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Aim To report the findings from an evaluation of the impact of the Compassion in Practice Vision & Strategy (CiPVS) (National Health Service England (NHSE), 2012) on nursing, midwifery and care staff.

Background The CiPVS was a programme of work to highlight the importance of compassionate care following the Francis Report in 2013 into the deficits in care in an NHS hospital trust. It was launched by NHS England in 2012 at a time when fiscal cuts were introduced by the Department of Health in England.

Design and setting Mixed methods.

Results Inferential statistics were used to test whether there were significant differences between staff at different levels of seniority with regard to awareness and involvement in CiPVS and their attitudes to it. Awareness and involvement of staff in CiPVS was high amongst middle and senior management but limited at ward level. Staff were not involved in CiPVS due to a lack of awareness. Ward level staff who were aware and involved perceived a lack of support and communication from senior leadership to deliver CiPVS.

Discussion Results reveal professional anger, distress and resistance to CiPVS and a view of the programme as a top down initiative which did not sufficiently recognise structural constraints on nurses' ability to deliver compassionate care. We discuss the implications of our findings for global nursing.

Conclusion Participants emphasised that compassion for patients is only sustainable where there is compassion for staff and many participants felt that they were not being treated with compassion.

Relevance for practice NHSE should strongly affirm that nurses and midwives *in general* provide compassionate care. Trust leadership should provide support for ward level staff who deliver compassionate care in difficult circumstances.

Summary box: what does this paper contribute to the wider global clinical community?

- Compassion among other values and traits is an important global feature of modern nursing which is perceived by nurses as being under threat in the NHS.

- The CiPVS, designed to invigorate the values based practice of nurses in England, failed to effectively reach bedside nurses, who provide nursing care to patients and their families. This suggests communication between senior management and ward staff should be improved.

- The Francis Report on failures of nurses and care staff in one NHS Hospital Trust in England appears to have had a profound effect on nurses' self-confidence in their delivery of nursing care. Support for clinical ward staff needs to focus on rebuilding morale post Francis.

INTRODUCTION

The global economic crisis triggered the introduction of 'managerialist' systems into health systems globally (Rudge, 2015; Allan et al., 2016a). As a result there were extensive cuts to funding of health systems. These funding cuts were framed as efficiency savings and the effective use of resources. At the same time, health systems in Europe have become increasingly subject to new forms of governance (Allan et al., 2016) leading to restructuring of the relationships within traditional systems of governance (Saltman, 2003). Within this context, the value attached to compassion has appeared under threat as health professionals, care staff and the English health system as a whole appeared to be struggling to deliver compassionate care (Francis, 2013). Several factors underpin the rationale to evaluate CiPVS. First, the CiPVS, launched by NHS England in 2012, was a national programme of work to promote compassionate care following the Francis report in 2013 into the deficits in care in an NHS hospital trust. Second, CiPVS emerged at a time when public trust in nursing and nurses appeared to be declining (Paley, 2014; Traynor, 2014). Individual NHS trusts or public sector healthcare organisations were under pressure from regulators (Care Quality Commission, 2011) and were subject to media reports of poor care following the Francis Report (2013). Third, CiPVS nationally introduced the 6Cs (care, compassion, competence, communication, courage, commitment) and values based recruitment work streams among others (NHSE, 2012) all of which needed evaluation.

The aim of this paper is to discuss the findings from an evaluation of the impact of the CiPVS on nursing, midwifery and care staff. This evaluation fed into 'Compassion in Practice Evidencing the impact – Year 3' (NHS England 2016a) and informed the new framework for nursing, midwifery and care staff in England (Leading Change - Adding Value) NHS England (2016b) which articulate a clear commitment to support nurses, midwives and care staff to deliver compassionate care within the constraints of current financial allocations to the NHS in England.

BACKGROUND

The international nursing literature on caring (Allan, 2001), empathy (Richardson et al., 2015) and emotions is well established (Smith, 1992; Theodosius, 2008) while the literature which deals with compassion is relatively recent (Dewar et al., 2014; Blomberg et al., 2016; Papadopolous & Ali, 2016; Sinclair et al., 2016) with one or two notable exceptions(Dietze & Orb, 2000). Much of the UK literature was published leading up to, or following, the Francis Report (2013) and the Winterbourne View Report (2013) which were government initiated enquiries into reports of poor and abusive care in one hospital trust and a care home in England.

There is some critique of the CiPVS (Smith, 2008; Bradshaw, 2009; Paley, 2014; Traynor 2014). Two reviews of interventional studies of compassion in education and practice (Blomberg et al., 2016; Papadopolous & Ali, 2016) are published recently. Thus, in terms of nursing, compassion remains a contested and under-explored concept (McGrath, 2015; Timmins, 2015).

METHODS

Research aims and objectives

The overarching aims of the evaluation were:

1. To assess the impact of the CiPVS programme in terms of awareness and involvement of the CiPVS strategy and vision and whether CiPVS workstreams had changed the way that nurses deliver care, with particular reference to compassion.
2. To understand the impact of CiPVS according to staff level, as the commissioners of the research were keen to understand whether CiPVS had penetrated to all levels of the organisation, including ward level staff.

Research design

An embedded mixed methods evaluation was used that drew on constructivist pragmatic methodology , where different paradigmatic assumptions are acknowledged but methodologies are chosen from a more practical "what works" perspective to a given inquiry (Greene and Caracelli, 1997, pg8). Thus, we combined elements of both qualitative and quantitative research approaches to "enhanc[e] breadth and depth of understanding" (Johnson et al, 2007 in Creswell, pg4 2011).

Following an online survey of nurses, midwives and healthcare assistants distributed by NHS England, the evaluation team at Middlesex University analysed the survey data. Concurrently, they completed a scoping of the literature to inform online qualitative forms and an interview schedule for nine qualitative telephone interviews from a selected staff sample in 10 selected case study sites; distributed online qualitative forms to a larger self-selected sample (60) in the case study sites; collected and analysed secondary data from each case study site (Family & Friends Test (FFT) (NHS England 2016d), and Staff Family and Friends Test (SFFT) NHS England (2016c) data and NHS Staff Survey (NHSSS); an integrated analysis of all data was undertaken to complete the evaluation. A case study approach was used to inform data collection and analysis within the case study sites, the case 'unit' being the selected NHS trusts (NHS-funded English healthcare provider organisations). This paper only presents the findings from the survey data, the telephone interviews and the online forms. The secondary data analysis is to be reported elsewhere.

