative sense of meaning and creating collaborative systems'. The approach comprises 4 phases:

- Appreciate 'What is' - the best of what had been
- Imagine 'What might be'
- Determine 'What should be'
- Create 'What will be'

The project team developed an online toolkit of compassion resources that included digital stories, group activities such as identifying and sharing random acts of kindness, mindfulness exercises, compassion indicator statements and provided electronic links to published literature. The AI approach was utilised and participants' positive experiences were harnessed to produce the toolkit resources, such as the digital stories. These resources were uploaded to a dedicated website for participant access. An online tool was seen as most accessible and the toolkit resources were developed from what were already known to be effective approaches that enabled learning, such as digital stories written and narrated by service users (Merrell et al, 2014; Haigh and Hardy, 2010).

The project aims included a 'train the trainers' approach in order to effectively cascade learning activity (Levine et al, 2007) and promote a sustainable culture of compassionate care at all levels of an organisation. Members of the project team facilitated 'training days' in each of the participating organisations and monthly follow-up meetings were provided for participants. Levine et al (2007:1281) also identified that 'toolkits' were important in enabling peer-educators to facilitate learning. The 'train the trainers' model has been successfully used in public health initiatives where large numbers of people, spread across a range of settings, need to be reached. Eresk et al (2006: 42) found in their study examining the effectiveness of the model in the community hospice setting in America that "confidence in teaching end-of-life content increased significantly for participants who used the course materials to prepare and present in service". The evidence supporting the train the trainer model is not conclusive (Trabeu et al 2008) but would appear to be the most appropriate model when aiming to raise awareness across a wider workforce in a variety of clinical settings and the development of a toolkit is essential to this process.

For these reasons the project utilised a compassion toolkit and the first two ‘train the trainer’ sessions in the participating organisations were led by members of the project team. The digital stories were used to generate discussion and participants were invited to describe and share an act of compassion encountered in their recent practice. It was considered important to focus on the prevalence of compassion in practice rather than its absence, as a positive means of generating discussion, recognising and appreciating participants’ own positive experiences, and encouraging individuals to undertake a role in promoting ‘compassion awareness’ in their practice.

Ethical considerations

The Cultivating Compassion project adhered to the principles of research ethics in: the provision of accessible information (with Participant Information Sheets), ensuring that participation was voluntary with potential participants given sufficient time to ask questions and being aware that there were no adverse consequences from declining participation; the awareness that consent is a continuous process (consent forms were prepared with particular attention to audio/video contributions) and participants could withdraw at any time; and careful consideration of potential risks such as distress in the disclosure of personal stories or practice examples. The project was submitted to the Ethics and Governance Committees of all organisations involved for ethical review and favourable ethical opinions obtained before the commencement of recruitment and data collection.

Participants

Participants were recruited from among all staff within four NHS organizations: 2 large hospitals, a mental health service provider and a community based primary care service provider. Project team members facilitated the ‘training’ of these participants in the use of the online toolkit. The participants from each organisation met as an organisational group regularly throughout the project, with some participants identifying themselves as ‘compassion leads’, and most taking on the role of cascading the compassion activities within the toolkit to other staff within their organisation.

Data Collection

An iterative approach to developing the toolkit and individual resources within it was utilised by the project team as the project progressed, so resources could be introduced and amended based on user experiences. Data was collected through focus groups and individual interviews on participant experiences of using the toolkit resources and on their cascading of the resource within their organisation in order to ‘cultivate compassion’. The focus group method was chosen

because of its appropriateness to AI and to exploring the views, feelings, values and experiences of the groups (Curtis and Redmond 2007). Focus groups also offer an opportunity for shared meanings and shared values to be identified and explored. Semi-structured interviews were also used where individuals preferred this as a more convenient option due to time and work commitments. Data collection points were during the training days and at monthly follow-up meetings.

Data Analysis

The qualitative data from focus groups and interviews were digitally audio-recorded, transcribed and qualitatively analysed using thematic analysis (Braun and Clarke, 2006). Thematic analysis is a rigorous inductive method of analysis which involves the systematic generation and refinement of categories to themes and sub-themes. The process has the flexibility to validly represent patterns found in participants' accounts whilst facilitating a reflexive awareness of the researchers own biases and assumptions.

Findings

There were four overall themes with subthemes identified within the qualitative data that was collected using participant focus groups and individual interviews (Table 1).

(Insert Table 1: Themes and subthemes from focus groups and individual interviews)

Theme 1: Project Implementation Inhibitors

Some participants expressed scepticism and/or suspicion regarding the project objectives and their organisation leadership's interest in and commitment to the project. One nursing participant said:

The Trust has a tendency to do this thing which is to present it all happy clappy. And people think, that's not real life [...] There's absolutely that thought, who is trying to tell us what to do when we do it every day. We know because we're on the coal face, every day, day in, day out. Them up there, they don't know because they're not here with us where it's happening. So there's an element still of suspicion about the senior echelons of the organisation and what they're actually trying to do.

