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Developing Resilience in the Workforce:

A Health Visiting Framework Guide for
Employers, Managers and Team Leaders



Authors: Ann Pettit,
Rachel Stephen, Robert Nettleton
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on behalf of Health Education England and the
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Reader information box

Audience

Health Visitors

Health Visitor service leads, managers and team leaders

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Health Visitor Service Providers

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Local Authority Commissioners

Local Authority Councilors

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Document purpose

This document draws on the evidence gathered in 'Supporting Health Visitors and Fostering Resilience – Literature Review (2015) to provide leaders and managers of health visitors and the organisations they work within evidence based information to ensure that the health visiting workforce is resilient whilst remaining compassionate.

Title

Developing Resilience in the Workforce: A Health Visiting Framework - Guide for Employers, Managers and Team Leaders

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Supporting Health Visitors and Fostering Resilience – Literature Review (2015)

Developing Resilience in Practice: A Health Visiting Framework (2015)

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The Institute of Health Visiting is a Centre of Excellence:

- supporting the development of universally high quality health visiting practice;
- so that health visitors can effectively respond to the health needs of all children, families and communities;
- enabling them to achieve their optimum level of health, thereby reducing health inequalities.

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Thanks to all the health visitors who have shared their views and personal stories. We are creating knowledge together about how to build resilience in health visitors. Through engaging in this narrative we hope to transform organisational culture and facilitate the development of positive workplace relationships where health visitors can express their vulnerability and be responded to effectively and respectfully in ways that affirm compassionate practice.

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Task and Finish Group

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Expert Advisors

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Ann Pettit, Rachel Stephen and Robert Nettleton

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Executive summary

This document presents a Resilience Framework to help organisations support their health visitors and foster their resilience in the workplace.

The purpose of this framework is to continue to develop, support and retain resilient, compassionate health visitors thereby improving health outcomes and experiences for children and families.

This Resilience Framework is an innovative toolkit which can be applied to other professions and at organisational, team and individual level and to other professional groups.

Building health visitors' resilience requires an in-depth understanding of the context in which health visitors practice, combined with a preventative, strengths-based approach to working with organisations, groups, teams and individuals.

Compassion in the workplace has positive benefits for the quality of care and staff morale. Managing the emotional challenges and unpredictability of health visiting work requires resilience such that practitioners can cope positively, flourish, and practise effectively and compassionately.

The framework has been informed by a literature review and by consultation with the health visiting profession and experts in the field of resilience. It incorporates a menu of models and concepts of support with compassion at its centre. These include: supervision, mentoring, coaching, courageous conversations, relationship-based models, action learning, performance feedback, interagency/disciplinary groups, peer support and resilience with compassion. These sources of support are described and a range of supporting resources are referenced.

Resilience is a developmental process which results from a unique interaction between the individual and their environment. A systems approach is proposed which places individual practitioners in the context of wider systems including the team, organisation and wider interagency partnerships.

This document should be considered alongside the guide 'Developing Resilience in Practice: A Health Visiting Framework' prepared for practitioners by the Institute of Health Visiting as well as the induction / preceptorship Frameworks for health visitors, CPD programmes and communities of practice available at bit.ly/1HZjZX3.

Section 1 Background and Framework

Introduction

Managing the emotional challenges and unpredictability of health visiting work requires resilience such that practitioners can cope positively and flourish. In 2014, Health Education England commissioned the Institute of Health Visiting to produce this support framework for fostering resilience in health visitors.

The purpose of this framework is to continue to develop, support and retain resilient health visitors. This will ultimately improve health outcomes and experiences for children and families.

Building health visitors' resilience is a complex issue which requires an in-depth understanding of the context in which health visitors practice, combined with a preventative, strengths-based approach to working with organisations, groups, teams and individuals. Key considerations include the need for ongoing action to strengthen the workforce and aid retention following the significant investment in health visiting by the Health Visiting Implementation Plan (DH, 2011). Learning from other areas indicates that compassion in the workplace has positive benefits for the quality of care and staff morale. Hence compassion is identified as a key factor in the development of resilience.

The development of the Resilience Framework has been informed by consultation with the health visiting profession. Arising from a literature review of research and policy, multiple conversations, surveys, workshops and an expert Task and Finish Group, the Resilience Framework for health visiting has been developed incorporating a menu of models of support and concepts including: supervision, mentoring, coaching, courageous conversations, relationship-based models, action learning, performance feedback, interagency/disciplinary groups, peer support and resilience with compassion. Use of this range of models of support and concepts could enable health visitors to be more resilient when faced with challenges while retaining and enhancing compassionate behaviours in the workplace.

The framework is underpinned by the literature review and supported with further information provided in the practitioners' document bit.ly/1HZjZX3

Deliverables

The project has produced

- A literature review reporting the underpinning evidence on resilience, current models of support, relationship-based interventions and the concept of resilience with compassion.
- This guide for organisations, managers and leaders to introduce the framework informed by the added value of developing and supporting resilient, compassionate practitioners.
- A practice guide for health visitors supported by e-learning.
- Good practice points for developing resilience with compassion.
- The iHV will be developing a series of training resources to support health visitors developing resilience with compassion.

This guide is underpinned by the literature review and supported with further information provided in the practitioners' resource.

Resilience Framework Vision

- To address the challenges of recruitment and retention for managers; support positive practice environments for teams in the midst of service change; and prevent staff burnout particularly in areas of high staff turnover.
- To implement the Resilience Framework within health visiting practice.
- To develop a benchmarking process for organisations to demonstrate their ability to support their staff and to help them develop resilience in practice.
- Support provider organisations of health visiting services throughout England to adopt the framework and consider the contextual nature of resilience and compassion.
- To improve client and staff safety, reduce client complaints and improve outcomes for children and families.

Theory of change

The theory of change (Anderson, 2005) inferred as the rationale for this project is that retention of the health visiting workforce is a desirable outcome and that this is likely to be determined to a significant extent by the resilience of the health visiting workforce.

Furthermore, the resilience of the workforce is likely to be determined by interactions between the health visiting workforce and their work environment that are likely to be affected by the availability and uptake of supportive interventions. This project has not tested this theory, but supplies information about its key components, notably 'resilience' and 'models of support' reflecting the contemporary context of change affecting health visiting.

The Guide

Section 1 of this guide focuses on the context of fostering resilience for health visitors from an organisational perspective. It then outlines the components of a proposed framework for resilience in line with the implicit theory of change outlined above.

It goes on to provide, in tabulated form, key characteristics of the range of models of support reviewed in preparation for this project (that is 'inputs'); and then outlines key concepts related to resilience ('outputs').

Section 2 of the guide provides examples of how some the various 'inputs' referred to in Section 1 can be selected and combined in practice. While the Framework for Resilience offers a menu based upon a review of evidence, a 'cookbook' cannot be provided, but rather Section 2 is structured around three illustrative case studies that demonstrate the implied theory of change in action, focusing in turn on the level of the individual practitioner, teams, and across an organisation. The case studies have in common the enhancement of resilience to meet the contemporary demands of health visiting practice by fostering 'positive practice environments'. For a theory of change to be of value, it needs to be tested. While this is outside the scope of this project, such testing would involve developing indicators and tools to track causal pathways and feedback loops. Appendices to the guide provide further information on resources that can be used for such purposes, in particular a prototype benchmark tool (see Appendix 2).

Considerations for Organisations, Managers and Leaders.

In 2015 the commissioning of health visiting services is to be transferred to the Local Authority.

Health visitors are ready and prepared to deliver and lead an enhanced programme of care having received extra training in areas such as relationship-based parenting programmes, leadership, motivational interviewing and perinatal and infant mental health. It is a skilled workforce and expectation is high but the service demands are increasing from clients and commissioning in an environment of uncertainty and change. Ensuring that these practitioners remain within health visiting, developing their skills and remaining compassionate should be a priority for commissioners and managers to ensure that all children and families receive a high quality responsive service from practitioners with the qualities and skills to improve outcomes for all children.

Four key considerations have been identified from policy and research-based literature of relevance to organisations including: (1) learning from successful business models and research, (2) safety and wellbeing (3) value for money and (4) integration through considering a contextual systems approach.

1. Learning from successful business models and research

Reviewing the business models used by successful organisations (e.g. Google, LinkedIn, Walt Disney) and the evidence for what creates a positive practice environment (Bryar et al, 2012), enhances staff wellbeing (NHS Employers, 2014, POSHH, 2012) and aids retention of staff (Whittaker et al, 2012, NHS Employers, 2011) has indicated a number of considerations when enhancing organisational support for promoting the resilience of staff. These factors contribute to enhancing the quality of client care, staff satisfaction and retention, efficiency, productivity and innovation.

Factors warranting consideration are:

- Professional identity and competence with clarity of role, responsibilities and expectations.
- Organisational culture and leadership - including, open communications and transparency, engagement of staff, sharing constructive, timely feedback and enabling staff to see how they are making a difference in a culture of compassion.
- Developing flexible working practices which meet the needs of the service and enable employees to maintain a work-life balance.
- Providing opportunities for staff to reflect, share ideas as a team and develop innovative solutions.
- Regular appraisals where personal development plans are agreed and a career progression path identified and encouraged to pursue personal areas of interest.
- Models of support - providing access to appropriate supportive relationships which contribute to creating an environment where people feel safe and valued.
- Values-based recruitment which contributes to creating positive work environments and to staff feeling valued.
- Education and training to enhance understanding and skills including emotional intelligence and self-compassion.

2. Staff Wellbeing and Safety

The Point of Care Foundation (2014) points out that staff who exercise control over their work, are listened to and involved in decisions affecting services they deliver, engage in training and development, and who have the physical and emotional impact of caring work recognised seriously are essential to the delivery of high-quality patient focused care. Embedding staff health and wellbeing in NHS systems and infrastructure is a key recommendation of the NHS Health and Wellbeing – Final Report (Boorman Report, 2009) which aligns staff wellbeing with outcomes for services. More recently, the Francis Report (2013) and the Compassion in Practice Nursing Strategy (DH 2012) emphasise the importance of organisations creating a compassionate culture. Creating a compassionate organisational culture facilitates the safety of clients and practitioners. Safety of staff is important in preventing compassion burnout and sickness. The latest figures estimate that 30% of all NHS sick leave is caused by work-related stress, costing up to £400 million each year (NHS Employers, 2014). The Compassion in Practice implementation plans include supporting positive staff experience as an action area. It advocates the need to ensure staff are supported in the emotional labour of caring and recommends that healthy and safe work environments are promoted where staff are encouraged to support one another and be accountable, are involved in decision-making and embrace innovative practice (DH, 2013). Six core values (6Cs) have been described as underpinning this: compassion, communication, care, competence, commitment and courage. Health visitors have told us that having a compassionate leader is a key contributor to feeling supported at work (iHV survey, 2014) and this influences retention. Compassionate organisations prioritise staff wellbeing, which affects client safety and the quality of client care (National Nursing Research Unit, 2013).

