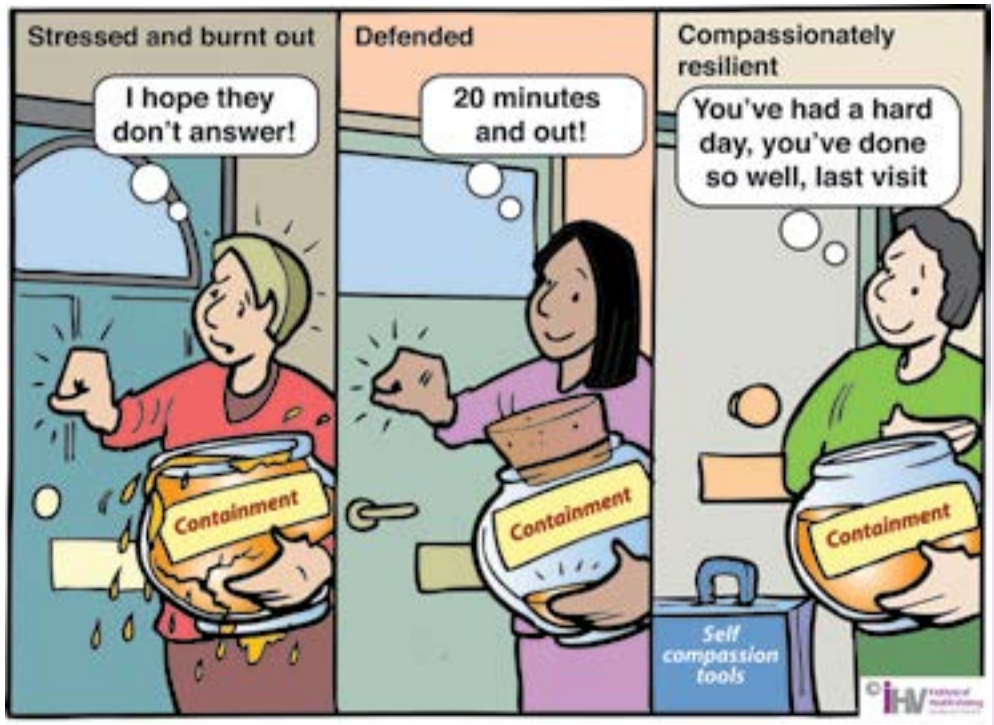
Supported by

Department of Health

NHS Health Education England

Developing Resilience in Practice:

A Health Visiting Framework



Authors: Rachel Stephen and Ann Pettit

March 2015

Developed by the Institute of Health Visiting on behalf of Health Education England and the Department of Health

IHV Institute of Health Visiting
Excellence in Practice

Reader information box

Audience

Health visitors

Health visitor service providers

Strategic leads health visiting practice

Local authority commissioners

Local authority counsellors

NHS and Public Health England area teams

Health Education England commissioners (Local Education and Training Boards)

Providers of health visitor education including Higher Education institutions, private providers, charities and other Voluntary Sector Organisations

Document purpose

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

Title

Developing Resilience in Practice: A Health Visiting Framework

Publication Date

March 2015

Cross reference documents

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

Developing Resilience with Compassion: A Health Visiting Framework, manager's Document (2015)

Review Date:

2017

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.

Acknowledgements

We would like to thank all the children and families who have enriched our health visiting practice, shaped who we are today and whose stories have been central to the development of the resilience framework.

Thanks to all the health visitors who shared their views and personal stories. We are creating knowledge together about how to build resilience whilst maintaining compassion in health visiting.

Special thanks to all the members of our task and finish group, particularly Sue Burridge who coordinated the recruitment and retention subgroup, and to all our expert advisors. Also to our illustrator Graham Ogilvie (www.ogilviedesign.co.uk). The support of our compassionate colleagues at the Institute of Health Visiting has also been invaluable.

Task and Finish Group

Martin Munro (HR Director, NELFT// iHV), Caroline Ward (Associate Director of Children's Services, NELFT), Chris Manning (Doctor, Action for NHS Wellbeing Chair), Paula Carr (Family Partnership Model Supervisor), Paulette Kerr (iHV Regional Lead South), Helen Lake (Restorative Supervisor), Anne Sinclair (HV, Central London CH Trust), Rachel Fulford (HV, Ealing Hospital NHS Trust), Sue Burridge (Practice Teacher, NELFT), Ruth Hudson (Practice Teacher, Virgin Care), John Lawrence (Health Visitor, Royal Marsden), Karen Whittaker (Senior Lecturer, University of Central Lancashire), Sue Mills (Health Visiting Locality Lead, Bedfordshire and Hertfordshire)

Expert Advisors

Professor Paul Gilbert (Professor, Derby University; Director of Compassionate Mind Foundation), Professor Aidan Halligan (Principal, NHS Staff College, Director of Well North), Professor Angie Hart (University of Brighton), Caroline Hudson, Josh Cameron and Penny Lindley (Senior Lecturers, University of Brighton), Juliet Hopkins (Consultant Child Psychotherapist), Naomi Misonoo (Clinical Psychologist), Paquita De Zulueta (Honorary Senior Clinical Lecturer, Imperial College London),Professor David Peters (Professor, University of Westminster; Centre of Resilience), Dr. Stephen Pettit (Reader, Cardiff University), Ruth Rothman (Family Nurse Partnership Education Manager), Mark Williamson (Director, Action for Happiness).

Finally we would like to thank our families and friends whose love and care have enabled us to remain compassionately resilient.

Rachel and **Ann**

This framework was commissioned and supported by Health Education England and the Department of Health.

Contents

Executive summary

Health Education England (HEE) commissioned the Institute of Health Visiting to produce a support framework for fostering resilience and improved retention of health visitors in the workforce.

During the research process, the project managers developed an awareness that not only do health visitors need to be resilient, they also have to remain compassionate to the suffering and distress they encounter. If they can remain both resilient and compassionate they will be able to continue to work effectively with children and families to maximise health outcomes. Although there is much that health visitors can do to support their personal resilience, primarily it is the responsibility of employers to create a working environment that protects the emotional wellbeing of its staff. This starts with compassionate leaders who develop compassionate organisations where the health and emotional wellbeing of staff is central to the realisation of the overall vision.

There has been some research exploring resilience in nursing and other professions (e.g. Mc Cann et al 2013, Hunter and Warren 2014, Adamson et al, 2012, Wendt et al, 2011) but research relating to health visitors is limited (Lindley, 2013, Hudson et al 2014). Resilience is not just about survival, it is about learning and finding healthy ways to cope (Hunter and Warren 2014). Resilience can be planned for, developed and practised. However, context and process are also important considerations (Cowley 2008). Much progress has been made in health visiting and the recent investment in the profession has given way to a resurgence of interest and opportunity – but there remains much to be done. Health visitors in some areas of the country (in particular London) report low morale and barriers to "making a difference" to children and families (iHV 2014). In particular this appears to relate to a lack of opportunity to build consistent relationships with families due to pressures such as record keeping and safeguarding (iHV 2014, Bidmead 2013). The iHV carried out a survey of health visitors in November 2014 (State of the Nation), and out of the 1002 respondents 45% of health visitors said the current support they were receiving was not enough.

This framework is underpinned and informed by the iHV document *Supporting Health Visitors and Fostering Resilience – Literature Review* (2015), where more in-depth information and research can be sourced. There is also an accompanying document *Developing Resilience in the Workforce: A Health Visiting Framework Guide for Managers and Team Leaders* (iHV 2015), which outlines the role of managers and organisations that employ health visitors to enable the profession to continue to flourish and to maximise the opportunity we have been given with recent investment. The practitioner's document outlines models that can support the development of resilience in health visiting practitioners.

This document outlines the 10 models and concepts of support for health visitors which have been identified through iHV surveys, focus groups, discussion with experts and the literature. They include:

- Coaching
- Courageous conversations and influencing skills
- Mentoring
- Peer support
- Interagency/ disciplinary discussion groups
- Relationship-based models of support
- Supervision with a restorative function
- Action learning
- Performance feedback
- Compassionate resilience

Each of these models and concepts have their own merits. However, and perhaps unsurprisingly, informal peer support continues to be the most accessed and consistently supportive means by which health visitors buffer the effects of the stress they encounter (iHV 2014b, NHS survey 2013). This highlights the importance of the 'team around the health visitor' and the containing effects of peer support.

Restorative approaches to supervision have gained much interest in recent years and many health visitors talk about the benefits they have gained from this type of support (iHV 2014a). In a recent iHV survey (State of the Nation) it would appear that supervision does provide a supportive function for health visitors, with 27% surveyed specifically mentioning restorative supervision (iHV 2014b). There is likely to be limited access to the restorative model of supervision in some organisations as there may not be suitably trained staff to deliver supervision with a restorative function or it is not included in supervision policy. The survey also found 78% of respondents considered child protection supervision supportive – this is of course a mandatory requirement and it may be that supervisors are incorporating a restorative element as recommended by (Barker and Hodes 2007).

Relationship-based models of intervention such as the Solihull Approach, Mellow Parenting and the Family Partnership model were also mentioned by health visitors in the iHV survey as providing a supportive function. There is evidence that these models of support not only lead to improved engagement and outcomes for families, they also have benefits for the professionals delivering the programmes. Increased confidence, improved job satisfaction and better relationships with clients and colleagues are amongst a number of known positive outcomes for health visitors (Douglas and Whitehead 2005, Bashford and Seal 2012). Forming relationships with clients would appear to be an important factor for health visitors if they are to find meaning and job satisfaction, which has been found to provide a buffering effect against stress (Ausbrooks 2011). Health visitors value the frameworks that relationship-based interventions provide them with to further develop their work with families. Signposting families to other services, although an important part of the health visitor role, is not enough for many practitioners who seek to deliver effective interventions and develop their practice in a more meaningful way. There is, however, some concern that having the time to build relationships with clients can be hampered due to conflicting pressures (Bidmead 2013, iHV2014b). Health visitors need to be supported by their managers and organisations to develop relationships with their families in an unhurried way (Bidmead 2013).

We are entering uncertain but exciting times with the transfer of health visiting services to local authorities. Health visitors are likely to be welcomed by these organisations. However, they will require the skills to influence commissioners and local counsellors if they are to ensure their services flourish in the desired direction. Guidance on having 'courageous conversations' and 'influencing', perhaps better defined as 'how to communicate best when it matters the most', is included within the models of support with information on how to access more help.