Lack of direction from senior management within participating organisations was a prevailing factor in areas where compassion leads expressed uncertainty about how to progress the toolkit activities beyond the self to the team or wider organisation. Another pressing concern

expressed by participants was how to integrate the compassion activities into their everyday work. One participant working within staff development said:

I was hoping to ease it into induction as I facilitate the HCA perspective but the day is very structured... there isn't the opportunity on that day at the moment.

Other organisational factors that inhibited the progress of the project included the timing of the project which coincided with an exceptionally busy winter period and the need to recoup the financial cost of project participation when time out had to have locum cover, such as for the General Practitioners. This latter factor had not been considered by the project team and revealed the difficulties of engaging participants in project work where individual staff needed to find funding for backfill cover.

Theme 2: Project Implementation Enablers

An important project enabler was the commitment of individual participants and also of some leaders within the participating organisations. For example, participants who engaged with the project reflected on their experience of the project in relation to their professional and personal background. Such a background may influence a participant's commitment to the project. One clinical psychologist participant said:

My view of compassion is one that probably most people have, of it being about viewing others as being humans and, you know, your kin, your fellow kin, showing kindness and noticing other people's suffering and also their achievements [...] Compassion has been important in my training as a psychologist, in that compassion focused therapy is something that has sort of developed in the last 10 years or so [...] And also in my own upbringing and life experience compassion is very important.

Positioning in the organisation greatly helped the participants' perceived ability to cascade the cultivating compassion activities. A leadership role in a clinical position with access to many different staff was associated with the more active participants who were in roles such as ward manager, team leader, professional development trainer or head of education for nursing and midwifery. These participants had authority, reach, and could negotiate time slots where compassion activities could be *squeezed in*. They also had the capacity to have some control over the use of their time and to integrate the compassion activities within existing mandatory training initiatives. A hospital based clinical educator participant from within a hospital commented:

Nothing was sacred. We could use 5 mins, 10 mins, 20 mins we could use bits of other meetings. We have band 5 development. We are developing a band 7 programme so one of the key things they will now get is a cultivating compassion session.

Theme 3: The Value of Project Resources

There was a general enthusiasm amongst participants regarding the toolkit. Those who attended the Cultivating Compassion training days shared many examples of how they would use the Toolkit resources, for example, to stimulate reflection by using quotations from acts of compassion discussions, to recognise and celebrate compassion in the team and to stimulate discussion drawing on the digital stories. The value of many of the online toolkit resources were praised by a number of participants, as expressed by a nurse participant working within a hospital based palliative care team:

They are just fantastic to have as something we can use anytime, that is really useful as a bank of skills.

Participants found the digital stories were a quick and easy way of instigating a conversation about compassion. Some who expressed initial anxiety about introducing the idea of compassion gained confidence from using the toolkit. The compassion indicators also proved useful for highlighting existing good practice, generating critical dialogue within teams with some of this centred on emotional labour self-compassion and peer support, and emphasising the multiple and diverse ways in which compassion is lived out in practice. The development and implementation of the digital stories and compassion indicators are beyond the scope of a single paper and will be published separately.

There were examples of individual creativity where participants had built on the toolkit developing complementary activities, for example an idea from Facebook of “100 days of happiness”:

I wasn't sure about it but we came up with a compromise 100 days of doing this [mindfulness, sharing acts of kindness, displaying quotes on compassion, forming a reflective space]..... and then reviewing it... not stopping, but reviewing and that seems to work quite well.

Theme 4: Shifts in Perspectives

One of the most powerful findings was that the majority of interview and focus group participants reported changes in their thinking from their engagement in the project. These shifts in perspectives related to participants' views of self-compassion, compassion towards others, and of the potential of compassion initiatives to impact on practice. Despite a belief that *they already understood compassion* and “*it's that word again*”; exposure to a toolkit of materials raised awareness:

This has made me think I need to try and realise when I am being compassionate and praise myself for it.

Exposure to the toolkit and the group activities increased awareness of a responsibility to

recognise compassionate acts in others, as explained by a hospital based chaplain participant:

Congratulating people on compassion where I've recognised it [...] changing people's mindset to be compassionate to each other'.

Another 'shift' related to the change in the commissioned project title. The team raised questions about how 'compassion awareness training' would be received by the workforce in the participating organisations. Concerns were raised by participants indicating an irritation and undercurrent of hostility to the implications that a project designed to train them or their colleagues in compassion was questioning their capacity, understanding and expression of compassion within their work. Hence, through the use of AI and listening to what already worked well within their organisations, the project title was changed from 'Compassion awareness training' to 'Cultivating Compassion'.

Discussion

The 'Cultivating Compassion' project findings confirm the value of using and cascading a toolkit of peer-facilitated compassion activities to promote compassion within a healthcare organisation. The findings suggest that using a variety of toolkit resources promotes more flexibility and opportunity for engagement, particularly among a diverse group of staff. However, appropriate supportive leadership within an organisation is also central to the success of individual engagement in cultivating compassion because, without support, staff feel powerless to have an impact or find time or space to engage.