Having the courage to be more self-compassionate has created a profound shift in how I go about being a leader. As I continue to learn and develop my improved performance has become far more sustainable and resilient, which I attribute to bringing compassion into my leadership". **Managing Director – Fujitsu Services (Wickramasinghe, 2014).**

3. Value for money

High quality health visiting services build resilience and reduce costs in later life (NICE, 2014). The five-year plan for the NHS (NHSE, 2014) outlines the importance of using a preventative approach. It highlights how patient safety, clinical effectiveness and patient experience are achieved through a caring culture, professional commitment and strong leadership. Organisations that achieve high levels of staff engagement and prioritise staff wellbeing within a culture of compassion are more effective and efficient (Dutton et al, 2014). The Resilience Framework includes all these components.

4. Integration through using a contextual systems approach

There is a need to address the structural and contextual sources of stress that contribute to workplace adversity. Resilience is not the sole responsibility of individuals but requires active support from employers. The Resilience Framework provides tools which can be used across organisations and teams to proactively assess whether they are creating a culture which fosters resilience with compassion. It builds upon learning from the study of what is required to establish Positive Practice Environments in primary care (Bryar et al, 2012). In order to contribute to positive practice environments that attract and retain staff, any interventions need to be well targeted to align with the five 'key features of effective primary healthcare nursing' (Bryar et al, 2012). In the context of health visiting (1), "People centeredness is reflected in the relational basis of health visitors" engagement with families and communities with the demands on personal and professional resilience that this entails. It is also reflected in the renewed focus on compassion in the healthcare and organisational culture in the UK. (2) A "public health perspective" is reflected in the mandate of health visiting as a branch of public health nursing that focuses on the determinants of health at community level, exposing practitioners to the complexities of intersectoral and interagency working where boundaries are fluid and pressures are difficult to regulate. However, resilience is essential if practitioners and services are to positively embrace (3) 'partnering and inter-professional working'. (4) 'Information and communications technology' needs to support

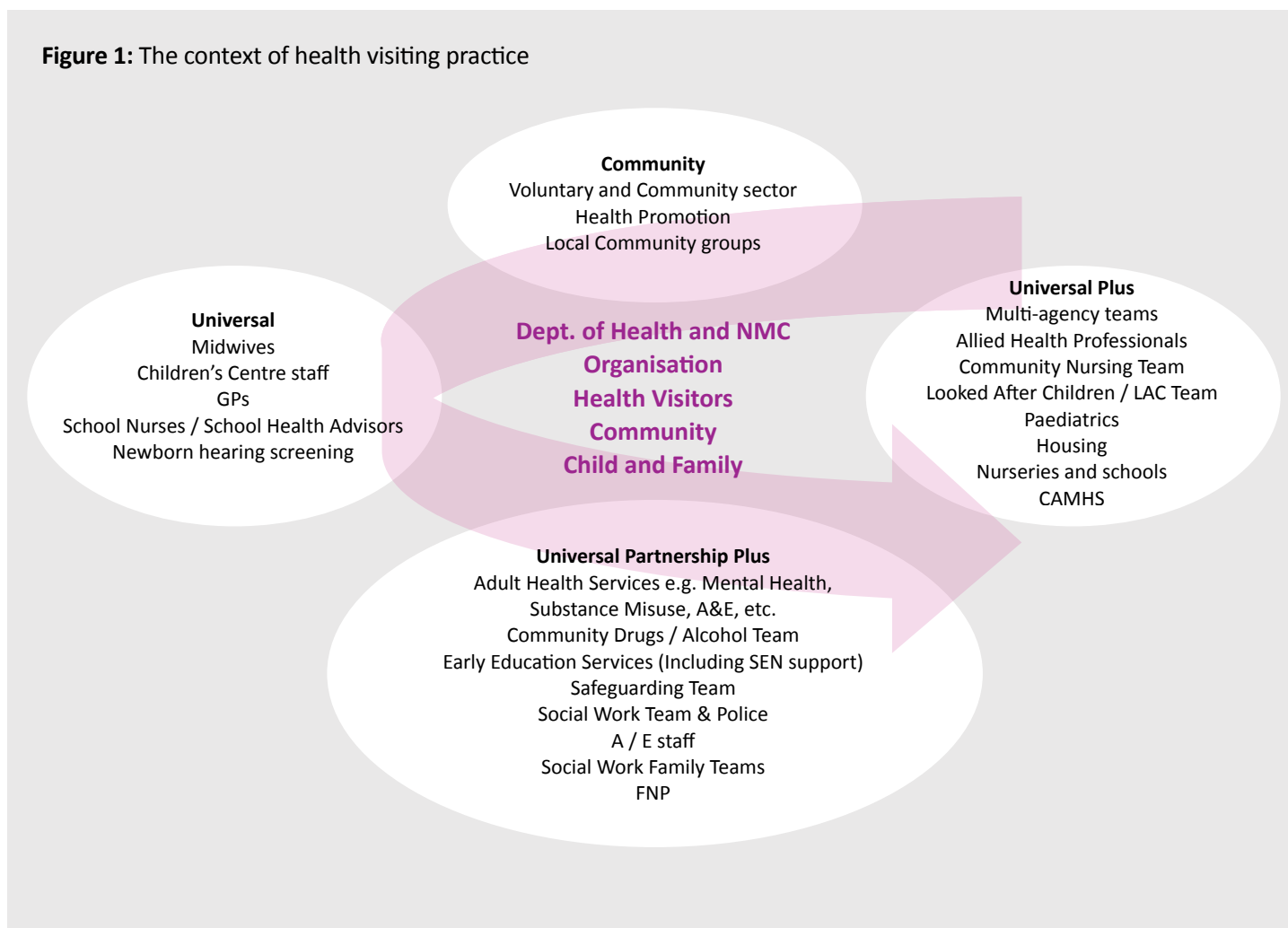
rather than frustrate effective engagement of practitioners who straddle boundaries beyond those established by organisational structures to reach out to where families and communities live; and finally staff engagement and wellbeing need to be integral and essential to the (5) “quality improvement agendas” of organisations.

This Resilience Framework is part of a wider Institute of Health Visiting (iHV) educational programme entitled “Making the Most of Health Visiting”, which is supporting the professional development of health visitors. This includes the creation of a CPD framework and supporting the development of actual and virtual communities of practice. The iHV survey (2014) found that 90% of HV respondents thought that learning how to personally develop resilience was important. However only around 12% agreed strongly that they were currently able to achieve this, while 50% reported not having time to reflect and develop self-awareness. This highlights the importance of utilising a systems approach to address the question.

To effectively support health visitors we need to consider the context of health visiting practice and develop resilience promoting environments. A contextually sensitive systems approach is utilised with the child and family at the centre, as outlined in Figure 1. This diagram highlights the complexity of health visiting and the wide range of contextual influences on practice. The diversity of contextual influences includes consideration that health visitors engage with multiple care pathways and systems spanning geographical, organisational, professional and cultural boundaries.

Systems are therefore open systems that make regulation of demand unpredictable and boundary maintenance is challenging. Hence, developing resilience is of critical importance to remaining effectively engaged without being overwhelmed by environments that extend beyond the immediate sphere of control.

Figure 1: The context of health visiting practice



The Resilience Framework

The *Resilience Framework* for health visiting has been developed incorporating a menu of models of support and concepts, with compassion at its centre, based upon a consultative [literature review](#).

These include: supervision, mentoring, coaching, courageous conversations, relationship-based models, action learning, performance feedback, interagency/disciplinary groups, peer support and resilience with compassion. An acknowledgement is made that there may be other models of support which could be of benefit to health visitors and this framework can be developed further. It is important to note that high-trust relationships with peers and senior leaders in whatever role help the physical and emotional impact of highly engaged practice in challenging practice contexts to be acknowledged. This contributes to supportive conditions so that practitioners do not shut down from these demands or alternatively suffer dysfunctional stress states. This is what is meant by a 'containing compassionate relationship' (see case study 2) which health visitors should model and promote in their engagement with families. Without these conditions being met it is unlikely that practitioners will avail themselves of other support structures or interventions that may be available. Hence, health visitors' professional values, principles and relational approaches to practice are also key, as is adopting a systems approach.

The *Resilience Framework* is an innovative approach which can be applied at organisational, team and individual levels. This framework can also be applied to other professional groups in various agencies. It adds value by:

- Integrating theoretical and practice-based evidence reviewed for this resource.
- Incorporating what works well from business.
- Adopting a systems approach.
- Having applicability across organisations.
- Using innovation to integrate compassion and resilience.
- Having a design with the child and family at its heart.
- Acknowledging the person delivering the care.
- Emphasising prevention and early intervention.
- Using a consultative, strengths-based approach to build on what is working well.

Figure 2 represents the menu of support measures for employers and individuals to consider in supporting health visitors and fostering resilience. This menu is drawn together from the requirements of the commissioning brief for this project, the literature reviewed and the interactive consultation with practitioners, managers and subject specialists. The grey night is representative of the stresses in health visiting, which can result in health visitors worrying night and day about vulnerable children and families. Health visitors may feel alone with their responsibilities and the picture also represents the fact that they are part of a wider environment or set of interlinked systems. The stars, the moon and the planets represent the key support components to foster resilience. Understanding the components of support available facilitates implementation of proactive, strengths-based compassionate strategies to foster resilience. 'Compassion' is placed centrally within the proposed framework, being the heart that supplies the life-blood for health visiting practice for clients and practitioners alike. From this secure base, there is a diverse range of models of support that can be drawn upon to enhance the resilience of health visitors within the workforce. The individual models of support are then tabulated with brief reference to the evidence base reviewed in the research and policy [literature](#) to inform the framework. Detailed information and guidance on the benefits and utility of each individual model of support is provided within the companion [Guide for practitioners](#).

Figure 2: The Resilience Framework



The table below provides a summary of each of the models of support including a description, an outline of the benefits and resources available to support it.