In addition, models and concepts such as positive psychology, mindfulness, self-compassion, and emotional self-regulation have a growing body of evidence demonstrating effectiveness in building individual resilience. Compassionate resilience is an emerging model which has been developed by the iHV and piloted in two areas in England. This model incorporates what we see as the best of the above and combines them in one model of support.

Coaching, mentoring, action learning sets, performance feedback, interagency disciplinary groups such as Schwartz Centre Rounds and Compassion Circles™ are also explored. Each model plays an important part in developing health visiting resilience. It is not expected that health visitors access all, but that they can make an informed choice regarding what suits their particular needs at any given time.

Introduction and purpose

This work aims to build on the Health Visitor Implementation Plan (HVIP) (DH, 2011a) by ensuring that the workforce continues its journey of transformation to provide a gold standard service to children, families and communities.

This document aims to provoke thought and awareness about personal and organisational resilience and to provide an evidence-based framework of information on models of support which can be developed or accessed to build resilience. It is hoped that the models within this document will, together with the development of compassionate leaders and organisations, enable health visitors to remain resilient and to transform the stress, conflict and adversity they may face into learning opportunities for personal and professional growth. In addition the workforce has to be able to remain compassionate to the often overwhelming levels of need, demand and distress that they face in their day-to-day work. This has remained a constant consideration throughout the project.

The Health Visitor Implementation Plan (DH, 2011a) has seen a rapid expansion in the health visiting workforce, with an increase of 4200 whole time equivalents by 2015. It has been estimated that by mid 2015 around 60-70% of the health visiting workforce will have qualified since 2012. Whilst this is exciting for the profession, it has brought challenges to recruitment, training, support and retention of health visitors. There has perhaps never before been such a time where supporting resilience is so key to the continued development of the health visiting profession. Supporting and nurturing newly-qualified health visitors to enable them to flourish within what can be complex and challenging environments must be kept high on the agenda. This document will enable new practitioners to consider support that would best suit their individual temperament and needs. However, the pressures on experienced health visitors are great as it is they who hold the key to helping new staff transform from novice to expert. These experienced health visitors will provide the foundation from which to build, and providing them with opportunities to grow, develop and remain driven and motivated is essential. This document is also for them and, although we recognise their role in providing mentoring and supervision, we would also urge them to use this document to build their own resilience.

This evidence-based framework has been developed by engaging with clients, health visiting students, qualified health visitors, managers, commissioners, educators and experts. It is part of a wider educational programme entitled ‘Making the Most of Health Visiting’, which is supporting the professional development of health visitors. This includes the creation of preceptorship, induction and CPD frameworks, and supporting the development of communities of practice. In particular this resource recognises that resilience should not be at the expense of the capacity to practise compassionately, but rather that compassion is a foundation for resilience.

What is resilience?

The concept of resilience is complex and interlinks with that of emotional wellbeing (Mguni et al, 2011). Resilience is viewed as a dynamic process that considers both the past and the future, enabling a person to build resilience before they reach a crisis.

However, if we focus on wellbeing without considering resilience we may overlook practitioners who have high wellbeing but are vulnerable to future shock. Resilience is not just about survival it is about learning and finding healthy ways to cope (Hunter and Warren 2014). Resilience can be planned for, developed and practised, but context and process are also important considerations (Cowley 2008). The complex context of health visiting practice can contribute to an increased risk of adversity and therefore it is important to understand what contributes to health visitor's resilience. Cultural norms are an important consideration as they influence how vulnerability is expressed, what responses are regarded as effective, and what values and beliefs underpin these responses (Dutton et al 2014). When faced with similar adversities there is a wide variation across cultures in how people cope (Ungar, 2008). For example, Music (2011) describes how egocentric western cultures promote autonomy and individuality. This may reduce our exposure to the buffering, protective factors that living within close networks of support and communities can bring. There has been some research exploring resilience in nursing and other professions (e.g. Mc Cann et al 2013, Hunter and Warren 2014, Adamson et al, 2012, Wendt et al, 2011) but research relating to HVs is limited (Lindley, 2013, Hudson et al 2014).

This framework adopts an ecological definition of resilience as described by Hart and Gagnon (2015), which considers the person in the context of the system in which they are working and the interaction between the two. It supports Diprose's (2015) argument that resilience should not be about helping people to cope with intolerable situations. Rather it is about helping people cope and even transform the adversity through addressing the systems that are contributing to sustaining it. Nevertheless, systems take time to change and it would therefore be unethical not to offer support to individuals. Equally, within systems that function there may be individuals who need to build resilience. They may be in need of support not only to deal with the work environment but wider issues that may affect their performance at a point in time. Adopting an ecological, preventative approach in developing resilience -promoting environments is recommended.

Case study

Two years ago a young child on my caseload died – she was killed by her mother's new partner but the abuse had probably been going on for some time.

I remember so clearly being taken into the manager's office before I could get to my desk – she told me what had happened and I froze. Over the next two days and nights I didn't sleep or eat. I kept going over and over in my mind all that I had done. I wanted to go onto RiO and access my records but I couldn't. It was one of the worst episodes of my life. My colleagues were really kind to me and became so worried about me that they spoke to my manager. It was arranged for the designated nurse for child protection to come to see me.

The designated nurse was amazing; she listened to me and told me that she had been through a very similar experience 10 years ago. She empathised with me and explained the process that she had been through and all the feelings she had experienced. It made me feel normal again and I think I breathed properly for the first time since hearing the news. She told me that my records would be looked at and that a Serious Case Review would most likely review my practice. She warned me that this can be a very difficult process as in many cases they will find something that could have been done differently that we can learn from. She said very clearly to me "This is not your fault – you did not kill this little girl". She told me to think about all the times that I had taken action that had protected children.

At the end she apologised to me that it had taken so long for someone to come and support me, she said she felt personally responsible for that.

Several months later the designated nurse contacted me and asked me to help her write a policy for providing support to practitioners following child death. I was more than happy to do that and I think that's very important and hope that organisations realise the enormous impact that our difficult work has on staff. (Practising health visitor)

Why do we need to develop resilience in health visiting?

The NHS Staff Survey (2014) found 41% of health visitors have felt unwell in the last 12 months as a result of work-related stress.

The impact of excessive stress is not a sign of weakness or an inevitable consequence of professional practice. However, this is a clear indication that health visiting as a profession, and organisations that employ health visitors, need to consider ways in which to build resilience. There is also a need to address the structural and contextual sources of stress as there is a link between staff wellbeing and patient quality of care (The National Nursing Research Unit 2013).

In order to effectively support health visitors the context of health visiting practice needs to be considered and resilience-promoting environments developed (McCann et al 2013). One component of this system is government and professional bodies. The government strategy for mental health (DH 2011) highlights the importance of individuals and employers recognising and building resilience. The consequences of failing to consider the emotional impact of the work and working environment on the emotional wellbeing of health visitors are great – high sickness rates and escalating problems with recruitment and retention to name but a few.

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 supportive framework; these are compassion, communication, care, competence, commitment and courage. Compassionate organisations prioritise staff wellbeing, which effects client safety and the quality of client care (National Nursing Research Unit, 2013).

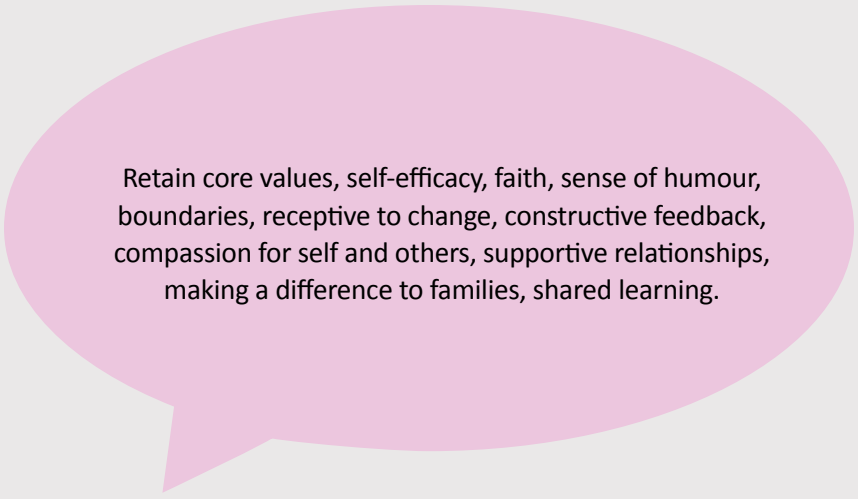
The current stresses of health visiting

While stress is experienced by many frontline practitioners, today's health visitors are subject to their own particular combination of stressors that include:

- A significant number of inexperienced staff with many experienced staff retiring.
- High caseload sizes.
- Limited career structure for practitioners.
- Making time for continuous professional training.
- Conflicting roles that impact on professional identity.
- The economic climate and tendering processes leading to service reductions e.g. Child & Adolescent Mental Health Services (CAMHS) and voluntary groups.
- Increasingly high thresholds for referral to CAMHS and social care.
- The target-driven culture and transfer of commissioning to local authorities in October 2015.
- Mobile working leading to the loss of designated work spaces and a reduction in informal support.
- Increasing client needs such as poverty, mental ill-health, domestic violence, substance misuse.
- Insufficient time to build relationships with families and discuss practice with colleagues.
- Pressures of record keeping and fear of blame.
- Insufficient access to clinical supervision.
- Challenging long-term work with complex families, safeguarding and child protection issues.

These factors can stir up negative emotions such as fear, anxiety, helplessness and hopelessness which, when uncontained, contribute to increasing stress, sickness levels and compassion fatigue. This then compounds challenges with recruitment and retention. However, the health visitor's role can be extremely rewarding and many health visitors are resilient, adapting positively to the challenges and remaining in the profession. A summary of the factors which health visitors have told us enables them to remain resilient is shown below in Figure 1:

Figure 1: Factors that help health visitors remain resilient



Case study

I work in London and it's really stressful. There is just so much work to do and so many challenges to overcome. I worry about some of the newly-qualified staff and hope they can cope with the pressures. I came into health visiting because I like people and I was attracted to the emotional aspects of health. However, sometimes it's difficult to give families the time that I would like to be able to give. I do what I can in the time that I have and I always make an effort to find something that they can be proud of. Some of the mothers I see have been criticised all their lives and that's what they expect me to do. When I draw their attention to something they are doing well, they are shocked but you can also see the pleasure on their faces. These little things make me feel good about what I do and keep me going.