Insert Figure 1 here

The evaluation was registered on the Integrated Research Application System (IRAS) and the evaluation was not classed as research not requiring NHS ethical approval. Research and governance (R&D) approval was required from the NHS organisations taking part. R&D approval in the UK is required for all studies, both evaluations and research, involving NHS staff participating by virtue of their profession in order to give assurance as to the scientific quality of the study and provides insurance/indemnity for research projects. R&D approval was sought in each of the identified NHS Trusts and approval was given (through trust governance systems) in 37 (62%) of the 60 Trusts which were approached to participate in the evaluation. Ethical review was also conducted by Middlesex University in accordance with UK requirements for all studies involving people undertaken by university academics.

Survey Data

Sampling

The initial sampling frame was constructed by NHS England, stratified by speciality to include all acute, community and mental health NHS trusts in England (n= 235). A 25.5% sample (n=60) was randomly selected by speciality as per requirements of funders: Acute (n=41), Community (n=6), Mental Health trusts (n=13). Invitations to participate were sent to all 60 Directors of Nursing (DoNs) in 37 selected trusts. 36 agreed to do so, representing 15.74% of 235 NHS trusts nationally.

Data collection

In June 2015, following survey piloting, NHS England circulated the online survey link to DoNs at 36 trusts who agreed to participate. DoNs were requested to disseminate it to all nursing, midwifery and care staff within their trust along with a participant information leaflet in line with approved governance procedures for contacting NHS nursing staff for surveys. The survey collected data identifying the grades of staff, their clinical speciality and explored issues of awareness, programme activities and involvement of the CiPVS strategy and vision. These issues were aligned with the objectives of the CiPVS and remit of the evaluation. Email reminders were sent at one and two weeks after the start of data collection. 2,267 partially or wholly completed questionnaires were obtained but as it is not known exactly how many members of staff were invited to participate, a response rate could not be calculated.

Analysis

Data cleaning involved checking for anomalous responses (e.g. values outside the range of those offered) however none were found. As the data collection was online the range of valid responses had been set in the survey and so it was in theory not possible for 'out of range' response to be given. However, answers had not been set as compulsory in the survey so that there was some missing data (for instance 1957 of 2267 respondents, answered the question regarding their level of seniority and 14% did not answer). It was decided not to use imputation of any kind as a remedy for the missing data as it was not clear that this would make the data more reliable. However, filters and queries were used to make sure that the correct base was selected for each query (e.g. in all queries involving seniority those who had not supplied the information were omitted, as opposed to say having a category such as 'seniority unknown'.).

Following data cleaning, quantitative analysis was carried out in SPSS. Descriptive statistics were calculated for each survey item. A considerable number of the hypotheses which we wished to test involved a bivariate analysis of one categorical independent variable with three levels (seniority band) and an ordinal dependent variable (Likert scale items measuring attitude or behaviours in relation to CiPVS). The Shapiro-Wilk test showed that none of the dependent variables were normally distributed and therefore the non -parametric Kruskal Wallis test was preferred to the parametric one way ANOVA. Some hypotheses related to the seniority band variable and another categorical variables (e.g. whether aware or involved in CiPVS) and for such analyses, involving two categorical variables, the chi-square test was used.

Analysis was carried out on open-ended survey responses to two survey questions: 1) 'Have you any suggestions or comments on how you think the CiPVS strategy could be improved in order to support staff and their delivery of care?'. 2) ''Is there anything in particular you would like to see in the new strategy 'Our Vision'?''. Following O'Cathain & Thomas (2004), two of the research team read the raw data closely (HA, MO'D) before HA analysed the data fully by question rather than respondent. Inductive coding with word frequency tools and word searches followed.

Qualitative Data

A schedule for qualitative interviews was designed following the literature scoping with input from the CiPVS team at NHS England. These qualitative data contextualised the survey data responses (Creswell, 2011).

Sampling

Ten case study sites were chosen for maximum variability (Patton, 2002) in terms of size of trust, geographic location, type of local population. All survey respondents in the ten selected case study sites were asked: ''Would you be prepared to participate in a telephone interview?'' 60 respondents agreed to an interview and were happy to be contacted by the researchers. All respondents in the case study sites who volunteered (N=60) were emailed an invitation to participate in a short telephone interview. Participants (n=9) were selected on a first come first served basis from each trust.

Data collection

Nine telephone interviews were completed by two members of the team (HA, KC) at a time to suit the participant. After interview completion, a second email was sent to nine staff in each selected case study site who had participated in the telephone interviews, inviting them to complete an online form which requested details about specific activities they had undertaken as part of the CiPVS Strategy. Five completed the form.

Qualitative analysis

To ensure rigour, data from the qualitative interviews were transcribed verbatim, checked and analysed descriptively following O'Cathain & Thomas (2004) by the lead researcher (HA). The online forms were analysed to give details of trust activities related to CiPVS including actions by the individual, by their team and by their organization. In addition respondents were asked to provide more detail generally on the 6Cs, listening to patients' voices/feedback and staff.

RESULTS

Survey

The survey carried out by NHS England contained a relatively large number of questions (approximately 70 variables) regarding aspects of CiPVS and the results were analysed according to seniority of respondents, size, specialty, and region of trust. The NHS England survey did not collect demographic information from respondents. In this paper, we test the independent variable of seniority in relation to dependent variables of awareness and involvement in CiPVS and perceived

outcomes of CiPVS to establish whether a key objective of CiPVS (engagement with staff at all levels) was achieved.

Role of respondents

A key aspect of the survey analysis was to understand the extent of awareness and involvement in CiPVS according to the role of respondents. In order to avoid having categories with very small numbers (which we defined as fewer than 100), , the respondent roles variable was recoded to three categories: senior management nursing and midwifery, middle management nursing and midwifery ward level nursing and midwifery (see Fig 2). The numbers of care staff, health visitors and student nurses were considered too small to be representative of those groups , so they were recoded into one category 'other' (Table 1) but were omitted from most analysis as the 'other' category was not considered analytically useful. A distinction between middle and senior managers is drawn, as the latter have no daily contact with ward staff or patients in the British clinical setting, while middle managers retain daily contact with clinical staff but assume no patient responsibility.