Models of Support and Resources

Source of Support	Benefits	Description	Resources \ links
Relationship-based models of intervention	<ul style="list-style-type: none"> ■ Improves job satisfaction ■ Improves competence ■ Improves self-awareness and managing stress ■ Improves relationships <p>These factors are related to enhancing resilience and staff retention as well as improving outcomes for children and families.</p>	<p>Two models are Solihull training and the Family Partnership Model. These models provide practitioners with evidence-based frameworks of intervention and the skills to work in partnership with complex families to facilitate change. These models focus on identifying the strengths as a starting point from which to build attuned and sensitive relationships.</p>	<p>Solihull: bit.ly/1GJbJc</p> <p>Family Partnership Model: bit.ly/1NEN2j1</p>
Peer support	<ul style="list-style-type: none"> ■ Viewed as a key element in the delivery of quality patient care ■ Positively affects psychological and physical health directly and through buffering, and mediating effects. <p>While peer support is a potentially cost-effective intervention, the possibility of overburdening exists through the inappropriate use of peers as a replacement for professional services.</p>	<p>Defined as the giving of assistance and encouragement by an individual considered equal or a voluntary, non-evaluative and mutually beneficial partnership between two practitioners of similar experience who have participated in training and who wish to incorporate new knowledge and skills into practice. Application is complex and variable.</p> <p>Informal support from colleagues sharing an office is widely valued in HV professional culture and should be recognised and positively cultivated.</p>	<p>Waddell, D. L. and Dunn, N. (2005) Peer coaching: the next step in staff development. <i>The Journal of Continuing Education in Nursing</i>. 36 (2) 84-9.</p> <p>Dennis, C. (2003) Peer support within a health care context: a concept analysis. <i>International Journal of Nursing Studies</i>. 40, 3, 321-332.</p>
Safeguarding Supervision	<ul style="list-style-type: none"> ■ Promotes an effective response to safeguarding children ■ Reduces the emotional impact on staff ■ Decreases stress ■ Decreases risk of burnout <p>The quality of supervision has a direct bearing on the quality of service delivery, and outcomes for children, families and communities (Turbitt, 2012).</p>	<p>A safeguarding supervisor provides expert child protection advice.</p> <p>Health visitors should receive a minimum of 3 monthly safeguarding supervision sessions. The supervisor should have expert knowledge of child protection (NHSE, 2014).</p> <p>Supervision should “maintain a focus on the child and consider the impact of sadness and anger on the quality of work with the family” (NHS England, 2014, p14).</p>	<p>NHS England (2014) <i>National Health Visiting Service Specification</i>, (2014/15). Available at: http://bit.ly/1D4Kpkn</p> <p>Proctor, B., (1986) Supervision: A Co-operative Exercise in Accountability in: Marken, M. and Payne, M. (eds.) (1986) <i>Enabling and Ensuring - supervision in practice National Youth Bureau</i>, Council for Education and Training in Youth and Community Work, Leicester, UK.</p> <p>Turbitt, U. (2012) <i>Safeguarding Children Supervision: Development and Implementation of a Regional Approach In Northern Ireland</i>, HSC Public Health Agency (Presented to BASPCAN conference, April 2012).</p>

Source of Support	Benefits	Description	Resources \ links
Clinical supervision	<ul style="list-style-type: none"> ■ Promotes safety of the client and practitioner ■ Reduces stress ■ Improves practice 	<p>Clinical Supervision can be provided by a peer or more experienced practitioner, individually or in groups. The focus is on clinical competency.</p> <p>Clinical supervision provides support and stress relief for practitioners (restorative function) as well a means of promoting professional accountability (normative function) and skill and knowledge development (formative function).</p>	<p>Palsson, M., Hallberg, I.R., Norberg, A. and Bjorvell, H. (1996) Burnout empathy and sense of coherence among Swedish district nurses before and after systematic clinical supervision. <i>Scandinavian Journal of Caring Sciences</i>. 10(1), 19-26.</p> <p>Walsh, K., Nicholson, J., Keough, C., Pridham, R., Kramer, M. and Jeffrey, J. (2003) Development of a group model of supervision to meet the needs of a community health nursing team. <i>International Journal of Nursing Practice</i>, 9(1), 33-39.</p>
Restorative supervision	<ul style="list-style-type: none"> ■ Enhances the capacity of the professional to engage in their clinical work ■ Develops the capacity to cope ■ Decreases stress ■ Decreases risk of burnout 	<p>The Restorative Clinical Supervision model underpins managerial and child protection supervision by focusing on the capacity of the professional to engage in their clinical work and to develop the capacity to cope.</p> <p>The restorative supervisor requires both personal aptitude and training. Training sufficient supervisors requires organisational commitment for it to become embedded in the culture of the organisation.</p>	<p>bit.ly/19aeGp0</p>
Mentorship	<ul style="list-style-type: none"> ■ ‘Fosters talent’ in the organisation ■ Increases productivity ■ Improves communication ■ Improves retention <p>The Institute of Health Visiting Fellows Programme offers a promising vision of mentoring in support of resilience.</p>	<p>Mentorship is provided by an experienced practitioner who role models and guides learning. The focus is on career and personal development and it involves an ongoing relationship.</p> <p>Mentoring emerging leaders with the support of the NHS Leadership Academy is a positive development.</p>	<p>Downie, C. and Basford, P. (2003) <i>Mentoring in Practice</i>, A Reader. London: University of Greenwich.</p> <p>NHS Leadership Academy (2012) <i>The Leadership Academy and 360 degree feedback</i>. bit.ly/1H7qpUz</p> <p>Public health online resources for mentoring and coaching bit.ly/1HhCMJD</p>
Coaching	<ul style="list-style-type: none"> ■ Unlocks a person’s potential to maximise his or her performance. ■ Develops skills ■ Enhances self-efficacy and competence which contribute to retention ■ Useful to develop practice teacher and mentor skills 	<p>Coaching can be provided by someone with a different professional background. It focuses on specific developmental issues and achieving goals. It involves a relationship with a set duration. It is personal, behaviour-oriented and targeted to the individual. More structured than mentoring with regular meetings.</p>	<p>Brandt, R. (2013) Calling In a Coach, <i>SHRM Human Resources Magazine</i>, September , 54-55.</p> <p>Fielden, S. (2005) <i>Literature Review – Coaching effectiveness: a summary</i>, NHS Modernization Agency Leadership Centre.</p> <p>Sinclair, A., Fairhurst, P., Carter, A. and Miller, L. (2008) <i>Evaluation of Coaching in the NHS</i>. Report 455, NHS Institute for Innovation and Improvement.</p>

Source of Support	Benefits	Description	Resources \ links
Courageous Conversations	<ul style="list-style-type: none"> ■ Strengthens the individual's relationships with themselves and others. ■ Increases the validity of information such as thoughts, opinions, reasoning, inferences and feelings. ■ Increases respect and commitment. 	<p>These have been described as "learning to communicate best when it matters most". This is an important component of professional relationships in health visiting, and practitioners and managers have identified this as a training need.</p> <p>Learning from challenging situations and sharing experience is a key factor in building resilience.</p>	<p>Patterson, K., Grenny, J., McMillan, R. and Switzler, A. (2002) <i>Crucial Conversations: Tools for Talking when Stakes are High</i>, McGraw Hill.</p> <p>Rosenberg, M. (2013) <i>Nonviolent Communication: A Language of Life: Life-Changing Tools for Healthy Relationships</i> (Nonviolent Communication Guides), Puddle Dancer Press.</p>
Action learning sets	<ul style="list-style-type: none"> ■ Contributes to improved performance ■ Enhances critical thinking ■ Develops creative solutions ■ Increases self-confidence ■ Improves communication skills. 	<p>A process of reflecting on one's work and beliefs in the supportive/ confrontational environment of one's peers for the purpose of gaining new insights and resolving real business and community problems in real time (Dilworth and Willis, 2003). Facilitation skills influence engagement in action learning.</p>	<p>Dilworth, R. L. and Willis, J. (2003) <i>Action learning: Images and pathways</i>. Malabar, FL: Krieger.</p> <p>Edinburgh Napier University and NHS Lothian (2012) <i>Leadership in Compassionate Care Programme: Enhancing Patient Care by promoting compassionate practice</i>. Action learning helped participants to explore challenges to developing compassionate caring practice, to develop communication strategies and encourage research in practice.</p>
Performance Feedback	<ul style="list-style-type: none"> ■ Enhances effective behaviour change ■ Enhances employee morale and job satisfaction ■ Enhances health and wellbeing ■ Reduces workplace stress ■ Contributes to improving patient outcomes <p><i>360-degree feedback</i> is a tool to help employees improve and focus on their development.</p> <p><i>The Action After Review (AAR)</i> process provides insight into performance, team work, leadership and culture.</p> <p>It enhances engagement, responsibility and facilitates self-efficacy which is important for job satisfaction, engagement and retention of staff.</p> <p>Learning from challenging situations and sharing experience is a key factor in building resilience.</p>	<p>Health Visitors describe feedback as something they value for developing their knowledge and skills. Open communication and transparency are important components of positive practice environments.</p> <p>Constructive feedback is timely and starts with the positive, is specific, refers to a behaviour that can change, offers alternatives and choice.</p> <p>Two specific models are multisource (360-degree) feedback and After Action Review.</p> <p>360-degree feedback can identify a starting point for the development of new skills, measure progress as skills are worked on over time, and identify blind spots in behaviour.</p> <p>After Action Review (AAR) is used predominantly to analyse specific events, using 4 key questions – What did you expect to happen? What happened? What was the difference? What did you learn?</p> <p>It increases awareness, generates understanding, facilitates behaviour change and learning.</p>	<p>Partnership for Occupational Safety and Health in Healthcare (2012) <i>Health and Wellbeing in Healthcare Settings</i>. Available at: bit.ly/1z7tyN6. Accessed 1.12.14.</p> <p>NHS Employers (2014) <i>Guidance on prevention and management of stress at work</i>. Available at: bit.ly/1Ep4fei. Accessed 1.12.14.</p> <p>NHS Leadership Academy (ND) <i>The Leadership Academy and 360 degree feedback</i>. bit.ly/1H7qpUz accessed 14.01.15</p> <p>Walker, J., Andrews, S., Grewcock, D. and Halligan, A. (2012) Life in the slow lane: making hospitals safer, slowly but surely. <i>Journal of the Royal Society of Medicine</i>, 105, 283–287.</p>