We have a fantastic team and we support each other really well. We have great fun together, lots of laughs and we have several 'feeders' who nourish us with their baking. I hear of some health visitors working until 8.00 – 9.00pm, we don't do that. Our manager is very clear with us that we should leave by 5.30pm at the latest and no emails from home and certainly not while on holiday!! I also attend restorative supervision sessions which allows me space to unpack what's been happening. She also challenges me sometimes, but in a good way. I've never had really good supervision before and now I wouldn't be without it. (Practising health visitor, London)

Although there are some extremely positive developments around the country where health visitors are reporting improved morale and improved engagement with families, there is a long way to go. We must not be complacent but rather prepare ourselves for the road ahead. It has been recognised for some time that the pressures on the London health visiting workforce are at their highest and it is hoped that particular attention will be given to practitioners working there. In a recent iHV Survey (State of the Nation 2014) 43% of the London health visitors surveyed stated that morale is low and pressure is greater than before This is compared with 35% for England as a whole. When asked if support was sufficient, 52% of health visitors in London responded 'no' and 50% said they were not always able to attend supervision. Whittaker et al (2013) found that the greatest factor that attracts people into health visiting and keeps them there is the opportunity to 'make a difference' to the lives of children and families. However, 70% of health visitors in London stated that the biggest barrier to 'making a difference' was the lack of continuity/chance to get to know the families. This was compared to 46% for England as a whole (iHV 2014 b).

However, perhaps surprisingly, when it came to worrying about safeguarding children, differences reported between London health visitors and health visitors in England as a whole were minimal. This may in part be due to differences in thresholds of concern, however, it would appear to indicate that no matter where you practise, safeguarding is an on-going source of anxiety. Figure 2a shows the responses of London health visitors in the iHV survey (2014b) to the question "How confident do you feel that children are being sufficiently safeguarded locally?". Figure 2b shows the responses from England as a whole.

Figure 2: London Health Visitor Responses: 126 respondents

Question: How confident do you feel that children are being sufficiently safeguarded locally?

A: You can never eliminate risk, but I am confident we are doing our best

B: I do sometimes worry that we can't quite do enough

C: I feel that we are stretched and there may be a tragedy in our area at some point

Figure 2b: Responses from **England**: 1332 respondents

Question: How confident do you feel that children are being sufficiently safeguarded locally?

A: You can never eliminate risk, but I am confident we are doing our best

B: I do sometimes worry that we can't quite do enough

C: I feel that we are stretched and there may be a tragedy in our area at some point

Clearly this level of professional anxiety being carried by health visitors with respect to safeguarding cases on their caseloads will also have a significant personal impact and they should have support to protect their personal wellbeing and to build personal resilience.

Signs of reducing resilience

Figure 3: Signs of reducing resilience

Figure 3 shows some of the feelings, thoughts and behaviours that might alert us that additional action is needed to maintain our resilience.

Measuring resilience

How feasible it is to measure resilience is questionable, however, it is worth considering key transition points in development (Cowley 2008) e.g. preceptorship and induction. Bearing in mind the limitations, you can test your own resilience by completing questionnaires such as Wagnild & Young's (1993) scale at www.resiliencescale.com.

Why do we need to consider compassion alongside resilience?

Professor Aidan Halligan (Director Education, UCHL) in a discussion with the project manager said *"underpinning all serious untoward incidents is a lack of compassion"*. Implementing the Resilience Framework will facilitate client and staff safety, integration of services, education and training and is value for money.

Resilience is a complex and evolving concept with varied interpretations. For example, building practitioners' resilience could be perceived as a way to "toughen people up". Harry Cayton (2014), Chief Executive of the Professional Standards Authority, described how it could be applied to individuals who are coping through the use of defensive strategies such as shutting off from problems. Menzies-Lyth (1960) described how nurses adopted defensive behaviours in responding to the anxieties of practice. A compassionate response, however, involves paying attention to suffering and taking action to alleviate it. Hence compassion needs to be kept in focus if we are to remain resilient whilst effective.

The Five Year Forward view for the NHS (NHSE 2014) advocates a preventative approach to health and service improvement. It highlights how patient safety, clinical effectiveness and quality patient experiences are achieved through a caring culture, professional commitment and strong leadership.

The Francis Report (2013) and the Compassion in Practice Nursing Strategy (DH 2012) emphasise the importance of organisations creating a compassionate culture. Resilient cultures will start with compassionate leaders who build resilience individually and organisationally (Dutton et al 2014, White 2013). Compassionate organisations are more effective and efficient (Dutton et al 2014). They prioritise staff wellbeing, which influences client safety and the quality of client care (National Nursing Research Unit 2013). Implementation of positive practice environments, and effective models of support, have been supported by the International Council of Nursing and WHO as an approach to supporting staff and recruiting and retaining the best possible workforce (Bryar et al 2012). High quality health visiting services build resilience and reduce costs in later life (NICE 2011).

The Resilience Framework

The picture below represents the key components for building resilience whilst remaining compassionate.

Enabling the emotional aspects of practice to be expressed through the medium of art can be effective in providing opportunities for learning (Warne & McAndrew 2008). The grey night sky is representative of the specific 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 system. The stars, the moon and the planets represent resilient factors. Understanding the system and resilient factors facilitates early identification and implementation of proactive, strengths-based compassionate strategies.

The Health Visiting Resilience Framework (Figure 4) is designed to proactively support practitioners, and employers to be prepared for and cope positively with adversity. At its heart, it is underpinned by compassion and resilience models including; the compassionate mind model (Gilbert 2010), self-compassion (Neff 2011), mindfulness (Berry 2014) and resilience (Hart & Heaver 2013). Within health visiting it is important to consider this framework as inclusive of a range of other forms and sources of support, notably the preceptorship and induction frameworks developed by the Institute of Health Visiting. There are ten models and concepts of support, each one is outlined within the document with references and links to sources of further information. It is recognised that the list is not exhaustive and that there are other models of support and information that could be of great benefit to health visitors. It is hoped that we can use this document as a starting point from which to build.

Figure 4: Diagrammatic representation of the Health Visiting Resilience Framework

Relationship-based models of intervention

There is substantial evidence in the literature showing that what makes health visiting most professionally satisfying is the opportunity and capacity to form effective and sensitive relationships with families in the community.

Crowther and Cowan (2011) state that study and evaluations demonstrate that the development of the relationship with the client is what makes the 'real difference' in improving outcomes for service users. Whitaker et al (2013) identified in their studies that the idea of "making a difference" was the key motivating factor for students entering and remaining in health visiting. However, there is increasing evidence to suggest that it is increasingly difficult for health visitors in many areas of the country to develop relationships with their clients (Bidmead 2013, iHV 2014). There is also evidence to suggest that this affects morale, job satisfaction and professional self-esteem. This is important as a sense of job satisfaction is a protective factor that allows practitioners to withstand, endure and bounce back from the myriad of stressors they face in their working lives (Albrook 2011).

- Having the ability to engender trust in parents who are scared, angry and hypersensitive to criticism is arguably one of the most skillful areas of health visiting practice. It is what puts the forming and modelling of good relationships at the core of health visiting practice.
- Building trust takes time and effort that health visitors cannot spare if their caseload is too large or too complex (Barlow et al, 2007; Department of Health, 2009; Adams 1998).
- Bidmead (2013) has developed a suite of instruments, suitable for evaluating the parent-health visitor relationship and the extent to which organisations support them. These are now validated and available.
- Relationship-based models of intervention such as the Solihull Approach, Family Partnership model and Mellow Parenting offer evidence-based training, structures and frameworks for health visitors to further develop their skills in working with families.
- Research outcomes from relationship-based models include: Relationships appear to be stronger and mutual respect evident, even when working with families where traditionally engagement has been minimal. Staff also report improved relationships with other professionals, confidence and increased job satisfaction (Douglas and Whitehead 2005, Bashford and Seal 2012).
- Programmes that have a philosophy of strengths-based working with families present an opportunity for health visitors to build resilience in more than just their clients. The resulting shift in focus from deficits to strengths may also impact their own resilience and the resilience of the colleagues whom they mentor.

Considerations

Bidmead (2013) identified several important factors which affect the ability of health visitors to develop relationships with the families they work with. These are listed below:

The size of the health visitor caseload is a very important factor influencing the ability of the health visitors to establish relationships with parents.

Pressures to maintain complex recording systems significantly reduces the time spent with families. Lack of managerial support for relationship-based work was seen as a major issue.

Skill mix staff and children's centre workers increasing involvement with vulnerable families has meant that health visitors are often left with child protection work which was generally seen as less rewarding.

Courageous conversations

Inevitably part of many professional relationships for the health visitor – be it with clients, colleagues, other professionals or managers – will involve having courageous or difficult conversations.

These are conversations that many of us dread and either put off or do badly. This is because it is difficult for us to address issues that may arouse conflict especially when the 'stakes' are high. Patterson (2011) describes such conversations as "learning to communicate best when it matters most". It is important to remember that conflict and addressing difficulties is an important, functional and normal part of human relationships. When we learn how to manage it well, conflict presents an opportunity to strengthen and repair relationships, learn, and find new solutions. There are many best-selling books telling us how to have 'courageous', 'crucial' 'non-violent' or 'difficult' conversations, as they can be referred to; however, many of the approaches have much in common. Some of the basic steps are summarised below.

Basic steps

- It is much better to work directly with the other person in the conflict. Going via others makes an escalation of the conflict or further misunderstanding much more likely. Pointing out the distinction between the problem and the person, and confirming you wish to treat the other person respectfully and with compassion may help them do the same.
- Recognise that if the person is behaving in a difficult way, he or she may be suffering somehow. Approach the other person with a genuine desire to help reduce the suffering and to find common, constructive ground to move forward. Begin the process from a position of openness and honesty. Above all avoid making the other person feel bad, stupid or that you are trying to outwit them.
- When raising the issues be careful to do so in a very objective and factual way describing exactly what has happened or what you have seen. Try not to attach any judgmental statements to this as it is those statements that are likely to make the other person feel threatened, escalating their emotions. Acknowledge emotions – both yours and theirs.
- Look at and listen to each other, so each person feels heard and understood, and has their views acknowledged. Go back and forth listening to each other until each person has fully stated their views and you both agree that you have been heard and understood.
- You also need to ensure there is agreement about everything said so far, before going on to the next point at issue.

- Look for mutually satisfying agreements – one-sided offers tend not to work. Though it is common to think there must be a winner and a loser in a conflict, this is not necessarily true. Participating in negotiations where the goal is a 'win-win' solution is both possible and helpful.
- Offer options with an open mind, using your creativity to brainstorm possible ways of meeting the expressed concerns, needs and interests of both people.
- Conclude negotiations with agreements in good faith which are specific and satisfying for everyone. Keep your discussions confidential unless you jointly agree to tell any others who may need to know what your resolution involves.
- Finally, if you don't reach agreement, don't be afraid to try again another time. It can sometimes be better to try to resolve a conflict bit by bit, giving everyone concerned time to think – and rest.