(insert Table 1 here***)

 (insert Fig 2 here)

Awareness of CiPVS

Overall, 58.6% of all respondents said that they were aware of the CiPVS strategy; nearly one third (30.3%) were not aware of it and 11.1% were unsure.

insert fig 3 here **

Analysing awareness by role, more than 95% of senior nurses and midwives were aware of CiPVS as were 69.4% of middle management nursing and midwives but less than half (47.3%) of ward level nurses and midwives were aware of CiPVS. The proportion of respondents who were 'unsure' also varied widely by seniority – 15% at ward level; 7.7% at middle management level and just 1.6% at senior level. Differences in awareness on the basis of seniority were statistically significant (X^2 115.34, *df* =4, *p*<.001).

Where respondents heard about CiPVS, by seniority

Senior level staff were much more likely than middle management or ward level staff to have heard about CiPVS through emails, meetings, social media and journals

CIPVS being discussed or highlighted – by seniority of respondent

26.3% of ward level nurses and midwives felt that CiPVS was discussed or brought to their attention compared to 46.5% of middle management nursing and midwifery and 88.3% of senior management nursing and midwifery. The differences in awareness by seniority on this question were statistically significant (X^2, 136.20, *df*=4, *p*<.001). A possible explanation for these differences is ineffective cascading of information from senior management to middle management and then to ward level.

Involvement in CiPVS

Overall, 27.4% of respondents (n=2,242) said that they had been involved in CiPVS in some way; just under three-quarters of respondents (73%) had not been involved.

 Insert fig 4 here

Involvement by seniority of respondent

As shown in Fig 5, while over 83% of senior management had some involvement with CiPVS, the equivalent proportion amongst middle management was just 34.1% and ward level involvement (15.3%) was less than half of that. Involvement in CiPVS by seniority showed statistically significant ($X^{2\,q}$ 163.221, *df*=2, *p*<.001) differences.

(insert Fig 5 here**)

Reasons for not being involved in CiPVS

The most common reason for not being involved was 'I am not aware of any CiPVS programmes in my trust' (65.4%), followed by 'unsure' (18.3%), 'lack of time' (10.9%) and (relatedly) 'I am too busy' (6.4%). 6.1% of respondents (n=90) chose 'other' and amongst 'other' the biggest reason given was that respondents had not been invited to participate in a CiPVS work stream or initiative. Less than 6% of respondents identified lack of management support, lack of money / resources or lack of interest as reasons for not being involved. This suggests that low levels of involvement in CiPVS may not be explained by resistance to CiPVS but rather by insufficient information about CiPVS, not knowing how to get involved or perhaps insufficient motivation to find how to get involved. Even amongst those who were aware of CiPVS), lack of awareness of CiPVS initiatives in their own trust was a major barrier to involvement.

Reasons for not being involved, by seniority

The biggest reason for 'not being involved' across all levels of staff was 'I am not aware of any CiPVS programmes in my trust', followed by 'unsure' and 'lack of time'. Less senior staff were more likely to cite lack of awareness or lack of time as a reason for not being involved. Senior staff were more likely to identify lack of money / resources or 'other' as reasons for not being involved.

(**insert Fig 6 here)

Perceived outcomes of CiPVS

How respondents perceived the outcomes or impact of CiPVS was influenced by so many respondents being unaware of CiPVS.

Whether CiPVS is useful for supporting nurses

More than half of all respondents (56.1%) considered that CiPVS is useful for supporting nurses but 39.8% were 'unsure'. Of those respondents who were aware of CiPVS, an overwhelming majority (79.6%) considered it useful for supporting nurses, with 17.6% being unsure and just 3.4% saying that CiPVS was not useful for supporting nurses.

Perceptions of the achievement of specific CiPVS objectives

Mean agreement with all the five items relating to the achievement of specific CiPVS objectives was relatively high. On a scale of one to five where five was highest agreement, the highest scoring item was ''I actively listen to, seek out and act on patient and carer feedback, identifying issues and ensuring the patient and carer voice is heard'' (4.46), followed by ''I support the measurement of care to learn, improve and highlight the positive impact on the people cared for'' (4.29).

These are interesting findings as they suggest that despite a large proportion of respondents being unaware of CIPVS, a large majority still felt that they were delivering care in ways which were consistent with the intended outcomes of the CIPVS strategy.

Again, there were more positive responses as seniority increased; senior management were more likely to agree with the statements than were ward level or middle management staff (see Table 2). Differences on the basis of seniority were found to be statistically significant on all items (Kruskal Wallis $p<.001$) except for the item ''I have developed skills as a 'health promoting practitioner' making every contact count'' (Kruskal Wallis $p=>.05$).

(**insert Table 2 here)

Attitudes to Outcomes of CiPVS

Our findings (Fig 7) show that the levels of agreement (agree and strongly agree) ranged quite widely from 77.5% for ''The CiPVS Strategy has the ability to improve the delivery of patient care'' to 50% ''The CiPVS Strategy has made a positive difference to my overall experience as a nurse/midwife/care staff. There were clearly mixed opinions, even amongst those who were aware of CiPVS, regarding the extent to which CiPVS had supported staff development. Most respondents agreed that ''CiPVS has made me think about how I deliver compassionate care''; ''CiPVS has helped to improve the patient experience'' and ''CiPVS has positively influenced my actions in delivering compassionate care''.

(**insert Fig 7 here**)

On every item in Q12, which attempted to measure respondents' views on the impact of CiPVS, senior management nursing and midwifery have the highest mean agreement, followed by middle management nursing and midwifery and then ward level nursing and midwifery (see Table 3). The differences were statistically significant on all items (Kruskal Wallis test, $p<.05$).