Source of Support	Benefits	Description	Resources \ links
Interagency / Disciplinary Groups	<ul style="list-style-type: none"> ■ Clarifies roles and responsibilities ■ Contains the emotional impact of the work ■ Supports the development of shared meaning ■ Benefits clients, team working and potentially facilitates cultural change. <p>Work discussion groups support participants to develop their understanding of institutional and interpersonal dynamics and the possible emotional meaning of communications.</p> <p>Schwartz centre rounds have a growing evidence base. They enable multidisciplinary reflection on the emotional impact of work and shared learning.</p> <p>Compassion Circles™ are offered to people connected through health and social care and aim to facilitate self-compassion. Anecdotal evidence suggests positive outcomes.</p>	<p>Interagency/disciplinary groups can support the development of meaning, clarify roles and responsibilities, and contain the emotional impact of the work. Models include work discussion groups, Schwartz rounds and Compassion Circles™.</p> <p>Work discussion groups have approximately five members, are facilitated by a trained, experienced facilitator. This approach enables members to explore unconscious processes, share their experience and reflect on the implication of what has been seen and experienced in the group through discussion.</p> <p>Schwartz centre rounds are multidisciplinary forums where health professionals meet monthly to reflect and acknowledge work-related psychological, emotional and social challenges.</p> <p>The development of Compassion Circles™ has been informed by the compassionate mind model (Gilbert 2010), Professor Jon Kabat Zinn, and Nancy Kline (2005). They are designed to offer a safe place for facilitated reflective dialogue for groups of up to 12 people and to facilitate the development of self-compassion.</p>	<p>Canham, H. (2000) Exporting the Tavistock Model to Social Services: Clinical Consultative and Teaching Aspects, <i>Journal of Social Work Practice</i> (14) 2: 125 - 133</p> <p>Goodrich, J. (2011) <i>Schwartz Centre Rounds: Evaluation of UK Pilots</i>. London: Kings Fund.</p> <p>The Point of Care Foundation (2014) <i>Staff Care; How to engage staff in the NHS and why it matters</i>. Available at: bit.ly/1BH3iMc.</p> <p>Gilbert, P. (2010) <i>The Compassionate Mind: a new approach to life's challenges</i>. London: Constable.</p> <p>Kline, N. (2005) <i>Time to Think: An Imperative of Behaviour, Not Time</i>. Available at: bit.ly/1DnsSc7. Accessed 1.11.5.</p> <p>Jon Kabat Zinn is the Executive Director of the Centre for Mindfulness at the University of Massachusetts. His research has included the clinical applications of mindfulness meditation training, and the effects of stress in various corporate settings and work environments. bit.ly/1EZz58U</p>
Compassionate Resilience	<ul style="list-style-type: none"> ■ Develops compassion skills ■ Develops resilience skills ■ Develops ability to contain and alleviate emotional distress ■ Contributes to maintaining health and relationships ■ Enhances ability to cope with stress 	<p>Incorporates three components: 1) Self-compassion, as a key to resilience; 2) Learning how to maintain resilience in order to sustain compassion even in challenging situations; and 3) a culture of compassion including compassionate leadership. These are underpinned with models including the compassionate mind model (Gilbert, 2010), self-compassion (Germer and Neff, 2013), vulnerability (Brown, 2012), mindfulness (Berry, 2014) and resilience (Hart and Heaver, 2013).</p>	<p>De Zulueta, P. (2014) Compassionate resilience - why we need it in healthcare. <i>Human Values in Healthcare Forum. Summer Update, 2</i></p> <p>iHV (2015) Supporting health visitors and fostering resilience: a literature review</p>

Potential outcomes of implementing models of support

Providing support to health visitors, using the models described has the potential to foster their resilience and compassion.

Resilience and compassion are key outcomes to assure retention of health visitors in the workforce who are able to deliver safe, sensitive and effective care for children and families. The concepts of resilience, compassion and compassionate resilience are briefly explained below. A fuller account of each can be found in Appendix 1.

Resilience:

Resilience is the ability to overcome difficulties, bounce back and even thrive from adversity. Resilience is a process that it is built through the development of self-efficacy following successful coping with repeated brief stress experiences. It is not just a reactive process; a preventative approach can be applied. Potentially stressful events can be identified, planned for by managers and organisations, taking into account exposure to adversity and its impact, as well as the availability of protective factors such as the models of support outlined in this resource.

Key Points

- Resilience is not just about survival it is about learning and finding healthy ways to cope.
- There is a need to grow professional resilience through addressing common adversities.
- The government strategy for mental health and staff wellbeing in the NHS highlights the importance of individuals and employers recognising and building resilience and need reference.
- Values-based recruitment contributes to creating positive work environments and to staff feeling valued, which are key factors influencing resilience.
- Transparent processes which engage employees in decision-making and are responsive, adopting supportive management styles and creating learning opportunities are important considerations.

Compassion:

Compassion is an essential attribute for health professionals identified in the NHS Constitution (DH, 2013) and is one of six key nursing values, the '6Cs' (DH 2012), which also apply in a health visiting context (NHS England, 2014).

Key Points

- The creation of resilient and compassionate cultures starts with compassionate leaders who foster resilience at the individual, team and organisational levels.
- Organisations need to consider employees' core needs: competence (to feel effective); autonomy (to feel in control); and relatedness (to feel connected to others) to enhance staff satisfaction, motivation and retention.
- Compassion enhances staff satisfaction and engagement and contributes to the performance of organisations.
- Compassion can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity.
- Compassion involves a dynamic interpersonal process which unfolds at three levels personal, relational and organisational.

Self-Compassion:

Key Points

- Self-compassion involves turning towards our own suffering and taking action to alleviate it.
- Self-compassion fosters connectedness rather than separation or self-centeredness and is a skill that can be taught.
- Enhancing self-compassion develops our ability to be compassionate towards others.

Compassionate Resilience: a new concept

Key Points

- Compassionate resilience incorporates three components: Self-compassion, as a key to resilience; learning how to maintain resilience in order to sustain compassion, even in challenging situations; and compassionate cultures, including compassionate leadership.

Six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances have been identified: These are represented by the acronym – SHARENOW: enhancing Self-awareness, fostering Hope, developing Acceptance, forming supportive Relationships, Expressing vulnerability and being in the NOW.

Clearly, there are many factors that contribute to or diminish the resilience of health visitors. In Section 2, guidance is given on selecting from the range of approaches to promote resilience in the workplace for health visitors.

Section 2 Practical tools for assessing and developing resilience and building effective practice

Selecting tools to assess, monitor and promote resilience

In health visiting practice, the ability of a family to be resilient may depend on many factors and the intrinsic ability of the parent(s) to manage these and, in so doing, protect the emotional wellbeing of the child and enhance his/her emotional capacity.

Bronfenbrenner (1989) described there being an ecological environment of interconnected micro, meso, macro and exosystems and the importance of this environment should be understood by the health visitor with respect to the wellbeing of the family. Likewise, when considering occupational resilience a contextual, systems approach to resilience incorporating individual, societal and environmental interaction and the capacities of individuals to actively engage with and change structures through emancipatory actions is recommended. Hence, while the vignette presented in the first case study below describes an individual, the factors that impact upon and affect resilience can only be understood in terms of the wider context of practice.

In this resource, we do not present a 'cookbook' of ways to promote the resilience of health visitors. Rather, we present a menu of supportive inventions in this and the companion 'Guide for Practitioners' based upon evidence from a literature review conducted for this purpose bit.ly/1HZjZX3.

We suggest how managers and leaders can be alert to signs of stress that impact on the resilience of individuals, and then provide case studies of interventions at team and organisational levels. These are not intended to be exhaustive or prescriptive, but rather to be exemplary and illustrative in order to inspire thinking and action about how leaders and managers can creatively and responsively mobilise supportive strategies to create positive practice environments (Bryar et al, 2012).

In the remainder of this resource, a range of key concepts and tools are presented that relate to different levels within the ecosystem of the organisation. Applying a public health approach to staff support and building resilience we can readily appreciate the social, environmental and organisational determinants of resilience in the workplace, while acknowledging that these will impact upon individuals and groups in distinctive ways, for example depending on past histories of adverse experiences or level of capability building through training and development activities.

The companion document to this resource has been developed so that individual health visitors can use it to assist them in developing their own resilience. This will also be of value for teams of health visitors. iHV survey data indicates that the most accessible and effective support is the informal support between peers in their 'office' base. Therefore, the practitioners' guide is equally of use to managers who wish to empower their staff and validate a culture of team support by creating time and space for this to take place.

Tools are presented to assist managers within the organisation to consider and respond to individual needs. For example, there are pointers on how you might recognise that an individual's resilience is diminishing. Moreover, while assessment may be undertaken at a point in time, building resilience is a process that takes place over time (Bronfenbrenner's (1979) 'chronosystem'). Hence, for example, the iHV's National Framework for Induction and Preceptorship may be recommended for supporting and facilitating recently qualified or newly recruited practitioners: bit.ly/1BG7vib.

At the **team** level, outlined in Figure 3, there are key questions that could facilitate reflection and discussion with staff in relation to the themes influencing resilience. On the **wider organisational** level, a prototype benchmark tool has been developed to help organisations determine how effective they are in supporting staff to manage stress in their work and to build personal and professional resilience. This can be found in Appendix 2. A range of other self-assessment tools have also been identified and these can be found in Appendix 3, while Appendix 4 provides additional resources for organisations in the form of an annotated list of useful web links to support resilience.

Ten steps for managers to create supportive environments and build resilience in their staff at individual and team level

Given the plethora of concepts and resources available, the following diagram sets out ten steps to assist managers and team leaders to gain a rounded picture of the individual and team context of resilience.

Figure 3: 10 steps for managers to create supportive environments and build resilience with their staff



Resilience at individual level: Signs of reducing resilience

It is important to be able to recognise signs of reducing resilience in self and others and offer/seek appropriate support.

These signs are outlined in Figure 4 below.

Figure 4: Signs of reducing resilience

Figure 4 shows some of the feelings, thoughts and behaviours that might alert us that additional action is needed to maintain our resilience.



How feasible it is to measure resilience is questionable, however it is worth considering that sickness absence, retention and engagement with change are proxies for resilience.

Bearing in mind the limitations, individuals can test their own resilience by completing self-assessment scales such as Wagnild & Young's (1993) scale at bit.ly/1NANPQj.

Key questions to facilitate reflection and discussion with staff in relation to the themes identified in the literature that influence resilience are outlined in Figure 5.

Figure 5: Key Questions for facilitating reflection

<p>Professional Identity</p> <ul style="list-style-type: none">■ Are you clear about your role boundaries and responsibilities?■ What are your professional principles/values?■ How congruent are they with your personal values?	<p>Leadership and Organisational Culture</p> <ul style="list-style-type: none">■ Do you think you are making a difference to the health of children and families?■ Do you have a sense of autonomy in your work and decision-making?■ How are you managing your workload?■ Do you feel connected with professional colleagues?■ Do you feel encouraged and supported by the organisation?
<p>Models of Support</p> <ul style="list-style-type: none">■ Are you accessing supervision regularly?■ Are you able to talk to your supervisor about your support needs?■ What other sources of support are you accessing e.g. peer, mentor, coach, occupational health, therapist?	<p>Education and Training</p> <ul style="list-style-type: none">■ Have you developed a CPD plan?■ Do you access any online resources? e.g. iHV website.■ What additional training would be helpful to support you?

Case Study 1: Supporting resilience at individual level

The following vignette, written by health visitors, is provided to illustrate the importance of accessing relevant models of support for effective professional practice.

Ruth had been working with a family with complex needs where the children had been victims of a crime. She feels the children may still be at risk but is feeling the need for support as to how she can manage the case and her own feelings about it going forwards. She asks the multi-professional team around the child following a meeting if they could explore some of their own personal thoughts and feelings about what is happening. This open, peer safeguarding discussion led to interesting and useful observations on how the case had affected each of the professionals individually and had triggered significant concerns with all of them. Ruth was also able to take this case to her groups supervision with a specialist therapist who was also able to explore the family's behaviour and what it may mean for the children and also feelings Ruth had of confusion and vulnerability in more depth. Hence, using a variety of support models in this way proved helpful to enable Ruth to maintain her role in this case.