Compassionate resilience

The concept of compassionate resilience combines the work of a number of different models and ideas all of which have a growing body of evidence (Germer and Neff 2013, Gilbert 2010, Browne 2012).

At the core of this model lies the belief that if we can learn skills that help us to be more compassionate and nurturing to ourselves we will be more able to cope with stress and adversity. In addition there is a body of research that shows that people who score higher on self-compassion are more able to tolerate and help alleviate the pain and suffering of others, stay healthier and have better relationships. Self-compassion skills incorporate a range of well-known approaches such as 'mindfulness' and 'positive psychology', in addition to some new.

- **Developing self-awareness:** Gilbert (2010) has developed a very simple model to demonstrate how our brains work. Keeping this model in mind can develop our awareness of our reactions in particular to perceived threats. It can also give us a better understanding of the reactions of others. This can be accessed at bit.ly/1Gtkeqq
- **Developing acceptance:** Having the ability to accept that pain and suffering are an inevitable part of life and learning to accept and tolerate that can help us to adjust to stress and trauma. It also helps us to preserve our energy to work on things that we can influence and change as opposed to fretting about what we can't.
- **Being in the now:** 'Mindfulness' has a fast-growing body of followers and is used as part of a wide number of psychological interventions within the NHS. It involves 'paying attention without judgement'. It can reduce stress, help us to regain focus and manage emotions, reduce depression, help manage pain and improve our general health.
- **Expressing vulnerability:** Having the ability to express feelings of vulnerability to someone we trust can help us manage, recognise and tolerate our emotions. Brown (2012) believes it can also facilitate growth and help develop our relationships with others.
- **Forming supportive relationships:** Establishing relationships that provide containment, acceptance and hope is a key factor to building our resilience.
- **Fostering hope:** Having the capacity to remain hopeful by reflecting on what we are grateful for has been identified as a contributory factor to resilience.

Interagency/ disciplinary groups

Coming together regularly in an interagency/disciplinary group can support the development of professional meaning, clarify roles and responsibilities and contain the emotional impact of the work.

Sharing experiences of vulnerability and resilience facilitates learning, emulating strengths and avoids pitfalls (McAllister & McKinnon, 2009). Through story-telling, fresh insights are developed, creativity is enhanced and groups can respond more effectively to change (Allen et al, 2001). Three models of interagency/multidisciplinary support are outlined below.

Work discussion group

Work discussion groups have been developed as a component of professional training at the Tavistock and Portman NHS Foundation Trust. Professionals from varied backgrounds discuss their work with children and families using a psychoanalytical framework of understanding (Canham, 2000). The group has approximately five members and is facilitated by a trained, experienced facilitator. Participants bring a written record detailing an interaction observed between themselves and others involved in a work situation. The group enables members to share their experience and their concerns through discussion. Although it is based on psychoanalytic theory, the discussion is theory-free and emphasises a non-judgmental approach to everyone involved, including oneself (Rustin, 2008).

Schwartz Centre rounds

The Francis Report (2013) identified the potential of Schwartz Centre rounds to support staff to deliver compassionate care. These have now been implemented in a number of organisations in England who receive training and support from The Point of Care Foundation. Schwartz Centre rounds are multidisciplinary forums where health professionals meet monthly to reflect and acknowledge work-related psychological, emotional and social challenges (Goodrich, 2011). They describe the impact that the cases have on them and a trained facilitator guides discussion, allowing space for the audience to reflect with the panel on similar experiences they may have had (King's College London, 2014). There is a growing evidence base (Goodrich, 2012) that suggests that offering this kind of support benefits clients, team working and potentially facilitates cultural change (The Point of Care Foundation, 2014).

Compassion Circles™

The development of Compassion Circles has been informed by the compassionate mind model (Gilbert 2010), the work of Professor Jon Kabat Zinn, and Nancy Kline (2005). Compassion Circles are offered to people connected through health and social care. They are designed to offer a safe place for facilitated reflective dialogue for groups of up to 12 people. Anyone with an interest in being compassionate to themselves and in building sustainable compassionate cultures in health and social care can attend.

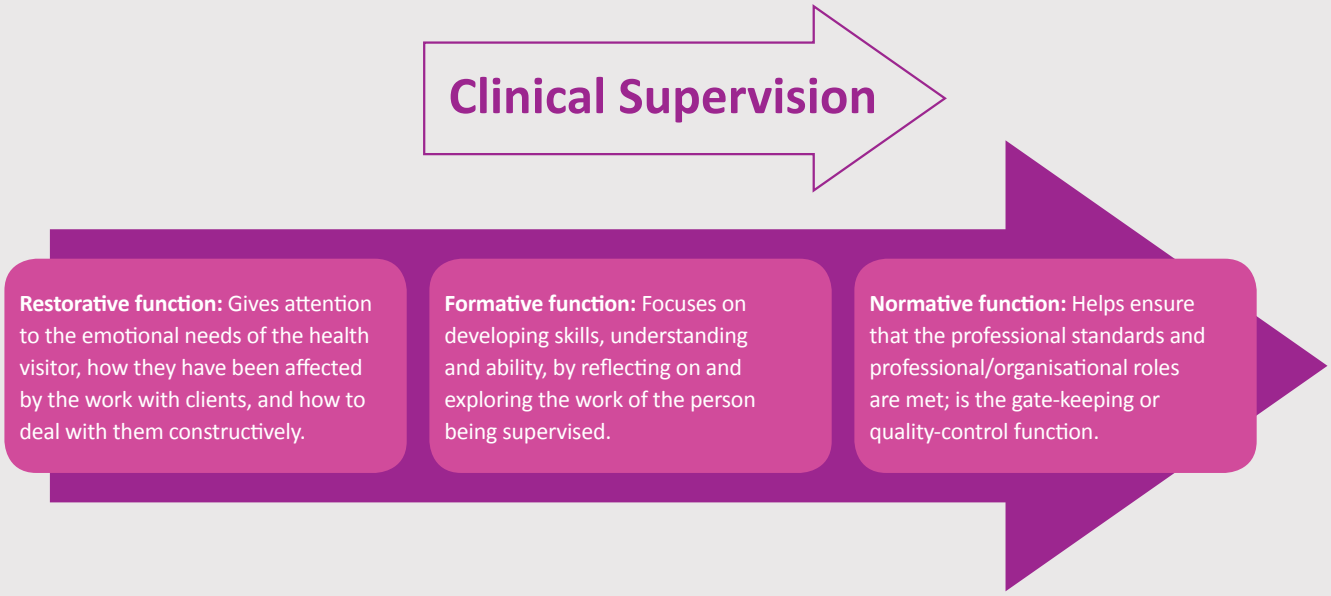
Supervision

Clinical supervision

Clinical supervision is viewed as having a separate function to safeguarding supervision and does not have to be carried out by a professional with expert skills in safeguarding. Clinical supervision has been around now in health visiting for many years and its value in combating stress and improving practice is acknowledged by many in the field (Palsson et al 1996; Walsh et al, 2003). Currently within health visiting in England, the picture is varied and supervision is carried out at various levels and in several different guises.

Sloan and Watson (2002) cited by Botham (2013) found that Proctor's (1986) model is the most commonly used model. However they also contest that one model does not fit all aspects of nursing, and a 'one fit all' philosophy should not be sought; rather, individual organisations and supervisors should choose a model to suit themselves and their service. Clinical supervision has been an integral part of successful interventions in health visiting (Davis and Spurr 1998; Barlow et al, 2003; Brocklehurst et al 2004; Davis and Tsiantis 2005; Barnes et al 2011).

Figure 5: Proctor's model of supervision (Proctor, 1986)



Safeguarding supervision

All health visitors will receive some form of safeguarding supervision, to ensure that, in families where existing risks and vulnerabilities have been identified, their health visitors are provided with guidance and a forum to consider the safety of the child.

Turbitt (2012) states that the quality of supervision has a direct bearing on the quality of service delivery, and outcomes for children, families and communities. The National Health Visiting Service Specification (NHVSS) 2014/2015 stipulates that health visitors must receive a minimum of three-monthly safeguarding supervisions of their work with their most vulnerable babies and children. It also stipulates that this supervision should be provided by colleagues with expert knowledge of child protection. Importantly, it states that supervision must "maintain focus on the child and consider the impact of sadness and anger on the quality of work with the family" (NHS England 2014 p14). Barker (2007) believes that safeguarding supervision should incorporate Proctor's (1986) model (see Figure 2) to promote an effective response to safeguarding children.

Restorative supervision

Supervision with a restorative function has seen a growing interest in health visiting in recent years.

This type of supervision contains elements of psychological support including listening, supporting and challenging the supervisee to improve their capacity to cope, especially in managing difficult and stressful situations (Proctor, 1986). Hunter and Warren (2013) who carried out a study of resilience in midwifery suggest that, whereas traditional clinical supervision has focused on clinical competency, recommendations from the literature also encompass the need for interventions aimed at enhancing personal confidence and self-efficacy, and addressing stress management techniques (Gillespie et al, 2007; Arvidsson et al, 2008 – cited by Hunter and Warren 2013).

Many of us naturally regulate how much distressing information we can cope with; for example, we might choose to skip a newspaper article or change the channel on the television. However, health visitors are regularly exposed to the stress, suffering and emotional pain of the families they visit. Accessing supervision with a restorative function can help health visitors cope with this 'emotional labour'. In addition, it can support them to work within complex and challenging environments. During the process of restorative supervision, difficult emotions that professionals are exposed to are processed through a supportive, confidential relationship rooted in the concepts of containment and reciprocity, so that the worker feels restored.