(**insert Table 3 here)

Open-ended survey responses

Our findings describe a workforce that feels frustrated, overworked and unsupported; that lacks morale and is experiencing a lack of leadership after the extensive criticism of nursing which followed the Mid Staffordshire Inquiry's (Francis 2013) examination of UK healthcare commissioning, supervisory and regulatory organisations viz a viz their role with the English Mid Staffordshire Foundation NHS trust between 2005-2009:

"..it was soul destroying when I read the Francis report { } – and then when the compassion in action document came out ………… it's so obvious isn't it; …… that something sometimes goes wrong, .. when people have been doing a job for a very, very long time – I think most people come into the profession for all the right reasons, when they're doing it, day in day out, with all the challenge, all the resources, they sometimes get desensitised" (Site 2 middle manager).

Some respondents found CiPVS insulting and time-wasting:

"Compassion in practice is just a box ticking exercise, all nurses should act with compassion and care anyway, having to spend an hour explaining how you do this in a PDR [performance development review] is insulting and a waste of time."(Open ended response 42 Other)

However some respondents suggested that the poor care was allowed to go unchallenged and unreported and were strongly critical of staff who failed to deliver compassionate care. The following comment shows that the respondent felt there was a need for this to be addressed.

"There are still a lot of staff I work with who show no regard for compassion. Even when concerns are passed to management, these individuals are not challenged about their behaviours." (376 Midwife ward level)

At least one respondent indicated that a tougher approach to improving the delivery of compassionate care was needed:

"Compulsory training for all staff, time rostered into work rota by management" care staff" (98 Nursing ward level)

Responses also suggested that staff feel demoralised with little sense of feeling supported to deliver compassionate care. Consequently, staff expressed frustration at being exhorted, through CiPVS, to deliver compassionate care while feeling that they were not treated with compassion as employees. Some respondents suggested that a lack of support (in some cases manifesting as a bullying culture) prevented the delivery of compassionate care:

"Creation of a Care and Compassion Champion at ward level.   It should be extended to care of staff to combat or prevent bullying."(50 Nursing ward level)

"We are still working in a culture driven by anxiety and defensiveness which works against the ability to give compassionate care. Until the blame culture is widely discussed nurses don't feel supported or safe and are over anxious." (413 Nursing ward level)

These data suggest a working culture in which compassion may be difficult to deliver as staff feel under stress and at the same time observe a failure to address poor care and bullying.

The open ended responses showed clearly the extent to which CiPVS had failed to filter down to ward level *and* some middle managers as an overarching framework which include the 6Cs.

"I am aware of some aspects but on an individual basis. I was unaware of the umbrella term of The Compassion in Practice Strategy." (86 Nursing middle management)

Indeed, the responses showed that middle managers understood how poor awareness of CiPVS at ward level due the structural issues mentioned above:

"Although most staff are aware of the Compassion in Practice, not enough is really known at floor level. The majority of the nursing staff always work to their extreme best in delivering care to patients. Lack of resources, equipment and the constant movement of having to outlie patients instead of caring for them in a safe environment often results in the interruption of the continuation of care and delays safe discharging."(14 Nursing middle management)

In fact, survey responses contradict this respondent's assertion that most staff are aware of CiPVS, suggesting that management over-estimate awareness of CiPVS at ward level. Several respondents expressed a desire for NHS trust leadership teams to engage and support staff to deliver compassionate care and leadership to engage with the CiPVS Vision and Strategy. Many respondents felt it was down to managers or the trust to disseminate to them not their professional responsibility to keep up to date about current issues which affect nursing.

Despite the lack of awareness about CiPVS and the responses describing barriers to implementing compassionate practice, there were some useful suggestions for improving dissemination which indicates a belief that compassion is an intrinsic, although threatened, value for nursing:

"A continual dissemination of the programme to keep this in the forefront of all nursing practise otherwise it will come across as another flash in the pan"(6 Nursing middle management)

Telephone interviews

The telephone interview transcripts provide context to the survey findings on awareness and involvement. The number of interviews was relatively small (n=9), they were self-selected, and only one ward level practitioner and one health care assistant volunteered for the telephone interviews. Even among this small group of interviews, those who were aware of the 6 Cs or other particular work streams within CiPVS did not necessarily recognise that these were components of CiPVS. The health care assistant was aware of the need for compassion but not the CiPVS or 6Cs.

"No, personally no. Obviously, we make sure our care is up to scratch and meeting compassion standards and things like that, but no, I've not heard of any particular initiatives' (Site 6 middle manager)'.

Interestingly, the telephone data suggest that how staff think about compassion may shape their response to policy; if they believe compassion is innate, then they may be unlikely to seek out or be receptive to policy which promotes compassion. One interviewee described compassion as being 'automatic', which while not necessarily implying an innate quality, suggests that compassion is seen as a behaviour so fundamental that it need not be consciously practised as part of a 'work stream':

"No, well no, because you just do it as general practice, so it's not, I haven't had a specified work stream for it, but it's something that I promote so I don't really need a specified work stream for it." (Site 10 middle manager)

The health care assistant felt that a lack of compassion was because of the difficulty of recruiting 'the right type of staff:

"And why do you think the strategy was necessary? (Interviewer)

Because …. I'm working for the people, if the people are not satisfied, what's the point of working in the NHS, I should find another job! …..Yeah, if you don't like the job, why should you come to this job, the NHS, go to another job." (Site x health care assistant)

Conversely, other participants saw compassion as a competence to be learned:

"Compassion is a competence but I also see it as a core human value, so it's a difficult one isn't it but everyone has compassion at different levels and, depending on where you in your life journey, on your levels of compassion as well. " (Site 10 Senior manager)

While these (mainly) managers believed compassion was central to nursing and at the same time under threat, they also described barriers to caring compassionately.