Commentary

The vignette in this case study highlights the issue of resilience in terms of the individual experiences of a practitioner. However, these can also be seen in the context that they arose including the team, multi-professional working and wider organisational resources available. The practitioner was confident and resourceful enough to mobilise these resources for herself. However, managers and other leaders will need to bear in mind that threats to resilience may undermine this capacity and, hence, the need to actively search for and stimulate awareness of support needs at individual level, facilitate access and use of appropriate and acceptable support strategies, and make use of organisational policies to bring these into effect. In other words, the principles of health visiting (CETHV, 1977) are applicable to providing a positive practice environment (Bryar et al, 2012) for individual health visitors to remain effectively engaged with complex family situations without being overwhelmed by them and as a team member.

Case study2: Building resilience at team level within an organisation

In October 2014 I was asked to facilitate the merger of two health visiting (HV) teams in a northern trust who had been identified as struggling.

Not only were the teams failing to meet key performance indicators but morale was low, communication poor, conflict had emerged within both teams, long-term stress-related sickness was evident, and a number of staff had been seconded, requested a move, sought alternative employment or retired in a two month period leaving a deficit of 101.5 health visiting hours per week.

The Health Visiting Implementation Plan was almost complete, with newly-qualified health visitors being employed. Information technology services were being re-commissioned leading to the introduction of agile working, and although the trust is a values-based organisation, with innovation as a key theme, it was working within a back drop of sustained multifaceted change affecting the organisational context and service delivery which had led to a period of stagnation rather than innovation, with staff feeling exhausted by change, a view echoed by many colleagues in organisations across the country.

As a merged team we were supplied by the senior management with the 'tools to do the job' - two newly-qualified health visitors and three experienced health visitors (107.5 hours per week including 15 hours protected managerial time). We were provided with professional autonomy and control over the way we planned to restructure and practice as a team. The trust introduced an employee assistance program, counselling and physiotherapy services with a commitment to staff support to enhance the existing health and wellbeing, preceptorship, supervision and access to readily available training programmes at the trust.

Initially, as a team, we reviewed key documents and legislation relating to the Healthy Child Programme, early intervention, public health, commissioning, service specifications, and statutory frameworks for early years to develop a shared vision and understanding of what outcomes we both wanted and needed to achieve as a team at a local, regional and national level.

We analysed the various health visiting models using the key outcomes of the document review, and identifying the pros and cons from staff's previous experiences of working within each of the models, the team decided to adopt individual caseloads allocated pro rata antenatally, as they identified that the sharing out of clients was time consuming, while corporate caseloads can leave staff feeling overwhelmed with responsibility. Quality was perceived to improve with individual caseloads as relationships were built with both clients and the multiagency team.

The team ethos was reviewed with a good work-life balance, low stress levels, a supportive sympathetic team being identified as important. Individually the team members felt they were hard working and provided high quality care and interventions however they acknowledged the difficulties they experienced previously.

As a team we were now very clear on who we were and what we wanted to achieve so the next question was how.

It became apparent that before we were able to transfer clients to individual pro rata caseloads, we would have to undertake remedial work including transfers into school, caseload analysis, development of individual caseloads on System 1 for population, communication and staff training, over the next four weeks. These issues were resolved through delegation, empowerment and education, culminating in the transfer of caseloads in weeks 3 and 4 and a sense of achievement.

Communication was improved within the team through weekly team meetings (1 hour starting and ending promptly). The meeting has a high attendance rate demonstrating its value. Staff were encouraged to seek 1:1s to discuss issues and receive support. Organisational processes causing professional frustration were the team's primary concern. Solutions were found and communicated.

During team meetings a number of key themes became apparent that needed addressing including a concern that communication around safeguarding was reduced by the new working arrangements. As a solution, the first 15 minutes of every team meeting is dedicated to sharing safeguarding information.

Audits demonstrated that key performance indicators were not being reached, due to incorrect recording – solution System 1 training was arranged.

Team cohesion was improved by a team building event – 'geocaching'. The introduction of the agile working policy and raising expectations of communication between all staff helped to foster a culture of mutual trust, fairness and respect, with each member of staff receiving from the trust appropriate technology to enable agile working.

Performance indicators were reviewed and celebrated. Where improvements are suggested, the team develops an action plan. Thereby the team is aware of its performance and takes responsibility for improvement.

Every member of staff shared their previous experiences and identified an area of interest from the key documents to reveal individual expertise and develop not only themselves but the team as a whole. Preceptorship, supervision and training are now encouraged and supported by the whole team.

Anecdotally the team now reports a better work-life balance, manageable caseloads, improved stress levels, improved relationships with clients and the multidisciplinary team. Leadership was identified as key enabler and the most frequent comment is how improved relationships have improved the quality of client care.

Quantitatively the team is now meeting its key performance indicators, we have received positive feedback from clients regarding the service following the changes in practice, sickness has been significantly reduced to below national levels and staff turnover had been reduced to zero.

Team Leader, A Northern NHS Trust.

Commentary

This case study manifests a range of supportive interventions, as outlined in this document. It highlights how detrimental the stresses of contemporary health visiting can be for staff wellbeing and team performance affecting the delivery of care to children and families. However, overall it also demonstrates how staff engagement and the mobilisation of support strategies can be effective. In order to contribute to positive practice environments that attract and retain staff any interventions need to be well targeted to align with the 'key features of effective primary health care nursing' (Bryar et al, 2012) in the context of health visiting. Of the five features, four are prominent in this case study. **'People centeredness'** is manifest in taking seriously the impact of stress on individuals and teams and on facilitating a process of staff engagement. Improved relationships are identified as key at team, organisational and client levels of working. The adoption of individual caseloads enabled practitioners to fulfil the 'health visiting orientation to practice' that is focused on health, is relational and contextual (Cowley et al, 2013).

'Partnering and inter-professional working' was strengthened through improved systems of communication, and this was supported by **'information and communications technology'** to improve rather than frustrate effective engagement of practitioners straddling boundaries beyond those established by organisational structures to reach out to where families and communities live. Taking staff wellbeing seriously through the provision of a range of supportive and motivating interventions also contributed to the **'quality improvement'** agenda of the organisation.

The following quote (from another organisation) sums up the systemic nature of the impact of resilience and the key importance of relationships:

It's obvious to me that we work through relationships - so babies are cared for by their parents, health visitors care for the parents and managers care for the health visitors - so a positive organisational culture will impact on our clients.

Jill Beswick, Health Visiting Service Transformation Lead, NHS England (Greater Manchester) and Early Years Workforce Development Lead, Greater Manchester Public Service Reform Team.

Case study 3: Resilience at Organisational Level

Building resilience across South Warwickshire NHS Foundation Trust health visiting services through the use of Communities of Practice

The Health Visiting Implementation Plan – A Call to Action (DH, 2011) resulted in an increased number of students being placed within the organisation and consequent demands placed upon the resilience and capacity of all concerned. This was potentially stressful for all parties - mentors, students and practice teachers who were having to cope with a new way of working. Mentors were utilised for the first time and needed to be upskilled and supported to take on this task. Students were placed with practitioners who were knowledgeable health visitors but who might be new to teaching. Practice teachers were still overseeing the learning but were having less student contact than they were previously used to.

Communities of practice were developed across the organisation to help to reduce stress for staff and to help them build their own resilience. The notion of 'communities of practice' has been promulgated over recent decades by Etienne Wenger and Jean Lave (1991; Wenger, 2002) as a way of recognising and promoting shared organisational learning and identity. For the students the Monday Club was initiated. Utilising Wenger's communities of practice model, the club enabled students to meet together for shared learning experiences. Integral to this approach was that the students would support each other as they learned to become health visitors through legitimising participation and moving from the periphery of the organisation to find a sense of belonging. The social aspect of the group was important and students were encouraged to bring a shared lunch. Reflective practice underpinned each session and the sessions were designed be a safe arena were students were able to discuss practice issues. They were reassured that it was safe to explore issues and okay to get things wrong.

Communities of practice were also set up for the practice teaching team and for mentors using similar principles as outlined above.

As the students qualify and take up posts with our trust, the value of Monday Clubs is not lost. Students are allowed protected time to attend bimonthly communities of practice throughout their first 2 years as part of their preceptorship package.

Communities of practice are now also utilised within the trust to support practitioners undertaking the Building Community Capacity module.

Evidence of impact

Communities of practice have had a positive impact upon our organisation as a whole and have contributed to staff resilience. People want to work in Warwickshire. Our students have commented that their peers in other organisations comment very favourably on the level of support that is offered to our students. Retention of staff is good and our sickness levels have fallen. Staff surveys have reported that staff are proud to work in our trust. The shared learning that takes place within the communities of practice has led to better standardisation of practice across the trust. In January 2015 all of our students passed the course. A third of the students undertaking the course at undergraduate level achieved first class honours. Student feedback from Monday clubs and the communities of practice utilised during their preceptorship period is excellent. Mentors who were anxious about their mentoring role fed back that they felt well supported. Many of them now wish to be practice teachers. Our practice teaching team

has flourished. They have all developed themselves and the communities of practice has helped them to develop. Five practice teachers are now fellows with the Institute of Health Visiting and many of the practice teachers have led on exciting developments such as the Baby Steps programme for new parents and HENRY programme for families to improve nutrition and participation in physical activity.

In conclusion, utilising communities of practice has helped our trust to flourish as a learning organisation and this has seen an increase in standards, high levels of achievement and development. Staff feedback positively and enjoy being part of communities of practice. They help students and staff to learn and to feel supported. Staff feel motivated to do well and many staff have grown and developed to achieve great things. This has all helped to increased staff resilience.

**Tracey Biggs, Associate practice teacher, health visiting.
South Warwickshire NHS Foundation Trust**

Commentary

This case study manifests how communities of practice can encompass a range of supportive interventions as outlined in this document. It highlights how a major demand on the capacity of the organisation can be met through identifying assets and improving outcomes on a number of levels. In particular it demonstrates how staff engagement through legitimated participation can be effective for organisational learning. In order to contribute to positive practice environments that attract and retain staff any interventions need to be well targeted to align with the 'key features of effective primary health care nursing' (Bryar et al, 2012) in the context of health visiting. All five of these key features are implicit or explicit in this case study. **'People centeredness'** is evident through building relationships around a shared agenda, in this case student learning and practice orientation that is focused on health, is relational and contextual (Cowley et al, 2013). A **'public health perspective'** is evident in the use of the community of practice to engage in learning around building community capacity which inevitably requires **'partnering and inter-professional working'**. While Lave and Wenger's (1992) examples of communities of practice value tradition, they are also used to embrace new forms of community mediated by **'information and communications technology'**. Hence, the Institute of Health Visiting provides an e-community of practice, making use of web-based technologies. Finally, staff engagement and wellbeing are clearly impacted positively by the community of practice and have contributed significantly to the 'quality improvement' agenda of the organisation as indicated by qualitative and quantitative measures.