Considerations for restorative supervision

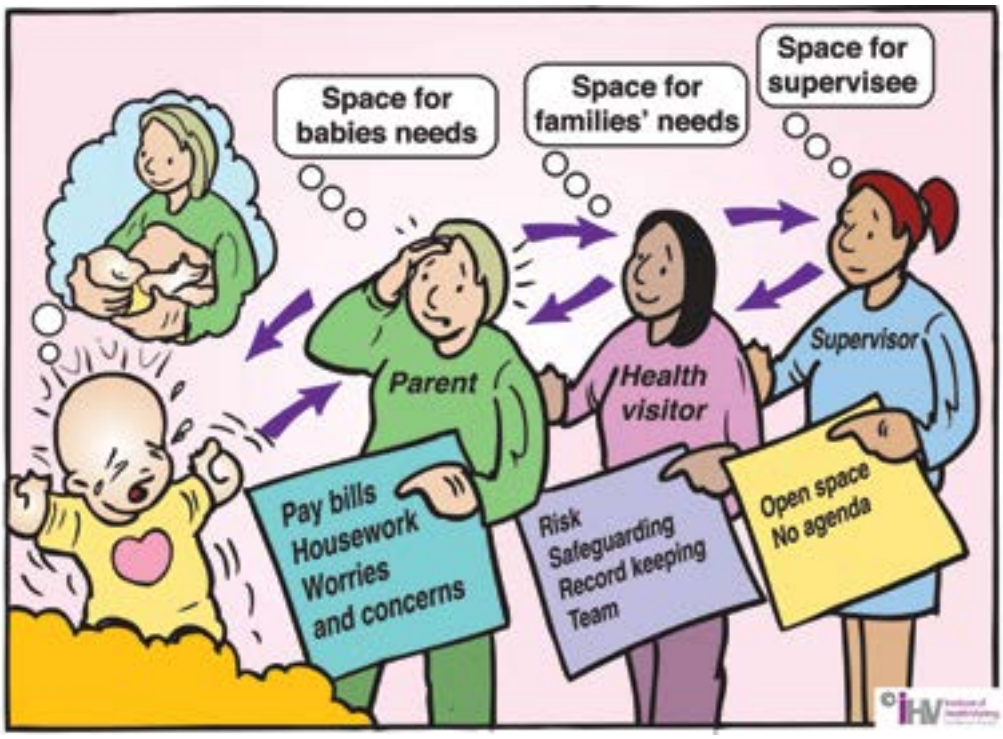
Supervisees should be able to contribute to the decision about which supervisor they are paired with as it is important to feel confortable and connected.

Groups should always be delivered by a facilitator who is trained in restorative supervision skills.

Effective restorative supervision should contain an element of supportive challenge. This may initially feel quite difficult to accept but is an important part of the process.

"As health care practitioners I think we are all used to racing around from job to job, task to task and there is always something else to add to your 'to-do' list. Some may initially see restorative supervision as 'another thing on the list' but I would urge you to put it to the top - restorative supervision has confirmed for me that it is vitally important that we look after ourselves…" – health visitor

- There are a variety of restorative supervision models that can help professionals to name, understand and process feelings of stress and anxiety arising from work.
- Individual sessions provide protected time for the practitioner to 'slow down'. Creating this thinking space can give the opportunity for reflection and new solutions.
- In some models, the individual progresses to group supervision. Being part of a group helps us to feel less isolated - reducing anxiety and also helps us to normalise what we are experiencing.
- Restorative models of supervision underpin managerial, clinical and safeguarding supervision. They can be integrated into these models or delivered separately.



Action learning sets

Action learning sets are used widely for organisational and workforce development. Action learning sets (usually comprising 6 to 8 people) bring participants together to support each other and to explore challenging experiences from the workplace.

Participants work to develop their own understanding of a situation through careful questioning and an expectation of being challenged. This allows the development of a new understanding of a situation which in turn allows them to take new actions. There is also a commitment to take responsibility in the process and to work with the personal values, feelings and attitudes that may arise. The process is cyclical and involves reflection and action. The learning sets are supported by experienced facilitators (Dewar & Sharp 2006; McCormack et al. 2009).

Evidence for the effectiveness of action learning sets highlights outcomes such as enhanced critical thinking, finding creative solutions to problems in the workplace, increased self-confidence in individuals and improved communication skills (Johnson, 1998; Booth et al. 2003; Dewar & Sharp, 2006). In a study undertaken by Napier University (Leadership in Compassionate Care Programme Team, 2012), action-learning helped participants to explore challenges to developing compassionate caring practice. Key actions were developed by participants to help them respond to such challenges in the workplace. The skills and confidence of participants as facilitators were also enhanced, with potential benefits for all aspects of their practice, including more effective communication strategies and the skills to continue to be researchers of their own practice.

Performance feedback

Feedback is important for employee morale and job satisfaction (Whittaker et al 2013), health and wellbeing (Partnership for Occupational Safety and Health in Healthcare 2012) and reducing workplace stress (NHS Employers 2014a) as well as improving patient outcomes (The Point of Care Foundation 2014).

In the iHV survey (2014), health visitors described feedback as something they valued and would like more of in order to develop their knowledge and skills. Open communication and transparency are recognised as important components of positive practice environments (ICN, 2007, cited WHPA, 2008 p.2).

Feedback is important to improve understanding and review progress. Feedback also helps the manager to assess their effectiveness and can develop their practice. It can motivate as well as develop knowledge and skills (McKimm 2009). King (1999) suggests that barriers to feedback may include a fear of upsetting the person, compromising their self-esteem and their relationships. The person may become defensive, and strategies to address this include naming and exploring the resistance and enabling the person to take responsibility (King 1999). Thus, the process by which feedback is delivered and the skills of the person providing the feedback are an important consideration.

Peer support

Health visitors frequently report that one of their most valuable and accessible sources of support is received from their peers (iHV 2014, iHV 2015, NHS Survey 2013, 2014).

This shouldn't surprise us; health visitors' skills in building relationships and supporting families equips them well for supporting each other. Many teams provide not only support to one another but friendship and nurture. By sharing food, stories, laughter, expertise and social occasions, they build a sense of connectedness, safety and belonging that is hard to replicate. Having access to good peer support remains an important factor in supporting resilience within health visiting.

- Peer support has been identified as a component of a positive practice environment (Bryar et al 2012) and as a contributing factor in fostering resilience (Jackson et al 2007; McAllister & McKinnon 2009, Mc Cann et al 2013; Hunter and Warren, 2014).
- Founded on shared experience and sense of belonging, there is evidence to suggest that peer support positively affects psychological and physical health outcomes in several ways with its direct, buffering, and mediating effects (Cohen et al., 2000; Helgesson and Gottlieb, 2000).
- In a recent iHV online survey, health visitors were asked 'How do you get support with pressure and stress at work?'. Out of the 1002 respondents 85% reported that it was through 'Informal support from colleagues sharing an office'. This underlines that regardless of any formal support measures, peer support is well established within the professional culture of health visiting.
- In the same survey formal/ scheduled peer support was the least frequently cited source of support at 14%. It would appear that the accessible and consistent nature of informal support, perhaps over lunch or coffee in the morning, is currently most developed within health visiting.
- The notion of the 'team around the health visitor' should be positively valued and recognised as an important resilience-building factor.
- The need for and value of informal peer support should be a major consideration when developing models of remote working which have the potential to remove this opportunity.

Considerations for peer support

Although peer support is valued greatly in health visiting there are always risks which include conflict, criticism, failed social attempts, emotional over -involvement, reinforcement of poor behaviour and diminished feelings of self-efficacy (Heller et al., 1991; Illich, 1981; Marshal et al., 1990; Rook, 1984; Stewart and Tilden 1995 – cited by Dennis, 2003). Further, while peer support is a potentially cost-effective intervention, the possibility of overburdening exists through the inappropriate use of peers as a replacement for formal support (Giblin, 1989).

Coaching

Health visitors are often working with complex families, whilst juggling large caseloads within demanding and ever-changing systems. At times this can seem overwhelming and it is difficult to think about goal setting and creative solutions.

This type of environment can leave health visitors second-guessing their decisions and feeling disempowered as they face what may feel like shifting goalposts. In their 'Evaluation of Coaching in the NHS', Sinclair et al (2008) explain that, through coaching, NHS staff from different areas can became more resourceful in their roles. Individual experience and perception of situations is based on individual perspective, coaching is based on the individual's objectives providing each with the opportunity to explore the areas that challenge them specifically and identify their resources to master that situation.

- Health visitors face daily challenges of managing clients within the changing context of healthcare provision and social care support. Coaching offers you the opportunity to search for resolutions to challenges you experience in a safe way that allows you the time and space to access all parts of your brain.
- By exploring your preconceptions to a situation you offer yourself the opportunity to reflect and understand what the situation is, and clarify what it is not and how you can improve your experience of it.
- Coaching is with a supportive third party, 'in sessions where you set your own outcomes (goal-specific)'. The coach will take you through a process of open questions based on your responses.
- You are given time and space to consider whether you can provide your own solutions to issues that might previously have seemed outside your control.
- You will come up with your own actions, it is your part of the process to take those actions forward, therefore empowering yourself in a tangible and defined way to demonstrate start and finish points.
- Anyone can be trained to use coaching skills which can be useful both in working with clients and mentoring or coaching peers.

Considerations for coaching

Health visitors can schedule coaching into their busy routines through in-person, phone or online sessions.

Coaching can be used at any time, for fixed outcomes or for longer-term support goal achievement.

Find a coach whose style/personality fits with yours; you need enough sense of challenge to help you to grow but feel supported in achieving your goals.

Coaching is currently offered through some organisations, with pilots having been launched in NHS organisations.

Coaching sessions should be scheduled initially each or every other week, and then at the frequency that is agreed between the coachee and the coach.

The NHS Leadership Academy has developed a coaching register.

Mentoring

"Mentors are guides, they lead us along a journey of our lives. We trust them because they have been there before. They embody our hopes, cast light on the way ahead, interpret arcane signs, warn us of lurking dangers, and point out unexpected delights along the way" (Daloz, 1986, p.17).

In all areas of industry and business, it has been established (Clutterbuck, 2004) that mentoring 'fosters talent' in the organisation, increases productivity, improves communication and improves retention. Humans have had mentors from time immemorial to help them to undergo the process of moving from novice to expert. In health visiting mentors have been used in the main for newly-qualified health visitors, however, many experienced health visitors and managers will choose to have a mentor to help them get to where they want to be in their professional lives.

"Some time ago when I was working as a clinical development lead for health visiting I was feeling a bit burnt out and I realised I wasn't enjoying the work anymore. I discovered Shirley Goodwin was working just a few miles away from where I worked. I picked up the phone and asked if she would mentor me. She agreed and over the next few months was a source of total inspiration to me. She helped me to set goals and take the action I needed to move forward with my career." **– health visitor**

- Mentors working with newly-qualified staff work under the supervision of a named practice teacher and it is necessary for the student, mentor and practice teacher to meet regularly to discuss progress and map this against the competency framework.
- Skills such as strengths-based approaches, motivational interviewing and coaching can support the mentor in his/her role.
- In a person-centred approach the mentee is encouraged to take responsibility for their own learning needs, taking a self-directed approach (Stuart, 2007).
- Characteristics or roles of a mentor range from 'role-modelling', 'energiser', 'teacher' and 'counsellor' (Darling, 1985).
- Effective mentors will spend quality time with mentees. They are good teachers and take time to work with mentees at their own pace. They are primarily a good role model.
- Although mentoring in health visiting is formally organised during the preceptorship period, mentors can support growth and provide encouragement, inspiration and containment at any time in the health visitors career.