"It's (CiPVS) increased the awareness. I think we're all horrified that we're having to be told to be compassionate, especially those of us at the front who've been around a long time. I mean, it's hard but my heart says that we're not here to cause anybody distress or we're not lacking in compassion – what we're lacking is time to produce that compassion and to make the patient experience more positive". (Site 6 middle manager)

Again, as in the open ended responses, the perceived lack of compassion for staff was seen as a barrier to enable them to care compassionately for patients:

"You can have all the strategies in place, but unless the team is supported, and working well, they've not got time to look at the strategy and nor do they want to care to look at the strategy, so it's going back a step before you start looking at strategies on how to improve.{ }……because if you're not supported and you're not fine, you can't do a job" (Site 10 Senior manager)

DISCUSSION

The recent importance of compassion in the UK, especially in England, contrasts with the relative dearth of literature on compassion internationally in nursing which suggests that compassion may have been emphasised strongly in response to the criticisms of English nursing in the Francis and Winterbourne View reports without consideration of other possible theoretical explanations (Paley 2014). This critical national context may explain the results in our evaluation, that is, compassion as a national policy for England achieved through the roll out of programmes of work inside English NHS trusts may assume greater importance according to the seniority of the research participants. To those in ward-based roles, compassion assumes importance in the context of the structural demands of their work and their ability or inability to deliver what is perceived of as good care to patients. The generalisations to be drawn from this evaluation were to some extent restricted by the challenges of sampling and representativeness that could be achieved due to the governance constraints of national processes. However, there were some key issues raised through the survey and engagement with participants which warrant highlighting.

Importantly for the new strategy (2016a, 2016b), responses across all staff groups suggested that compassion is viewed as an intrinsic value underpinning nursing. There is some evidence that a majority of respondents considered that they were already delivering care in ways which were consistent with the CiPVS objectives (Table 3) even though 41% of respondents were unaware of CiPVS itself. The perception of staff that they were delivering compassionate care was seemingly supported by the patient perspective - in a MORI (2015b) finding that 73% of those who had used the NHS in the last year agreed that patients were treated with compassion.

Viewing compassion as central to nursing may explain why awareness of 6Cs was relatively high across all staff – it caught staff attention and seemed to make sense of their working lives. But confusion existed over the relationship between 6Cs and CiPVS and there was lower awareness about CiPVS as a strategy which included the 6Cs as a programme of work. Awareness and involvement in CiPVS and programmes of work are rather obviously linked as the main reason for not being involved was not being aware of CiPVS, followed by 'unsure' and 'lack of time'. The lack of awareness meant that many participants could not give an informed opinion, contributing to the high proportion answering neutrally on these questions. However amongst those who were aware of CiPVS, significant majorities thought that the objectives had been achieved.

Respondents were less positive about the outcomes of CiPVS in terms of changing working cultures in the NHS; just 57% of those who were aware of CiPVS considered that CiPVS had promoted a culture of compassionate care in their organisation and just half of those who were aware of CiPVS felt that it had made a positive difference to their overall experience as a health professional. However, 79.6% of those who were aware of CiPVS said that it was useful for supporting nurses. Open ended survey responses supported the view that staff did not experience improvements to their working lives from CiPVS and particularly worrying are data describing a bullying and blame culture similar to the North American workplace findings of Gaffney et al., (2012). The conditions in which staff work, and over which they feel they have little or no control or agency (Allan et al. 2016b), such as poor staffing, high workload, feeling under-resourced and swamped paperwork, are acknowledged as vital to recruitment and retention of high quality staff who deliver high quality, safe care. These specific findings on the organisational workplace context have global resonances.

For example, Papdopoulos et al.'s (2016b) descriptive study from fifteen countries reported a lack of compassion shown to nurses by their managers. This implies that our findings could help inform implications for the further development of local nursing leadership and for driving the necessary changes that positively impact on organisational cultures.

Open ended responses indicated that the CiPVS work streams did not give sufficient emphasis to structural constraints of time and resources, as barriers to delivering compassionate care, which respondents resented. This recollects the findings from Christiansen et al (2015) on the effect of positive role modelling of leadership, good team interrelations and focusing on staff wellbeing as a means of enabling compassionate care. This structural deficit fosters resentment which could easily change into cynicism and policy fatigue (Sheppard 2014). The ensuing cynicism may partly shape staff expectation that managers will be proactive in disseminating changes to working practices. It reflects a wider issue in UK nursing regarding nurses' taking responsibility for their own learning, including keeping abreast of strategic change, all of which are historically evident professional characteristics identified within the global nursing literature (Biley & Smith, 1998). This may explain the low awareness of CiPVS reported among ward level staff while at the same time, recognition of specific elements of the strategy, such as the 6Cs.

The intertwined nature of staff and patient experiences is explicitly recognised in the CiPVS strategy (NHSE, 2012) and in the literature (Smith, 2008). Positive experiences of care for patients are intimately related to positive work experiences for health professionals (Allan et al., 2014). We should reflect on whether it is realistic to expect ever more compassionate care from nurses whilst they perceive (rightly or wrongly) that they themselves are not always being treated with compassion by employers.

The survey results show that organisational culture has also been important in shaping awareness, involvement and feeling supported by the CiPVS, with variable accounts of how particular supportive work environments can facilitate the delivery of compassionate care. The latter findings again relate to the international sphere as similar findings are reported from within cultural settings ostensibly different to those in our study e.g. Iran (Valizadeh et al 2016).

Limitations

The overall response rate cannot be calculated as the methodology used by NHS England meant that the total number of people who received the link to the online survey could not be determined. Furthermore, the population data for the trusts which took part in the survey was not available, so that a comparison with the sample could not be made (i.e. to determine the percentage of each role within each trust). However while this impacts on the generalisations that can be made beyond the sample, there are some important indicators which need highlighting for further consideration: it seems likely that middle management nursing were considerably over-represented in the survey, and that ward level nurses were considerably under-represented. If this is the case then it would represent a considerable source of bias since, these groups vary to a statistically significant extent on most questions in the survey. The number of senior level midwives in the survey was small (n=6) creating a high degree of uncertainty regarding their representativeness. The responses of student nurses (n=6) health visitors (n=54) and care staff (n=125) were excluded due to small numbers and their views may have been distinct from those of nurses or midwives.

The survey relied on self-reported data and the extent to which these are an accurate reflection of the way which respondents actually work or deliver care cannot always be determined reliably from surveys alone. The fact that some of the questionnaire items were explicitly linked with an outcome from a CiPVS strand in the questionnaire is likely to have unintentionally signalled what the 'desired' answer was.

O'Cathain & Thomas (2004) argue that although it is common to include open questions in questionnaires, collected data related to open responses in questionnaires are often never analysed or shared with a wider public despite being a useful source of information. Our analysis offers an integration of quantitative and qualitative data for a meaningful evaluation.