Further guidance on good practice points when developing communities of practice can be found at bit.ly/1BG7vib

Organisational benchmarking tool

A prototype organisational benchmark tool has been developed to identify factors from research and policy that have the potential to improve the retention of health visitors in the workplace.

This is presented in Appendix 2. The benchmarking tool has been developed for the iHV by Karen Stansfield, Principal Consultant, Mott MacDonald, based on methodology used by the Essence of Care Benchmarks for the Fundamental Aspects of Care (Department of Health (DH), 2010). Benchmarks in this context are employee-focused outcomes that express what employees want from their particular area of practice. Therefore, what health visitors want and expect from the workplace was the starting point in developing the benchmarking tool.

A literature review was undertaken to explore the priorities for improving staff retention both in general and in health visiting specifically, along with reference to findings from the Resilience Framework Consultation Group (Institute of Health Visiting, 2015). Analysis revealed the following seven factors as being fundamental to enable health visitors to be engaged and satisfied with their work: support, training and development, recruitment, involvement and participation, client relationships, health and wellbeing and culture. Each factor consists of an employee-focused statement on a continuum from poor practice through to best practice. Indicators are identified under each factor that facilitates the attainment of best practice and how this can be achieved.

The benchmark tool could be used in a number of ways. For example, as a quality assurance framework for health visitor retention, it provides a bottom-up perspective from health visitors of what is perceived to aid engagement and satisfaction with their employer. Specifically it can be used as an audit tool for employers and employees to assess themselves against. It has the potential to be used by a wide variety of individuals and teams, within and across organisations of all different sizes.

Whilst it is yet to be tested, it offers one tool for organisations to use to review whether they have the right processes in place to ensure retention of health visiting staff.

Conclusion

This document presents a *Resilience Framework* and resources for assessing and developing resilience with compassion and for supporting health visitors.

The Resilience Framework can be applied to other professions and at organisational, team and individual levels. It is underpinned by compassion with the principles of health visiting and 6Cs as key components. Compassion in the workplace has positive benefits for the quality of care and staff morale. A contextual, systems approach to resilience incorporating individual and organisational interaction is envisaged. Positive practice environments can enhance and facilitate the capacities of individuals to change structures through emancipatory actions. A range of models of support are included in the framework and provide a menu of support to choose from. It is acknowledged that there may be other models of support which could be of benefit to health visitors and this framework can be developed further.

The framework will be effectively delivered through leadership that shares and models the qualities it seeks to promote. It is envisaged that the development of resilience skills, whilst maintaining their compassion, could increase health visitors' capacity to tolerate distress and manage a broad range of effective experiences. Resilience and compassion can be planned for and developed.

Through the process of developing the framework the need for further research has been identified. This includes the need to understand how health visitors process experiences that are significant or traumatic and what helps them to cope.

This Resilience Framework is designed to help organisations facilitate resilience such that health visitors thrive in their dynamic workplaces, develop a strong professional identity and model resilience and compassion in working with clients. Supporting the development of resilient health visitors who model compassion will contribute to staff retention and to maximising health outcomes and experiences for children, families and communities.

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Appendices

Key concepts and tools for promoting resilience in the health visiting workforce

Appendix 1: Potential Outcomes of Implementing the Models of Support

Appendix 2: Assessment Toolkit – Organisational benchmarking tool

Appendix 3: Assessment Toolkit – Other Assessment Tools

Appendix 4: Additional Resources for organisations – Annotated list of useful web links to support resilience

Appendix 1 – Potential Outcomes of Implementing the Models of Support

Here the key concepts of resilience, compassion and self-compassion are explained at greater length.

Resilience

Resilience is described as an ability to overcome difficulties, bounce back and even thrive from adversity. Resilience is a process that it is built through the development of self-efficacy following successful coping with repeated brief stress experiences. It is not just a reactive process; a preventative approach can be applied. Potentially stressful events can be identified, planned for and practised.

The DH (2009) suggests that, by investing in the emotional resilience of staff, employers play a role in tackling health inequalities. An ecological definition of resilience incorporates individual, societal and environmental interaction and the capacities of individuals to change structures through emancipatory actions.

There is a limited but growing body of research on professional resilience. In a review of the literature across five professional groups (nurses, social workers, counsellors, doctors and psychologists) professional resilience is defined as “the ability to maintain personal and professional wellbeing in the face of ongoing work stress and adversity” (McCann et al, 2013,p61). Work-life balance was identified as a consistent influencing factor across all professional groups. Other factors included beliefs and self-reflection, insight gained through peer support and supervision and professional identity.

Key Points: Resilience

- Resilience is not just about survival it is about learning and finding healthy ways to cope.
- There is a need to grow professional resilience through addressing common adversities.
- The government strategy for mental health highlights the importance of individuals and employers recognising and building resilience.
- Values-based recruitment contributes to creating positive work environments and to staff feeling valued which are key factors influencing resilience.
- Transparent processes which engage employees in decision-making and are responsive, adopting supportive management styles and creating learning opportunities are important considerations.

Compassion

The Francis Report (2013) highlighted a lack of transparency and a culture of intimidation within the NHS and led to the governmental drive to create a culture of compassion. However, competition between services and targets are continuing to create challenges in enabling this process. The Department of Health (DH, 2012) emphasised the importance of addressing the burden of bureaucracy; however the largest ever study of NHS culture has found that quality of care is often compromised by too much regulation, excessive box ticking and highly variable staff support (Dixon–Woods et al, 2013). Dixon-Woods recommend developing person-centred rather than task-centred cultures. They argue that there are strong links between staff experience and patient mortality rates.

Compassion can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity. It can also prevent empathic distress, strengthening resilience and preventing burnout. Both self-compassion and compassion are associated with improved emotional resilience. Compassion is an essential health professional attribute, identified in the NHS Constitution (DH, 2013) and is one of six key nursing values, the '6Cs' (DH, 2012), which also apply in health visiting (NHS England, 2014).

Compassion is defined as *'a sensitivity to the suffering of self and others, with a deep commitment to relieve it'* (Dali Lama 1995, cited in Gilbert, (2010) bit.ly/1ajrIS8)

It involves an engagement with suffering and action to prevent or alleviate suffering (Gilbert 2010, as above).

Paul Gilbert outlines six core attributes of compassion:

- attentional sensitivity
- motivation
- empathy
- sympathy
- distress tolerance and
- non-judgemental positive regard

Compassion from others is important in preventing or reducing compassion fatigue which may arise when people are unable to do what they consider is the right thing. 45% of health visitors in the iHV survey (2014) expressed concern that they could not deliver the care they aspired to and 45% of health visitors in the NHS staff survey (2014) said stress was affecting their health. These figures suggest that there are a large number of health visitors at risk of compassion fatigue.

The creation of resilient cultures starts with compassionate leaders who foster resilience at the individual and organisational level. Compassionate leadership is a skill and a way of being which can be developed. Undertaking compassionate mind training can enhance the ability to respond compassionately. This develops the capacity for self-compassion and for understanding how to support people through difficult situations by understanding the pressures people experience and how this activates their threat system, how people respond when they feel threatened and how to support people to develop more productive ways to solve problems.

Key Points: Compassion

- Compassion enhances staff satisfaction and engagement, and contributes to the performance of organisations.
- Compassion can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity.
- Compassion involves a dynamic interpersonal process which unfolds at three levels: personal, relational and organisational.
- Organisations need to consider employees' core needs - competence (to feel effective), autonomy (to feel in control) and relatedness (to feel connected to others) - to enhance staff satisfaction, motivation and retention.
- The creation of resilient and compassionate cultures starts with compassionate leaders who foster resilience at the individual, team and organisational level.

Self-Compassion

Self-compassion fosters connectedness rather than separation or self-centeredness and is a skill that can be taught. When teaching self-compassion it is important to consider that for some people self-compassion can feel very threatening and they may be fearful of it. Enhancing self-compassion develops our ability to be compassionate, and mindfulness exercises resulted in people being five times more likely to have a helpful response to suffering.

Key Points: Self-Compassion

- Self-compassion involves turning towards our own suffering and taking action to alleviate it.
- Self-compassion fosters connectedness rather than separation or self-centeredness and is a skill that can be taught.
- Enhancing self-compassion develops our ability to be compassionate towards others.

“Only recently has compassion become a component of my own leadership development. The impact it’s having on my personal leadership style, performance and effectiveness is immeasurable. Having the courage to be more self-compassionate has created a profound shift in how I go about being a leader. As I continue to learn and develop, my improved performance has become far more sustainable and resilient, which I attribute to bringing compassion into my leadership”. **Managing Director – Fujitsu Services (Wickremasinghe, 2014).**

The Compassionate Resilience Concept

Health visitors' continued exposure to distress and suffering in conjunction with the challenges they face and the vulnerability of their client group puts them at particular risk of burnout and stress. On reviewing the literature it became evident that by adding self-compassion as a route to resilience to more mainstream approaches we could help build a sustainable workforce who will have the capacity to remain not only resilient but compassionate and nurturing to both themselves and others. After integrating and synthesising the evidence we have adopted the compassionate resilience concept described by DeZulueta (2014) as including: 1. Self-compassion, as a key to resilience and 2. Learning how to maintain resilience in order to sustain compassion, even in challenging situations and added a third component, which is 3. compassionate cultures and compassionate leadership.

This concept is underpinned by models including the compassionate mind model (Gilbert, 2010), self-compassion (Germer and Neff, 2013), vulnerability (Brown, 2012), mindfulness (Berry, 2014) and resilience (Hart and Heaver, 2013). Compassionate resilience is the ability to respond compassionately to adversity, using effective coping strategies. Responding compassionately can be challenging particularly if we feel threatened or dislike the source of this adversity. Developing an understanding of the neurobiology of emotions and how we relieve our distress is an important component in learning how to respond compassionately and remain resilient in these circumstances. Learning how to maintain compassionate resilience is a dynamic, continuous process incorporating a recognition and acceptance of challenges, identifying our reactions to challenging situations and having compassionate strategies to stay in control and enjoy life. A supportive, nurturing environment is crucial for developing compassionate resilience.

Self-compassion is a skill that can be taught by considering five key areas:

1. Physical - caring for your body/non-harm.
2. Mental - allowing your thoughts.
3. Emotional - accepting your feelings.
4. Relational - connecting authentically with others.
5. Spiritual - nurturing your values.

On reviewing the literature and a variety of resilience education and training programmes we identified six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances. These are represented by the acronym –

SHARENOW:

enhancing Self-awareness, fostering Hope, developing Acceptance, forming supportive Relationships, Expressing vulnerability and being in the NOW.