The influence of the leadership within organisations for compassion to thrive was evident in participants' comments and in particular, a leader's recognition and understanding of the challenges of working within busy and demanding environments. Leadership for compassionate care requires 'acknowledging and making provision for the difficulties and challenges of working in an anxiety-laden context' (de Zulueta, 2015) as well as genuine modelling of compassion. Where participants identified supportive leadership they also recounted more success in their cascading of cultivating compassion to peers and colleagues.

The project also found that it is important to harness the internal motivations of staff for compassion and by creating opportunities for reflection on and sharing of acts of compassion within group discussions, peers can promote that motivation. In support of Gustin and Wagner's (2013) study on self-compassion as a source of compassionate care, an important component of compassion coming from the participant discourse was the value of self-compassion, particularly when they have felt unable to act according to their value base due to negative external factors. De Zulueta (2015) provides an explanation for this in terms of how oppressive

management, dispassionate role models, and a lack of support for reflection can “extinguish the flame of compassion”. Health and social care policy could further support compassion through more explicit expectations on leaders of services for harnessing positive and adaptive responses to challenges that enable sustained compassion. This could be achieved in part through an improved culture of learning from what works well and from non-punitive learning from what went wrong; promoting the values of respect and trust throughout an organisation’s structure.

It is encouraging that within the project there were positive shifts in individual perspectives and it is important to note that integration of the project into existing initiatives, for example through embedding the Cultivating Compassion toolkit alongside an existing organisational values project, meant the initiative had more reach and thereby more potential impact. There was a genuine sense from participants that through raising their own awareness of compassionate acts, they were positive outcomes for those they cared for in receiving more compassionate care and for those they worked with in terms of compassionate teams. However, it is acknowledged that measuring that impact was not included within the project activity.

The creativity of compassion leads was also a contributory factor in the success of the project. The creativity seen by participants within the project highlighted the importance of giving ‘ownership’ to compassion leads to tailor the use of the toolkit and cascade of the activities in ways that suited their teams, their organisation’s expectations, and already existing programmes of staff development. In some of the participating organisations, positive change was introduced on a small scale; for example, within specialist teams with supportive managers. In other organisations, positive change was encouraged on an organisation-wide basis using an electronic notice board with endorsement from the senior executives. However, dissemination and integration across the wider organisation was seen as challenging by many participants and this was attributed to various factors such as organisational change, high demand on services due to winter pressures, leadership gaps, and financial considerations making staff development initiatives burdensome for NHS organisations.

One of the most positive outcomes from the project related to the increased awareness of self-compassion and the importance of recognizing and actively valuing the compassionate acts of others.

It is acknowledged may have been self-selecting individuals with a pre-existing commitment to compassion. However, even they found definite benefits from their involvement in the project.

Conclusion

The Cultivating Compassion project demonstrates the importance of an organisational culture that is receptive to, and supportive of, compassionate care. This was recognised as a welcome shift in perspective on compassion by most participants. Findings suggest that discourse on workforce development related to compassion needs to be supported from inside the organisations. The train the trainer model also requires systems-embedded support as the project rolls out, to encourage and support individuals to cascade compassion activities in their workplace. There is also a need for named leads at various levels of organisations to initiate, support and evaluate toolkit activity. The project findings also highlight the need to integrate compassion activities with existing training initiatives and suggest the need for staff support systems to enhance resilience and manage the emotional stresses of healthcare work.

Overall, the project provided a diverse group of health professional and support staff with opportunities and resources to prioritise compassion in their relationship with themselves, patients, families and colleagues. However there is still more to be done to integrate compassion-related initiatives more widely and to measure the impact of these initiatives on those receiving care. Engaging with and gaining the support of organisational leaders at the outset is crucial. Leadership commitment and integration are key elements of the success of cultivating compassion activity so that time and space can be allocated.

Limitations of the study

The timing of the Cultivating Compassion project coincided with one of the most demanding winter periods in the NHS and with significant changes (such as restructuring) in some of the participating organisations. It also had to be planned, implemented and evaluated within a relatively short period of time. This had an impact upon recruitment to the project, the participants' opportunities for cascading the learning activities and thereby potentially limiting the extent of participation.

Key Points

- Workforce development initiatives related to compassion must be supported by committed organisational leaders who facilitate the availability of time and space for compassion-related activities.
- Systems embedded support is required to maintain momentum and the sustainability of the train the trainer model.

- There is a need to integrate cultivating compassion activities with existing training initiatives and other values-based activities already in place.
- More attention needs to be paid to the importance of self-compassion and team compassion and for leadership within organisations to make time for this.
- Collaboration amongst researchers, practitioners, service users and organisational leaders is essential to more widely disseminate and utilise the online compassion toolkit.

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Themes			
Project implementation inhibitors	Project implementation enablers	The value of project resources	Shifts in perspectives
Sub-themes	Sub-themes	Sub-themes	Sub-themes
Scepticism regarding leadership commitment	Commitment of participants	Toolkit	Self-compassion
Missed opportunities for integration	Positive leadership	Confidence	Compassion towards others
Organisational factors	Integration opportunities	Individual creativity	Change in project title

Table 1: Themes and subthemes from focus groups and individual interviews