Although the sites of the telephone surveys were carefully sampled to maximise representativeness, those who agreed to take part were disproportionately from management and in any case it was only possible to carry out a small number of interviews due to the resources available.

CONCLUSIONS

Lack of awareness or involvement with CiPVS does not mean that compassionate care is not being delivered. Awareness of CiPVS and involvement in CiPVS were low but many research participants felt that they were delivering compassionate care as articulated in the CiPVS. There was some anxiety, anger and distress about the messages that CiPVS gives out internally to the profession and externally to patients. Many participants felt that individual agency in relation to delivering compassionate care was being stressed by the CiPVS initiative at the expense of structural constraints on delivering compassionate care which were seen as primarily related to resourcing. The implication therefore is that future initiatives should be careful to avoid any implication that nurses or midwifes *in general* are not already providing compassionate care and might also explicitly recognise that delivering compassionate care is not entirely a matter of individual agency. Leadership needs to be responsive to the demands on ward level staff when delivering compassionate care and leadership needs to provide support for ward level staff.

RELEVANCE FOR PRACTICE

Compassion, among other values and traits, is an important feature of modern nursing globally but its meaning is also contested (Blomberg et al., 2016; Stenhouse et al., 2016). The CiPVS, designed to invigorate the values based practice of nurses in England, failed to effectively reach bedside nurses, who in providing nursing care to patients and their families must emulate the highest professional values. At the very least, this suggests communication between senior management and ward staff should be improved. The Francis Report on failures of nurses and care staff in one NHS Hospital Trust in England appears to have had a profound effect on nurses' self-confidence in their delivery of nursing care. Support for clinical ward staff needs to focus on rebuilding morale post Francis. Finally, our results suggest that NHSE should strongly affirm that nurses and midwives *in general* provide compassionate care. Trust leadership should also provide support for ward level staff by acknowledging how they deliver compassionate care often in very difficult circumstances.

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Fig 1:   Research Design

SURVEY
Random stratified sample, selecting 25.5% of all NHS trusts in England (n=60). Ethical approval was sought in these 60 trusts and was granted in 37 trusts. Of these, all but one agreed to participate, giving a total of 36 trusts participating in the study.
The online survey link was distributed by NHS England to Directors of Nursing at each of the 36 trusts, who circulated it to staff within their trust.

Case studies

10 trusts were chosen as case studies (purposive sampling based on size, population diversity and rural / urban location) and 60 staff were sampled from across these

Literature scoping to inform further data collection

60 staff from the 10 case study sites were invited to complete online forms (n= 8)

The same 60 staff were invited to participate in Telephone interviews (n=9)

Collection and analysis of secondary data

SFFT, PFFT, NHS staff survey

Integrated analysis all data

Fig 2:   Survey respondents by seniority (n=1,763) Base: All nursing & midwifery respondents who identified their seniority

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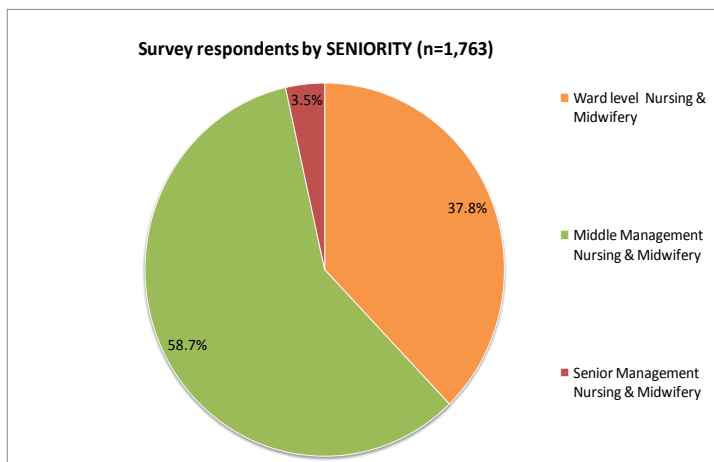
Fig 3: Awareness of CiPVS – overall (n=2,244) Base: all respondents answering the question
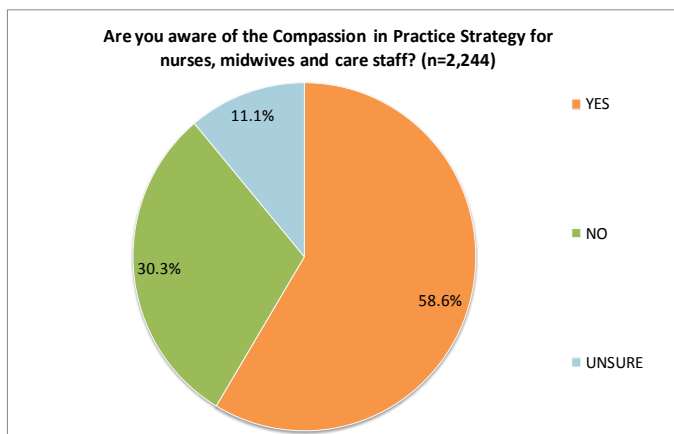
Fig 4:   Involvement in any aspect of CiPVS (n= 2,242) Base: all respondents

Involvement in any aspect of CIP
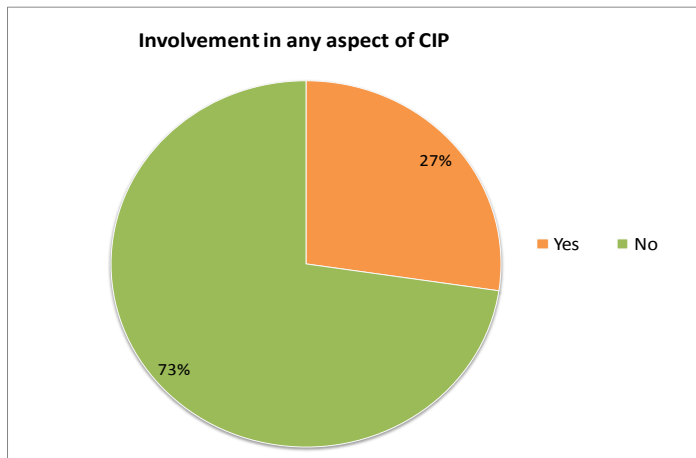
Fig 5:   Involvement in CiPVS by seniority of (n=1,754). Base: all nursing and midwifery respondents who identified their level of seniority)

Involvement in any aspect of CIP by seniority of respondent (n=1,754)

Category	Involved	Not involved
All	28.7%	71.3%
Senior Management Nursing & Midwifery	83.6%	16.4%
Middle Management Nursing & Midwifery	34.1%	65.9%
Ward level Nursing & Midwifery	15.3%	84.7%

Fig 6: Reasons for not being involved, by seniority (n=1,128). Base: All nurses and midwives answering the question who identified their seniority.