1. Enhancing Self-Awareness

Understanding our emotional tendencies and recognising early warning signs can prevent us from getting caught up in stressful responses. Recognising that it's not an adversity itself that triggers our emotional response and subsequent actions; it's actually our beliefs and interpretations about the adversity. Looking out for unhelpful "thinking traps" (e.g. mind-reading, blaming others, blaming self, believing it's permanent) is valuable.

2. Fostering Hope

The capacity for hope has been identified as a contributory factor in resilience. Hope can be enhanced through looking after our physical, mental, social and spiritual dimensions. This increases our capacity to handle the challenges that life brings. Gratitude can enhance our sense of hope and mental and physical health. Developing the ability to be grateful may contribute to more effectively managing life demands and help to build supportive relationships. We can cultivate gratitude by noticing positive events and keeping a gratitude journal. Writing supports the development of gratitude as it organises thoughts and facilitates integration and meaning.

3. Developing Acceptance

Accepting yourself for who you are and accepting responsibility for looking after yourself will build your resilience. Accepting that life is hard at times, suffering is an inevitable part of life and part of our common humanity contributes to resilience. Acceptance takes courage, involves our engagement with suffering and develops over time. It is a skill through which you become more adept at knowing what you can control and not wasting energy on things outside of your circle of influence. Acceptance has been found to be associated with greater psychological adjustment following exposure to trauma (Thompson et al, 2011) It is important to acknowledge and accept the uniqueness of individuals and cultural diversities and how they may influence acceptance.

4. Forming Supportive Relationships

Establishing supportive relationships which provide a sense of acceptance and support is a key factor in building resilience. A reliable network of trusted individuals can help you through difficult times. When life is difficult, your stress response releases oxytocin which motivates you to seek support. The American Psychological Association (2014) suggests that resilient-building relationships include:

- Relationships that create feelings of trust and love.
- Relationships that provide role models.
- Relationships that offer reassurance and encouragement.

Choosing to connect with others under stress can build resilience. Building relationships and connections also gives purpose and meaning to our lives (Brown, 2012) which also contributes to building resilience.

5. Expressing vulnerability

Life is unpredictable and one of the ways we deal with this is that we numb vulnerability. The ability to express vulnerability is a process that begins with an awareness of our own vulnerability and proceeds to acceptance and expression. It is important to consider cultural influences. Expressing vulnerability in the context of a supportive relationship can develop the ability to tolerate emotional distress, name feelings and recognise bodily reactions. This can facilitate growth and success.

Expressing vulnerability can:

- Facilitate growth and success (Brown, 2012).
- Develop ability to tolerate emotional distress, name feelings and recognise bodily reactions.
- Enhance attention and performance in workers (Gladwell, 2013).

6. Being in the NOW

Being present in the moment is challenging as the human brain is designed to look out for threats so we spend a lot of time thinking about the past and worrying about the future. We have the capacity to ruminate, plan, imagine and reflect. Recognising and naming negative automatic thoughts and feelings can reduce our stress. These skills can be developed through mindfulness. Mindfulness increases the likelihood of noticing our negative automatic thoughts and our suffering. It can help to reduce personal distress as it lessens emotional reactivity and enables us to make sense of our experience. We can shift our attention and train our brains to calm us down. There is a growing body of evidence for mindfulness programmes and a report by the all parliamentary group on wellbeing economics recommends mindfulness is taught to nurses, GPs and teachers (Berry, 2014).

Key Points: Compassionate Resilience

- Compassionate resilience incorporates three components: Self-compassion, as a key to resilience; learning how to maintain resilience in order to sustain compassion, even in challenging situations; and compassionate cultures, including compassionate leadership.

Six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances have been identified: enhancing Self-awareness, fostering Hope, developing Acceptance, forming supportive Relationships, Expressing vulnerability and being in the NOW.

It is envisaged that the development of compassionate resilience skills could increase health visitors' capacity to tolerate distress and manage a broad range of effective experiences. Through this process they could develop hopefulness, the courage to reach out and respond compassionately, and enjoy and thrive in their practice.

Appendix 2: Assessment Toolkit – Organisational benchmarking tool

The following tool has been developed to facilitate organisations in assessing where they are in terms of creating a positive practice environment to build resilience with compassion in their staff.

Author: Karen Stansfield,
Principal Consultant, Mott MacDonald.

Institute of Health Visiting

Benchmarks for Health Visitor Retention

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Introduction

A prototype organisational benchmark tool has been developed to identify factors from research and policy that have the potential to improve the retention of health visitors in the workplace.

The benchmarking tool has been developed based on methodology used by the Essence of Care Benchmarks for the Fundamental Aspects of Care (Department of Health (DH), 2010). Benchmarks in this context are employee-focused outcomes that express what employees want from their particular area of practice. Therefore, what health visitors want and expect from the workplace was the starting point in developing the benchmark tool.

A literature review was undertaken to explore the priorities for improving staff retention both in general and in health visiting specifically, along with reference to findings from the Resilience Framework Consultation Group (Institute of Health Visiting, 2015). Analysis revealed the following seven factors as being fundamental to enable health visitors to be engaged and satisfied with their work: support, training and development, recruitment, involvement and participation, client relationships, health and wellbeing, and culture.

Each factor consists of an employee-focused statement on a continuum from poor practice through to best practice. Indicators are identified under each factor that facilitates the attainment of best practice and how this can be achieved.

The benchmark tool could be used in a number of ways. For example, as a quality assurance framework for health visitor retention, it provides a bottom-up perspective from health visitors of what is perceived to aid engagement and satisfaction with their employer. Specifically, it can be used as an audit tool for employers and employees to assess themselves against. It has the potential to be used by a wide variety of individuals and teams, within and across organisations of all different sizes.

Whilst it is yet to be tested, it offers one tool for organisations to use to review whether they have the right processes in place to ensure retention of health visiting staff.

Benchmarks for Health Visitor Retention

Overall outcome

Health visitors are engaged and satisfied with their work

Definitions

For the purpose of these benchmarks, **health visitor retention** is defined as the initiatives and strategies in place that encourage health visitors to stay with the organisation.

The concept of engagement is defined as:

'The psychological state associated with feelings of commitment and loyalty to one's organisation and involvement in one's work'¹

Health is:

'A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'²

Wellbeing is:

'A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment'³

The term **culture** refers to the set of values, attitudes and beliefs which represent the unique character of the organisation.

The term **health visitor** or **staff** refers to registered nurses or midwives who have undertaken further post-registration training in health visiting and have agreed to work in the community to promote good health and prevent illness.

For simplicity, the individuals, children and families who receive care, advice and support from health visitors are referred to as the **client**.

The **care environment** is defined as an area where care takes place, such as client homes, GP surgeries and community centres.

¹ Improving NHS Care by Engaging Staff and Devolving Decision-Making (2014)

² World Health Organisation (1948) Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22nd July 1946 by the representatives of 61 states (Official Records of the World Health Organisation, no.2, p.100) and entered into force on 7 April 1948. The definition has not been amended since 1945.

³ Department of Health (2010) New Horizons. Working Together for Better Mental Health. ConfidentCommunities, Brighter Futures. A Framework for Developing Well-being

Overall outcome

Health visitors are engaged and satisfied with their work

Factor	Best practice
1. Support	Health visitors are provided with access to supportive relationships that enable them to perform their role confidently and effectively.
1. Training and development	Health visitors' education, training and career progression needs are identified, agreed, met and regularly reviewed.
3. Recruitment	Potential applicants receive sufficient information to enable them to make a well-informed decision about becoming a health visitor.
4. Involvement and participation	Health visitors are actively invited to participate in decision-making processes and their contributions are valued, recorded, acted upon and reviewed.
5. Client relationships	Health visitors are effectively able to develop relationships with their clients and feel they are 'making a difference'.
6. Health and wellbeing	The employer creates a working environment that protects the health and wellbeing of its staff.
7. Culture	The culture of the work environment encompasses a person-centred approach to care that emphasises the value of compassion and resilience in the workplace.

Factor 1 Support

Poor Practice

Health visitors do not have access to appropriate support to perform their role



Best Practice

Health visitors are provided with access to supportive relationships that enable them to perform their role confidently and effectively

Indicators of best practice for factor 1

The following indicators support best practice in health visitor retention:

- a) Health visitors are appointed a line manager who demonstrates a clear understanding and experience of health visiting professional practice and the individual's professional intentions.
- b) Initiatives are taken to provide health visitors with access to other more senior health visitors or staff members with similar roles and experience who can offer informal peer support. For example, newly-qualified practitioners are able to access preceptorship programmes which include peer support opportunities in protected time.
- c) Health visitors are appointed a more senior health visitor to co-work safeguarding families in the first three months from qualifying.
- d) Newly-qualified health visitors are provided by their line manager with clear guidance on their role whilst waiting for their Nursing and Midwifery Council PIN number.
- e) Health visitors meet regularly with another professional who has training in the skills of supervision, for example restorative supervision to discuss casework and other professional issues in a structured way.
- f) Health visitors receive a minimum of three-monthly safeguarding supervisions of their work with their most vulnerable babies and children in accordance with the National Health Visiting Service Specification (NHVSS). This is provided by colleagues with expert knowledge of child protection.
- g) Opportunities exist for health visitors to participate in mentorship programmes that acknowledge the importance of proximity, continuity, and reciprocal positive regard, together with clinical expertise of the allocated mentor.
- h) Mentors are provided with training to prepare them for their role.
- i) If desired, support is provided to health visitors by colleagues from a range of different disciplinary backgrounds to encourage cross-fertilisation.
- j) Links to national groups and external forums exist and information is readily available to health visitors.
- k) Support received by health visitors is evaluated, with outcomes acted upon in order to improve support given.

Factor 2 Training and development

Poor Practice

Health visitors do not have the sufficient skills and development opportunities to enable them to perform their roles effectively and progress in their careers



Best Practice

Health visitors' education, training and career progression needs are identified, agreed, met and regularly reviewed

Indicators of best practice for factor 2

The following indicators support best practice in health visitor retention:

- a) Areas of support required by health visitors are identified using hard and soft intelligence about staff experience and expectations.
- b) Health visitors' knowledge and experience is regularly assessed to identify any skill gaps.
- c) Education and training plans are developed and agreed with health visitors to reflect their individual needs. Plans incorporate goals, actions and outcomes.
- d) Coaching opportunities are offered to health visitors to improve performance of a particular skill.
- e) Practice teachers and mentors are provided with adequate training and coaching skills and are appropriately matched to their allocated students.
- f) Protected time for performance-related feedback is made available to guide health visitors on how to improve and focus their development, for example, multisource (360 degree) reviews, After Action Reviews (AAR) and provision of constructive feedback.
- g) Health visitors have in place a continued professional development (CPD) plan and are encouraged to pursue areas of personal interest.
- h) Opportunities are available for health visitors to move between different roles and departments.
- i) Health visitors are considered for opportunities to train as a practice teacher, manager or for specialist roles.