Considerations for mentoring

The impact of high workload, staff shortages and time conflict presents mentors with consistent dilemmas in relation to managing commitments.

Managers need to recognise and consider the additional work that the mentor undertakes.

In addition, providing adequate preparation of mentors is crucial to positive mentee outcomes.

Mentors require adequate experience and to have developed a sense of mastery for the role themselves if they are to be successful.

Proximity, continuity and reciprocal positive regard together with clinical expertise are important elements for the success of mentor/ mentee relationships.

Mentees appreciate mentors acknowledging their existing skills.

(Morton 2013, Devlin and Mitcheson 2013, Sayer 2013)

Influencing skills

From October 2015, the commissioning of health visiting services will transfer to the local authorities. This brings both many opportunities for health visiting but also significant challenges for the profession.

Having the skills to influence stakeholders, commissioners and local counsellors will play an important part in the success of this change. Many health visitors have most of the key skills required for successfully influencing others; these include, empathy, credibility, expertise and clear values. Influencing skills can be learned and developed; they can help us to influence the environments we work within to support our resilience and growth.

Key points

- PREPARE-PREPARE-PREPARE. Influential people prepare well for important conversation.
- When preparing for your meeting clearly define your starting point and goals. What do you want to achieve? Prepare and practise the key content. *"If you don't know where you are going you will probably end up somewhere else"* (Lawrence Peters).
- Articulate what you want to happen in a positive way! It is much easier for people to state what they want in negative terms. Stating what you don't want is not a positive influencing trait. To become more influential it is essential to state what you do want with clarity.
- Be simple and explicit – waffling and rambling should be avoided at all costs. It is helpful to distil your arguments to three key points, each backed up by evidence.
- Influential people understand the importance of self-belief, they are willing to come out of their comfort zones, take considered risks and build the resilience to bounce back from setbacks or knock backs and get back in the game. *"I never failed. I invented the light bulb, it was a 2000-stage process"* (Thomas Eddison).
- Influential people understand that to influence someone you have to be able to understand their point of view. They get the other point of view and work with what others think, feel and believe.
- Use examples that will engage people and media that will bring the issues alive. Short videos are often useful. Don't be afraid to bring a service user with you; there is nothing more compelling and powerful than the voice of the parent.
- Inspire by thinking creatively . *"There are those that look at things the way they are, and ask why. I dream of things that never were and ask why not."* (Robert Francis Kennedy).
- Demonstrate enthusiasm with authenticity. Genuine enthusiasm is infectious and people remember emotions more than words. "People will forget what you said, people will forget what you did, but people will never forget how you made them feel" (Maya Angelou).
- Remain open-minded and be willing to be influenced yourself. Challenge your mind to see things in a different, more flexible way.

Measuring the outcomes of strategies to build resilience

Measuring resilience is complex, however, work on this area is ongoing. Hart et al (work ongoing) are benchmarking resilience measures against their own definition of resilience, that "Resilience is overcoming adversity, whilst also potentially subtly changing, or even dramatically transforming, (aspects of) that adversity" (Hart, Gagnon, Aumann, & Heaver, 2013b - cited by Hart et al ongoing). However, as they also explore elsewhere (Hart and Gagnon 2014, Work in progress) there is also the potential for resilience-based interventions to actually affect the wider adversity context, so that is it not just the specific individuals who benefit but others too, with the potential to affect systemic change. At an individual level both qualitative and quantitative processes can be used. For example using 360 degree appraisal. Validated questionnaires such as Self-Compassion (Neff 2011), Professional Quality of Life Scale (Stamm 2009) and a Resilience Scale (Wagnild & Young 1993) can also be used at the individual level.

Conclusion

This framework adopts an ecological or environmental definition of resilience as described by Hart and Gagnon (2015), which considers the person in the context of the system in which they are working and the interaction between the two. It is recognised that resilience is a complex interplay of genetics, learning and the environment we live in. However, it is clear from the literature that there is much that can be done both by individuals and organisations to build resilience within the health visiting workforce. Although there is much we do not know about resilience there is little doubt that even in the most difficult of times resilience can be strengthened and built (Hart et al 2012).

The summary table below presents some of the key recommendations for practitioners.

Summary table of key recommendations for practitioners	
Look after your physical health	Get enough sleep, eat well, and find a way to fit in some exercise you enjoy.
Look after your emotional health	Build and nurture positive relationships, try to focus on the good things that have happened in your day. Build some mindfulness exercises into your busy schedule, even if it's while you're on the bus. Develop your self-awareness and emotional regulations skills. Be compassionate, kind and understanding to yourself – strengthening your inner container and silencing your inner critic. Accept your limitations and stay within your boundaries. Stay true to your values. Make time for the things you enjoy.
Recognise the importance of peer support	Help to build your team. It's the little things that are often important to building teams; offering support, expressing your own vulnerabilities makes it safe for others to do the same, remembering birthdays, having a laugh together. Look after and nurture one another. Join or start action learning sets, work discussion groups, communities of practice etc.
Manage conflict	Remember conflict is normal in any relationship. Develop your skills in managing conflict, be brave and use conflict as an opportunity to create better understanding and strengthen your team. Don't let conflict hurt, or anger fester.
Build opportunities for job satisfaction	Build on your strengths and the work you enjoy. Develop your expertise and sense of mastery. Develop your influencing skills to ensure that those who commission and manage health visiting recognise the importance of supporting health visitors to develop relationships with families in an unhurried way. Take responsibility for creating opportunities to develop health visiting practice. Be tenacious and bounce back quickly from set backs, believe in yourself.
Changing the culture you work in	Develop your knowledge on compassionate leadership and compassionate organisations. Practice with compassion – role-modeling the approach to others. Use your knowledge to influence peers, managers, leaders, commissioners and local counsellors. Maintain hope and a belief that change is possible.
Build your formal support	Embrace opportunities to engage in formal support that is offered and seek out other opportunities, for example, supervision which includes a restorative function, a mentor/mentoring (remember a mentor can be useful at any point in your career), coaching, action learning and feedback. Learn to accept and welcome constructive challenges.

References

Adams, C. (1998, unpublished) The role of community practitioners and health visitors in the tier one CAMHS workforce. Presentation given at 'The Future of CAMHS' conference, 2009.

Adamson, C., Beddoe, L., Davys, A. (2012) Building Resilient Practitioners: Definitions and Practitioner Understandings. *British Journal of Social Work*, 1-20.

Allen, J., Fairlough, G., Heinzen, B. (2001). The Power of Tale: *Using narrative for organisational success*. West Sussex: John Wiley & Sons Ltd.

Atkins, P. W. B., & Parker, S. K. (2012). Understanding individual compassion in organizations: the role of appraisals and psychological flexibility. *Academy of Management Review*, 37(4) , 524-546.

Ausbrooks, A. (2011). Why Child Welfare Supervisors Stay, *Journal of Religion & Spirituality in Social Work: Social Thought*, 30(4), 358-384, DOI: 10.1080/15426432.2011.619901.

Barker, J.,Hodes, D.(2007) *The Child In Mind: A Child Protection Handbook*. Routledge: London.

Barnes, J., Ball., M., Meadows, P., Howden, B., Jackson A., Henderson, J., & Niven, L. (2011). *The Family Nurse Partnership in England*. Department of Health.

Bashford, E., Seal, J. (2012). *A case study explaining the changing way we work with families through delivery of the Family Partnership*, Department of Public Health.

Barlow, J., Stewart-Brown S., Callaghan H., Tucker J., Brocklehurst N., Davis H. (2003). Working in Partnership: The development of a home visiting service for vulnerable families. Child Abuse Review, 12, 172-189.

Barlow, J., Davis, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007). Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. *Archives of Disease in Childhood*, 92, 229-233.

BBC, 2014, *Beyond Belief*, **bbc.in/1yAfdG5**, May.

Berry, C. (2014). *Wellbeing in Four Policy Areas Report by the All-Party Parliamentary Group on Wellbeing Economics*. New Economics Foundation.

Bidmead, C., (2013). Health visitor/parent relationships: a qualitative analysis. Appendix 1. In: Cowley, S., Whittaker, K., Grigulis, A., Malone, M., Donetto, S., Wood, H., Morrow, E., Maben, J. (Eds.), Appendices for Why Health Visiting? A Review of the Literature about Key Health Visitor Interventions, Processes and Outcomes for Children and Families. National Nursing Research Unit, King's College London. Available at: **bit.ly/1xkNjyg**.

Boorman Report. (2009). *NHS Health and Well-being – Final Report*. London. Department of Health.

Booth, A., Sutton, A., Falzon, L. (2003). Working together: supporting projects through action learning, *Health Information and Libraries Journal*. 20 (4), 225 – 231.

Botham, J. (2013). What constitutes safeguarding children supervision for health visitors and school nurses? *Community Practitioner*, 86(3), 28–34.

Brocklehurst, N., Barlow, J., Kirkpatrick, S., Davis, H. & Stewart-Brown, S. (2004). The contribution of health visitors to supporting vulnerable children and their families at home. *Community Practitioner* 77, 175-179.

Brown, B. (2012). *Daring Greatly: how the courage to be vulnerable transforms the way we live, love, parent and lead*. London. Penguin Books Ltd.

Bryar, R. Kendall, S. Mogotlane,S. (2012). *Reforming primary healthcare: a nursing perspective. International Council of Nurses*. Available at: **bit.ly/1D4Fsbp**

Canham, H. (2000). Exporting the Tavistock Model to Social Services: Clinical Consultative and Teaching Aspects. *Journal of Social Work Practice*. 14(2), 125-133.

Cayton, H. (2014). *Professional Standards, Resilience and Compassion*. Presentation. 26th July. University of Westminster.

Clutterbuck, D. (2004). *Everyone Needs a Mentor; Fostering talent in your organisation*, Fourth Edition, Chartered Institute of Personnel and Development (CIPD).

Collison, C. (2013). *After Action Review*. **bit.ly/1vPG3Nr**

Cohen S., Gottlieb B., Underwood L.G. (2000). Social relationships and health in S. Cohen, L.G. Underwood, B. Gottlieb (Eds.) (2000) *Social Support Measurement and Intervention: A Guide for Health and Social Scientists*, Oxford University Press, Toronto.

Cowley, S. (2008). Developing and measuring resilience for population health. *African Health Sciences*, 8(5): 41-43.