Fig 7[1]: Attitudes to outcomes of the CIPVS strategy amongst Respondents who were aware of CiPVS. N varies per item – average 1,285.

Q12. Below are a number of statements regarding experience of the strategy. Please indicate to what extent you agree or disagree with each statement (respondents who said they are aware of CIP average n per item =1,285)

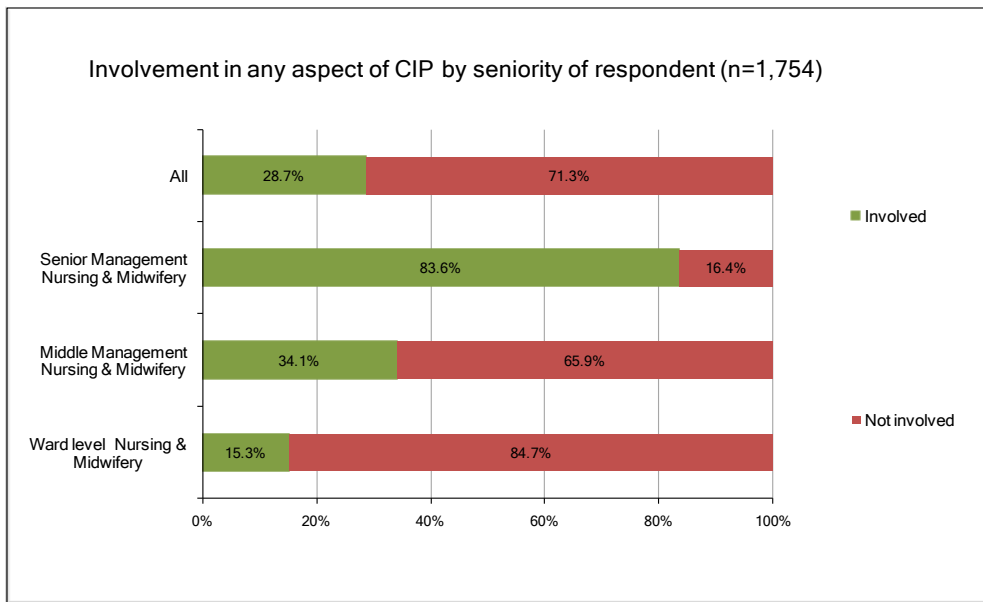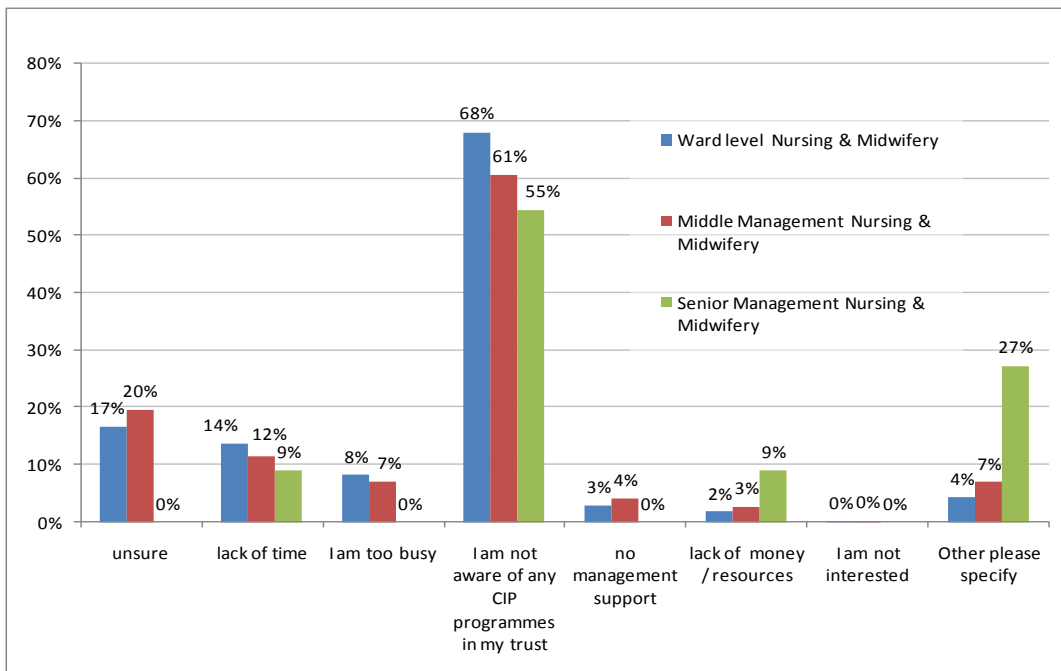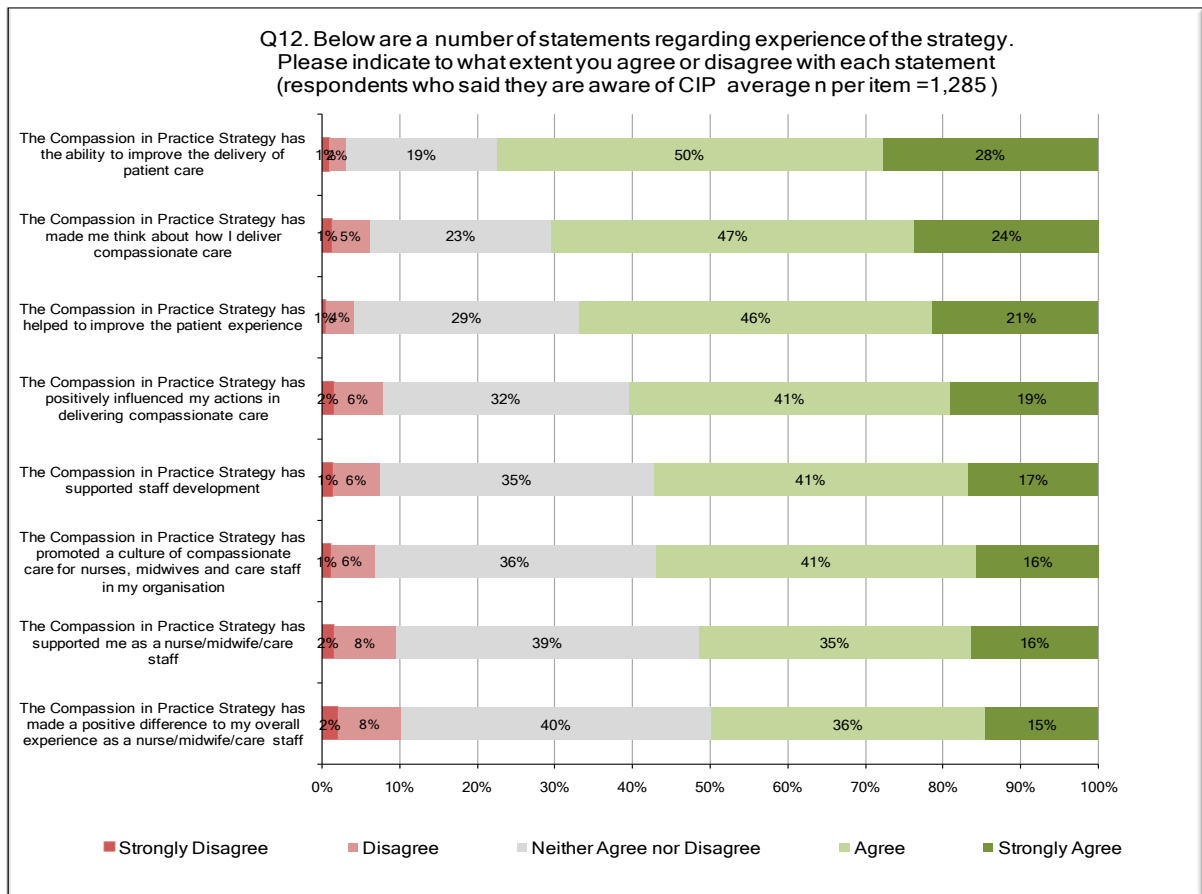| Statement	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
The Compassion in Practice Strategy has the ability to improve the delivery of patient care	1%	2%	19%	50%	28%
The Compassion in Practice Strategy has made me think about how I deliver compassionate care	1%	5%	23%	47%	24%
The Compassion in Practice Strategy has helped to improve the patient experience	1%	3%	29%	46%	21%
The Compassion in Practice Strategy has positively influenced my actions in delivering compassionate care	2%	6%	32%	41%	19%
The Compassion in Practice Strategy has supported staff development	1%	6%	35%	41%	17%
The Compassion in Practice Strategy has promoted a culture of compassionate care for nurses, midwives and care staff in my organisation	1%	6%	36%	41%	16%
The Compassion in Practice Strategy has supported me as a nurse/midwife/care staff	2%	8%	39%	35%	16%
The Compassion in Practice Strategy has made a positive difference to my overall experience as a nurse/midwife/care staff	2%	8%	40%	36%	15%