Factor 3 Recruitment

Poor Practice

Potential applicants receive minimal information about the role of a health visitor



Best Practice

Potential applicants receive sufficient information to enable them to make a well-informed decision about becoming a health visitor

Indicators of best practice for factor 3

The following indicators support best practice in health visitor recruitment:

- a) Information that is available to potential applicants is regularly identified and assessed to ensure it remains current and relevant.
- b) NHS Trusts and HEIs work together to map out the process of recruitment to the profession and undertake joint interviews. Systems include opportunities for applicant contact with practising health visitors and existing students to discuss the role and what to expect, for example through information events and shadowing opportunities.
- c) Managers establish each applicant's expectations of the role and provide up to date and accurate information about: salaries, terms and conditions, (including for sponsorship where relevant), role requirements, preceptorship arrangements and the availability of support with career and professional development.
- d) New applicants are encouraged to be proactive in informing themselves about the role and the organisation.
- e) It is acknowledged that recruitment is a continuous process, extending beyond initial application and entry to a programme of study, into the period of 'training'.
- f) Confidence is developed in newly-qualified health visitors and students by providing access to adequately trained practice teachers during their training.

Factor 4 Involvement and participation

Poor Practice

Health visitors are not involved in decision-making processes and their concerns are not listened to or acted upon



Best Practice

Health visitors are actively invited to participate in decision-making processes and their contributions are valued, recorded, acted upon and reviewed

Indicators of best practice for factor 4

The following indicators support best practice in health visitor retention:

- a) Health visitors' concerns and contributions to improving care are regularly reviewed and evaluated.
- b) Feedback is sought to ascertain if health visitors feel they are listened to, valued and respected. Results of feedback are used to make improvements.
- c) Systems are in place to ensure that communication between senior managers and staff is effective.
- d) When possible, health visitors are allowed to exercise control and autonomy over their work and are given responsibility and authority to respond appropriately and flexibly to client needs.
- e) Feedback received from clients and colleagues regarding health visitors' contributions to delivering care is reviewed and relayed to health visitors.
- f) Managers and leaders work with health visiting teams to articulate the service delivery plans.
- g) Management data gathered through electronic systems (RiO, SystemOne etc.) are regularly reported back to health visitors.

Factor 5 Client relationships

Poor Practice

Health visitors are not provided with the support required to enable them to build relationships with their clients



Best Practice

Health visitors are provided with sufficient support to effectively develop relationships with their clients and feel they are 'making a difference'

Indicators of best practice for factor 5

The following indicators support best practice in health visitor retention:

- a) Managers provide support and encouragement for practitioners to develop relationships with their clients.
- b) Relationship-based training programmes are available with a focus on developing strengths-based approaches that can help health visitors deal with emotionally challenging situations.
- c) Skills necessary for facilitating compassion and engendering trust in scared and vulnerable clients are developed.
- d) Approaches such as the Solihull Model and Family Partnership Model are applied which focus on the relationship between client and health visitor.
- e) Continuity and time to build relationships with clients is provided.
- f) Health visitors are encouraged to be known and visible in community settings such as clinics and community groups.
- g) Health visitors are given autonomy to match their advice and support to the client's needs.
- h) Systems allow health visitors to bring in other professionals, services and resources to provide necessary support for clients with complex health needs.
- i) Processes are in place for clients to provide direct and indirect feedback to health visitors on the services they have received.

Factor 6 Health and wellbeing

Poor Practice

Health visitors feel unwell as a result of work-related stress



Best Practice

The employer creates a working environment that protects the health and wellbeing of its staff

Indicators of best practice for factor 6

The following indicators support best practice in health visitor retention:

- a) Health visitors have access to occupational health services.
- b) Health visitors are provided with training on coping with the physical and emotional aspects of caring with clients, alongside tools to support staff through stressful situations, for example, stressful event plans and reflective diaries.
- c) Opportunities are provided for health visitors to reflect together, talk about the psychological, emotional and social challenges associated with their work, and share coping strategies in a safe environment, for example, Schwartz Rounds, Action Learning Sets, preceptorship programmes, peer support and interagency/disciplinary groups. Facilitators, when required, are trained in how to guide discussions.
- d) Health visitors are supported to develop constructive relationships with others, for example with peers, managers and clients.
- e) Safeguarding supervision is provided to help mitigate effects of vicarious trauma and compassion fatigue.
- f) An externally-run, structured and intensive debriefing session is provided for health visitors following serious incidents.
- g) Health visitors are provided with tools to encourage a healthy work-life balance such as diary planning and prioritising of workload.
- h) Managers recognise the increased workload and possible anxiety associated with the mentor role. Support is provided to ensure mentors are prepared and have the adequate clinical experience to be confident to undertake the role.
- i) The health and emotional wellbeing of health visitors is central to the realisation of the overall strategic vision.

Factor 7 Culture

Poor Practice

The organisational culture is focused around the needs of the business and health visitors feel conflicted to deliver care in ways that seem counter to their clients' interests



Best Practice

The culture of the work environment encompasses a patient-centred approach to care that emphasises the value of compassion and resilience in the workplace

Indicators of best practice for factor 7

The following indicators support best practice in health visitor retention:

- a) Health visitors feel confident with raising concerns about poor standards of care and are encouraged to report errors, near misses and incidents.
- b) Health visitors have the opportunity to participate in empathy and awareness training programmes to understand their impact on client experience. This involves practices to support compassionate behaviour such as selection and socialisation processes, which facilitate noticing, feeling, sense-making and acting in a compassionate way.
- c) Health visitors have the opportunity to develop skills in managing 'courageous' conversations and improve their ability at responding sensitively to their clients.
- d) Health visitors have the opportunity to undertake leadership training.
- e) Health visitors are provided with training to develop the necessary skills to facilitate self-compassion.
- f) Values-based recruitment is applied to recruit staff with the appropriate attitudes, values and approaches encompassed within a compassionate and caring culture.
- g) The employer facilitates narrative practices, contextualises challenges and develops future-orientated stories to enhance and institutionalise the compassionate ethic.
- h) Managers and leaders articulate values and demonstrate how they translate into behaviour by modelling compassionate behaviour in their own roles.
- i) Staff wellbeing is prioritised and a range of tools are provided to health visitors to help them deal with stressful and challenging situations.

Appendix 3: Other Assessment Tools

1. Assessing organisational culture

Cultivating better care toolkit (Social care).	bit.ly/1ajMh0X
Partnership for Occupational Safety and Health in Healthcare (2012) <i>Health and Wellbeing in Healthcare Settings</i> . Highlights practical ways to examine how organisational culture can help or hinder workplace stress.	bit.ly/1z7tyN6

2. Assessing how compassionate an organisation is

The Greater Good Science Centre has a quiz for organisations to assess how compassionate they are.	bit.ly/1IILBVB
Karamally has developed a questionnaire for business organisations to assess their level of compassion.	Karamally, F. (2013) <i>Compassion in Business</i> . Available at: bit.ly/1yLAoJF (accessed 1.12.14)

3. Mindful Employer®

Mindful Employer® is a chartermark for recognising organisations who wish to be better employers for people with mental health problems.	bit.ly/1DpURHV
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4. Department of Health/ Business in the Community (2009)

<i>Emotional Resilience Toolkit</i> provides practical guidance and case examples for promoting resilience of individuals and teams as part of an integrated health and wellbeing programme.	bit.ly/1BCypr3
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5. NHS Employers

NHS Employers provide a range of guidance including: Values-based recruitment; Health and wellbeing – sickness absence tool; Health and wellbeing – guidance on writing strategies; Managers’ guide on health and wellbeing in appraisals; guidance on prevention and management of stress at work, Emotional resilience training and a staff engagement toolkit.	bit.ly/1z7tyN6
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Appendix 4: Additional Resources for organisations

Annotated list of useful web links to support resilience

Compassionate organisations and leadership

Compassion in Practice Implementation Plan for staff experience	bit.ly/12vffq3
NHS Healthcare Leadership Framework	bit.ly/1whEflS

Resilience education and training

NHS ELECT - provide support to NHS teams to develop skills	bit.ly/1x3brd0
Pacific Institute STEPS course	bit.ly/1yAng5P
NHS employers provide information about resilience training	bit.ly/1z7tyN6
Resilience module is available as part of the e-learning for Healthcare, Healthy Child Programme	bit.ly/1qJDM2d
Assessing your resilience – an online scale is available for individual use only	bit.ly/1MyEVE5

Resilience research

University of Westminster, Centre for Resilience	bit.ly/1sdv4xK Aims to foster resilience and integrate research and practice.
University of Brighton	bit.ly/1vFrVkr Work mainly with children, young people and families, and those involved in supporting them but also interested in developing practitioner resilience. Have developed approaches, like Resilient Therapy (RT), and the Resilience Framework, for anyone to use.
Action for Happiness	bit.ly/1umzNbx Is a movement for positive social change, bringing together people from all walks of life who want to play a part in creating a happier society for everyone.
The Greater Good Science Centre	bit.ly/1whDnHf Studies the psychology, sociology, and neuroscience of wellbeing, and teaches skills that foster a thriving, resilient, and compassionate society.

Compassionate resilience

This section includes useful web links to resources to support self-compassion and resilience skills.

Self-compassion

Kristin Neff	bit.ly/1z7oBUx
Christopher Germer	bit.ly/1yQLVa4

The Compassionate Mind Model

Compassionate Mind Foundation - the Foundation aims to promote wellbeing through the scientific understanding and application of compassion	bit.ly/1AgqKwv
Compassionate Mind Foundation training materials	bit.ly/1umw3qs
Netmums 'compassionate mind approach' (CMA)	bit.ly/1Ba89TY

Mindfulness

What is mindfulness?	Mindfulness expert Dr. Jon Kabat-Zinn defines "What is mindfulness?" and discusses the hard work and rewards of practising mindfulness. 5 minutes. bit.ly/1BNuV1U
Benefits of mindfulness	bit.ly/1P00n7k - 3 min
Mindfulness mediation exercises	Free Video – "3-minute breathing space" Guided Meditation by Professor Mark Williams. bit.ly/1yzdC8s Chris Germer - Mindfulness self-compassion meditations – these can be downloaded for your personal use. bit.ly/1yQOdWO

Forums

Action for NHS Wellbeing runs a virtual discussion and peer-support network for over 80 concerned health and social care professionals at the leading edge of education and training.	Website: bit.ly/12NzvmH For further details, please contact: chris.manning@upstreamhealthcare.org
Human Values in Healthcare Forum	Is a network of individuals and organisations which aims to cultivate compassionate healthcare. Provides a forum to engage in creative conversations and share ideas, projects and ethical concerns. Website: bit.ly/1BzhTdr