Crowther, K., Cowen, G. (2011). *Effective Relationships with Vulnerable Parents to Improve Outcomes for Children and Young People: Final Study Report*, York Consulting. Available at: **bit.ly/1x22nX5**

Daloz, L 1986). *EffectiveTeaching and Mentoring*, San Francisco, ca: Jossey-Bass Publishers.

Darling, LAW. (1984). What to Do About Toxic Mentors. *Journal of Nursing Administration* 15, pp43-44.

Davis, H., Spurr, P. (1998). Parent counselling: an evaluation of a community child mental health service, *Journal of Child Psychology and Psychiatry*,39, 365-376.

Davis, H., Tsiantis, J. (2005). Promoting Children's Mental Health: The European Early Promotion Project (EEPP). *International Journal of Mental Health Promotion* 7, 4-16.

Department of Health/ Business in the Community (2009). *Emotional Resilience Toolkit*. Available at: **bit.ly/1BCypr3** Accessed 1.8.14.

Department of Health. (2011). *The Health Visitor Implementation Plan 2011-2015*; a call to action Available at: **bit.ly/16WhhBR**. Accessed 1.10.14.

Department of Health .(2012). Health Visitor Teaching in Practice: A Framework Intended for Use for Commissioning, Education and Clinical Practice of Practice Teachers (PTs).

Dennis, C., (2003), Peer Support within Health Care: a concept analysis, *International Journal of Nursing studies*, Volume 30, Issue 3, pp321-332

Department of Health. (2012). *Compassion in Practice*. **bit.ly/1IBveUj** Accessed July 2014.

Devlin, A., Mitcheson.(2013). An Evaluation of Three Models of Health Visiting Practice Teaching in the East of England, *Journal of Health Visiting*, 1(10), 574 – 582.

Dewar, B., Sharp, C. (2006). Using Evidence: how action learning can support individual and organizational learning through action research, *Educational Action Research*, 14 (2), 153-159.

De Zulueta P. (2014). Compassionate resilience- why we need it in healthcare. *Human Values in Healthcare Forum. Summer Update*, 2.

Diprose, K. (2015). Resilience is futile; Soundings 58; Available at : **bit.ly/1EbBgFQ**

Douglas, H., Whitehead, R. E. (2005). Health visitors' experiences of using the Solihull Approach. *Community Practitioner,* 78(1),20-23.

Dutton, J.E., Workman, K.M., Hardin, A.E., (2014). Compassion at Work. *Annual Review of Organisational Psychology and Organisational Behaviour*, 1, 277-304.

Epstein, R.M., Krasner, M.S., (2013). Physician resilience: what it means, why it matters, and how to promote it. *Academic Medicine*. Mar; 88(3), 301-303.

Fraiberg S, Adelson E, Shapiro V., (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child & Adolescent Psychiatry,* 14(3), 387-421.

Francis, R. (2013). *Report of the Mid Staffordshire Foundation Trust*. Public Inquiry. London: The Stationery Office.

Frankl, V. (2006). *Man's Search for Meaning. An Introduction to Logotherapy*. Boston, Beacon Press.

Germer, C. (2009). *The Mindful Path to Self- Compassion*. London: The Guildford Press.

Germer, C., Neff, K. (2013). A pilot study and randomised controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, 69, 28-44.

Giblin PT. (1989). Effective utilisation and evaluation of indigenous health care workers, *Public Health Reports*, 104 (1989), 361–368.

Gilbert, P. (2010). *The Compassionate Mind: a new approach to life's challenges*. London: Constable.

Gilbert, P., McEwan, K. Matos, M. & Rivis, A. (2011). Fears of compassion: Development of three self report measures. *Psychology and Psychotherapy: Theory, Research and Practice* 84, pp. 239–255.

Gladwell, M. (2013). *David and Goliath: Underdogs, Misfits, and the Art of Battling Giants*. New York, Little Brown Book Company.

Goodrich, J. (2011). *Schwartz Center Rounds: Evaluation of UK Pliots*. King's Fund,London.

Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: do Schwartz center rounds work in English hospitals? *Journal of Royal Society of Medicine*, 105(3), 117-22.

Grossman, P., Niemann, L., Schmidt, S,. and Walach H. (2004). Mindfulness-based stress reduction and health benefits. A meta-analysis. *Journal of Psychosomatic Research*. Jul; 57(1):pp35-43.

Hart. A., Blincow.D., & Cameron, (2012). Adult Resilience Framework. bit.ly/1vFrVkR

Hart, A., & Heaver, B. (2013). Evaluating resilience-based programs for schools using a systematic consultative review, *Journal of Child and Youth Development*, 1 (1), 27-53.

Hart,A., B. Heaver, S. Eryigit-Madzwamuse. (2014) *Resilience measures for children and young people: A review for practitioners and community-based researchers.* (Work in progress). University of Brighton, England.

Hart, A. and Gagnon, E. (2015). *Uniting resilience research with an inequalities agenda*: *Towards a fifth wave?* Unpublished paper: Work in Progress, University of Brighton, Brighton.

Helgesson V.S., & Gottlieb B. (2000). *Support groups in S. Cohen, L.G. Underwood, B. Gottlieb (Eds.) (2000) in Social Support Measurement and Intervention: A Guide for Health and Social Scientists*, Oxford University Press, Toronto.

Hölzel, B.K. Carmody, J. Vangel, M. Congleton, C., Yerramsetti, S.M. Gard, T. & Lazar, S.W. (2011). Mindfulness practice leads to increases in regional brain grey matter density. *Psychiatry Research*.

Hudson, C. Hart, A., & Dodds, P. (2014). *Towards an ecologically based intervention to grow professional resilience*, The Second World Congress on Resilience: from person to society, Timisoara, Romania. Conference proceedings.

Hunter, B. & Warren, L. (2014). Midwives' experiences of workplace resilience. *Midwifery*. Aug; 30(8), 926-34.

Institute of Health Visitors. (2014). *Institute of Health Visitors Survey*.

Jackson, D. Firtko, A. ,Edenborough,M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *Journal of Advanced Nursing*, 60(1), 1-9.

Johnson, C. (1998). The essential principles of action learning, *Journal of Workplace Learning*. 10(6/7), 296 – 300.

King, J. (1999). *Giving Feedback. British Medical Journal* [online] Available at: bmj.co/1yMoiLp [Accessed 29 November 2014].

King's Fund. (2014). *Developing compassionate leadership through mindfulness*. bit.ly/1wyyhcR

King's College London. (2014). Press release Friday 23 May. *Supporting NHS staff at work: could Schwartz centre rounds hold the key to happier, healthier workforce and enhance compassionate care?* Available at bit.ly/1BH3iMc. Accessed 10.1.15. *Neuroimaging*, 191 (1), 36-43. [Online] 1.usa.gov/1vFlluH

Konig. S. & Gluck, J. (2013). "Gratitude is with me all the time": how gratitude relates to wisdom. Journals of Gerontology, Series B: *Psychological Sciences and Social Sciences,* 1-12.

Lin, M., Hofmann, S.G, & Qian. (2015). Enhanced association between perceptual stimuli and trauma-related information in individuals with posttraumatic stress disorder symptoms, *Journal of Behavioral Therapy Psychiatry*. Mar; 46:202-7,

Lindley, P. (2013). *Practitioner Resilience: Building resilience in health visitor students for coping with adversity in practice*. Resilience Forum Presentation. Available at: bit.ly/1vFrVkR Accessed 30.7.14

McAllister, M., & McKinnon,J. (2009). The importance of teaching and learning resilience in the health disciplines: A critical review of the literature. *Nurse Education Today* 29,371-379.

McCann, CM., Beddoe, E. McCormick, K. Huggard, P. Kedge, S. Adamson CJ. & Huggard, J. (2013). Resilience in health professions: a review of the literature. *International Jnl of Wellbeing*, 3(1), 60-81.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L., & Tobin, C. (2009). Practice development: realising active learning for sustainable change, *Contemporary Nurse* 32(1-2), 92-104.

McKimm, J. (2009). *Giving effective Feedback. British Journal of Hospital Medicine*, March, 70(3), 158-161.

McGonigal, K. (2013). How to make stress your friend. TED Talk Video online. **bit.ly/1z7kDLE**

Mental Health Foundation. (2007). *Arts, Creativity and Mental Health Initiative. Participatory Arts Self Evaluation Approach Project Report*. London. Mental Health Foundation.

Menzies-Lyth, I. (1960). Social Systems as a Defence Against Anxiety. *Human Relations*, 13: 95-121: **bit.ly/1Gro693**

Mguni, N. Bacon, N. & Brown, J.F. (2012). *The Wellbeing and Resilience Paradox*. Available at: **bit.ly/1vPHpbc**

Morton, Sarah. (2013). What support do health visitor mentors need? *Community Practitioner*, 86 (8) 32-35.

National Health Service Staff Survey. (2013). Picker Institute Europe. **bit.ly/12Nri1O**

NHS England. (2014). *National Health Visiting Service Specification 2014/2015*. **bit.ly/1ppSMOD**

Neff, K. D., & Lamb, L.M. (2009). Self-Compassion. In S. Lopez (Ed.), *The Encyclopedia of Positive Psychology* (pp. 864-867). Blackwell Publishing.

Neff, K. (2011). Self-Compassion, Self-esteem and Wellbeing. *Social and Personality Psychology Compass*. pp.1-12.

Neff, K. (2013). *Mindful Self-Compassion*. Core Skills Training Workbook. August 3-4, Derby. Compassionate Wellbeing Workshop.

NHS Employers. (2014a). *Guidance on prevention and management of stress at work*. Available at: **bit.ly/1Ep4fei**. Accessed 1.12.14.

NICE. (2014). *Health Visiting. NICE local government briefings* **bit.ly/166M4eZ**

National Nursing Research Unit. (2013). *Does NHS staff wellbeing affect patient experience of care?* **bit.ly/16LpUii**

Nursing and Midwifery Council. (2008a). *The Prep Handbook*, (NMC: London).

Omansky, GL. (2010). Staff nurses' experiences as preceptors and mentors: an integrative review. *Nurse Management*, 18(6), 697-703.

Oxford Mindfulness Centre. (2013). *Oxford Mindfulness Centre Publications* **bit.ly/1CdrgB3**

Palsson, M., Hallberg, I.R., Norberg, A., & Bjorvell, H. (1996). Burnout empathy and sense of coherence among Swedish district nurses before and after systematic clinical supervision. *Scandinavian Journal of Caring Sciences*. 10(1),19-26.

Partnership for Occupational Safety and Health in Healthcare. (2012). *Health and Wellbeing in Healthcare Settings*. Available at: **bit.ly/1z7tyN6**. Accessed 1.12.14.

Patterson, K., Grenny,J., McMillan,R., & Switzler,A. (2011). Crucial conversations: Tools for Talking When Stakes Are High - Second Edition, McGraw Hill.

Proctor, B. (1986). Supervision: A Co-operative Exercise in Accountability in: Marken, M., Payne, M. (eds.)(1986). *Enabling and Ensuring - supervision in practice National Youth Bureau, Council for Education and Training in Youth and Community Work*, Leicester, UK.

The Point of Care Foundation. (2014). *Staff Care; How to engage staff in the NHS and why it matters*. Available at **bit.ly/1wzpf92**. Accessed 10.1.15.

Rocha, T. (2014). *The Dark Night of the Soul*. **theatln.tc/1zQiPGk**

Rustin, M. (2008). Work discussion: some historical and theoretical observations, p3- p21. In Rustin, M. Bradley, J. (ed) *Work Discussion: Learning from Reflective Practice in Work with Children and Families*. London: Karnac Books.

Rutter, M. (2012). Resilience as a dynamic concept. *Development and psychopathology*, 24,335-344.

Thompson, R. Arnkoff, D., & Glass, C. (2011). Conceptualizing Mindfulness and Acceptance as Components of Psychological Resilience to Trauma. *Trauma Violence Abuse* October, 12 (4), 220-235.

Sayer.L. (2013). *Production of Community Nursing - the journey of professional socialisation: a grounded theory of community nurse practice teachers*, Unpublished PHD Thesis.

Sapolsky, R.M. (2004). *Why Zebras Don't Get Ulcers: The Acclaimed Guide To Stress, Stress Related Diseases, and Coping*. 3rd Ed, New York: St. Martin's Griffin.

Sinclair, A., Fairhurst, P., Carter , A., & Miller, L. (2008). *Evaluation of Coaching in the NHS, Report 455, NHS Institute for Innovation and Improvement*, April 2008, ISBN: 978-1-85184-397-8, pp. xiv + 100

Stamm, B.H. (2009). The Professional Quality of Life Scale. In Stamm, B.H. 2010. *The Concise ProQOL Manual*, 2nd edition. Pocatello,ID: **bit.ly/1AFBTW6**

Stewart MJ., & Tilden V. (1995). The contributions of health care science to social support. *International Journal of Nursing Studies*, 32 (1995), 535–544.

Stuart, C.C. (2007). *Assessment, Supervision and Support in Clinical Practice*. Second edition. London: Elsevier.

Turbitt, U. (2012). *Safeguarding Children Supervision: Development and Implementation of a Regional Approach In Northern Ireland*, HSC Public Health Agency (Presented to BUSCPAN conference April 2012).

The American Psychological Association. (2014). *The Road to Resilience*. **bit.ly/1Gktfjk**

Ungar, M.(2008). Resilience Across Cultures. *British Journal of Social Work*, 38,218-235.

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. *International Journal of Nursing Practice*, 9(1),33-39.

Wagnild, G.M., Young, H.M.(1993). Development and Psychometric Evaluation of the resilience Scale. *Journal of Nursing Measurement*. 1(2), 165-178.

Warne, T. and McAndrew, S. (2008). Painting the landscape of emotionality: colouring in the emotional gaps between theory and practice of mental health nursing. *International Journal of Mental Health Nursing*, 17,108-115.

Wendt, S., Tuckey,M.R., & Prosser,B. (2011). Thriving, not just surviving, in emotionally demanding fields of practice. *Health and Social Care in the Community*. 19(3),317-325.

White, M. (2013). *Building a Resilient Organisational Culture*, UNC, Kenan Flagner Business School, UNC Executive Development.

Whittaker, K., Grigulis, A., Hughes, J., Cowley, S., Morrow, E., Nicholson, C., Malone, M., & Maben, J. (2013). *Start and Stay: The Recruitment and Retention of Health Visitors*. National Nursing Research Unit. King's College London. **bit.ly/1tlMmJb**

Wickremasinghe, N. (2014). *Is that All There Is? Self Compassion and the Imperfect Life*, Middlesex University: Doctorate Thesis: Ashridge Business School.

World Health Professions Alliance (2008) *Positive Practice Environments for Health Care Professionals*. Factsheet p.1 Available at: **bit.ly/1ysaxkV** (Accessed 12.1.15).

Resources

A range of resources have been developed to facilitate application of the framework. These include:

- A briefing paper on the importance of compassionate resilience in health visiting.
- Good practice points for health visitors which are based on self-compassion and the 6 skills. These steps are included in the preceptorship and induction frameworks. They could be laminated and held personally or displayed in team bases.
- Resilience training packages for organisations can be commissioned from the iHV.
- An online interactive decision tree; designed to help practitioners and managers develop their resilience can be accessed via the iHV website.
- E-learning resilience training packages can also be accessed via the iHV website.

Section 1
Self-compassion and the six resilience skills

This section includes useful web links to resources to support self-compassion and the six 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/1sjxrJK
Benefits of mindfulness	Professor Mark Williamson - Oxford Mindfulness Centre bit.ly/1zQoufs. Guided Mindfulness Meditation bit.ly/1OBiJva
Mindfulness meditation 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 download for your personal use. bit.ly/1yQOdWO

Meditation

Free Guided Meditation App Relax Kids free downloads	Headspace bit.ly/1yze6vu Relax Kids bit.ly/1yzeiuI

Resilience Research and Training

University of Westminster, Centre for Resilience	**bit.ly/1sdv4xK** Aims to foster resilience and integrate research and practice.
University of Brighton	**bit.ly/1vFrVkR** Works mainly with children, young people and families, and those involved in supporting them but also interested in developing practitioner resilience. Has developed approaches, like Resilient Therapy (RT) **bit.ly/1DwsRMO**, and the Resilience Framework, for anyone to use. Facilitates communities of practice and resilience forums. A range of resources can be downloaded from the website.
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 Center	**bit.ly/1whDnHf** Studies the psychology, sociology, and neuroscience of wellbeing, and teaches skills that foster a thriving, resilient, and compassionate society.
NHS ELECT	**bit.ly/1x3brd0** Provides resilience training
Assessing your resilience – an online scale is available for individual use only	**bit.ly/1MyEVE5**

Section 2
The main components

This section includes useful web links to resources to support the main components.

Compassionate organisation and leadership

Compassion in Practice Implementation Plan for staff experience	bit.ly/12vffq3
NHS Healthcare Leadership Framework	bit.ly/1BG7vib

Resilience Education and Training

NHS ELECT - provides support to NHS teams to develop skills	bit.ly/1x3brd0
Pacific Institute STEPS course	bit.ly/1yAng5P
Resilience module (Cowley, S.) is available as part of the e-learning for Healthcare, Healthy Child Programme	bit.ly/1qJDM2d

Models of support

Public health online resources for **coaching**	Public Health Online resource bit.ly/1GkEAQv Literature Review - Coaching effectiveness bit.ly/1CfekL1 NHS Leadership Academy bit.ly/18JuXkc
Restorative supervision	DH - A Health Visiting Career bit.ly/1z6Jo9m South Warwickshire Foundation Trust bit.ly/19aeGp0
Courageous conversations	London Leadership Academy bit.ly/1x3SCYd Centre for Non-Violent Communication bit.ly/1FkNb8O Developing Conflict Resilient Work Places bit.ly/1GCK9uB Petterson, K., Grenny,J., McMillan,R., Switzler,A. (2011). Crucial conversations: Tools for Talking When Stakes Are High - Second Edition, McGraw Hill. Rosenberg, M. (2012). Living Nonviolent Communication: Practical Tools to Connect and Communicate Skillfully in Every Situation, Sounds True Incorporated. Crucial Conversation - Joseph Grenny - TED talk bit.ly/1xmaEzw You Tube video role play difficult conversations bit.ly/1EJQJT2
Influencing skills	The seven habits of highly effective people (2012) - Covey, S., 978- 0684858395 Borg.J (2009) – Persuasion - The Art of Influencing people, Prentice Hall UO Learn bit.ly/1FkThWC Stephen Covey Website bit.ly/1AzRO8v
Relationship-based models of support	Solihull Approach Website bit.ly/1GJbJJc Family Partnership Model bit.ly/1xmaUi8 Mellow Parenting bit.ly/1EjKClD Report of Christine Bidmeads PHD bit.ly/1xkNjyg
Interdisciplinary /agency groups	Swartz centre Rounds bit.ly/1GRFl8n Point of Care Foundation bit.ly/1b8UoNK Compassion Circles™ bit.ly/1Edb65E Work Discussion Groups bit.ly/1BgnMXs

Action Learning Sets	Dilworth, R. L., Willis, J. (2003). Action learning: Images and pathways. Malabar, FL: Krieger. Revans R (2011) *ABC of Action Learning Gower* Edinburgh Napier University and NHS Lothian (2012) Leadership in Compassionate Care Programme: Enhancing Patient Care by promoting compassionate practice. In this study, action learning helped participants to explore challenges to developing compassionate caring practice. The potential benefits for participants included more effective communication strategies and the skills to continue to be researchers of their own practice.
Performance feedback	Whittaker, K., Grigulis, A., Hughes, J., Cowley, S., Morrow, E., Nicholson, C., Malone, M., Maben, J. (2013). *Start and Stay: The Recruitment and Retention of Health Visitors*. National Nursing Research Unit. King's College London. **bit.ly/1tlMmJb** Partnership for Occupational Safety and Health in Healthcare (2012) *Health and Wellbeing in Healthcare Settings*. Available at: www.nhsemployers.org. Accessed 1.12.14. NHS Employers (2014). *Guidance on prevention and management of stress at work*. Available at: **bit.ly/1Ep4fei**. Accessed 1.12.14. NHS Leadership Academy (ND) *The Leadership Academy and 360 degree feedback*. **bit.ly/1H7qpUz** accessed 14.01.15
Further recommended TED Talks to support resilience	Brene Brown - The Power of Vulnerability **bit.ly/1G1FPVI** Sawn Achor - The Happy Secret to Better Working **bit.ly/1Cfg32Y** Kelly McGonigal: How to Make Stress Your Friend - TED talk **bit.ly/1b8UDbz**

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 organisations which aims to cultivate compassionate healthcare.	Website: **bit.ly/1BzhTdr**

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.

Published by
The Institute of Health Visiting
c/o Royal Society for Public Health,
John Snow House,
59 Mansell Street,
London E1 8AN
Email: info@ihv.org.uk