[1] Some further questions were asked about experiences of the CiPVS strategy and for these questions it was felt that those who had said that they were unaware of CiPVS could not meaningfully answer and they were excluded from the analysis.

Table 1: Role of survey respondents (n=1,957)

Role of respondent	Frequency	Percentage
Ward level nursing and midwifery	667	34.1
Middle Management nursing and midwifery	1034	52.8
Nursing – Senior Management	62	3.2
Other	194	10
Student Nurse	15	0.8
Health Visitor	54	2.8
Care Staff	125	6.4
Total	1,957	100

Table 2: Mean agreement with statements relating to CiPVS objectives. N varies per item, as shown in table. Base: All nursing and midwifery respondents who had identified their seniority (scoring = 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree) The hypothesis in all cases is that there will be statistically significant differences in responses to the statements (representing attitudes or behaviours relating to CiPVs) according to level of seniority.

Listed below are the six action areas (AA) of the Compassion in Practice Strategy and the call to action for every nurse, midwife and care staff. Please indicate to what extent you agree or disagree with each statement	Ward level Nursing & Midwifery	Middle Management Nursing & Midwifery	Senior Management Nursing & Midwifery	Total	N	P value Kruskal Wallis test
I actively listen to, seek out and act on patient and carer feedback, identifying any themes or issues and ensuring the patient and carer voice is heard	4.32	4.52	4.79	4.46	1,707	.000
I see myself as a leader in the care setting and role model the 6C's in my everyday care of patients	3.95	4.53	4.85	4.33	1,697	.000
I support the measurement of care to learn, improve and highlight the positive impact on the people cared for	4.12	4.37	4.70	4.29	1,692	.000
Where applicable I deploy staff effectively and efficiently; identify the impact this has on the quality of care and the experience of the people in our care	3.79	4.40	4.79	4.20	1,548	.000
I have developed skills as a 'health promoting practitioner' making every contact count	4.00	4.07	4.11	4.04	1,685	.101

Table 3: Attitudes to aspect of the CIPVS strategy amongst Respondents who were aware of CiPVS. N varies per item – as shown in table (scoring = 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree). The hypothesis in all cases is that there will be statistically significant differences in responses to the statements (representing attitudes or behaviours to CiPVs) according to level of seniority.

Below are a number of statements regarding experience of the strategy. Please indicate to what extent you agree or disagree with each statement	Ward level Nursing & Midwifery	Middle Management Nursing & Midwifery	Senior Management Nursing & Midwifery	Total	N	*p* on Kruskal Wallis test
The CiPVS Strategy has the ability to improve the delivery of patient care	3.93	4.02	4.24	4.01	1065	0.015
The CiPVS Strategy has made me think about how I deliver compassionate care	3.82	3.84	4.20	3.85	1081	0.003
The CiPVS Strategy has helped to improve the patient experience	3.72	3.84	4.28	3.83	1070	0.000
The CiPVS Strategy has positively influenced my actions in delivering compassionate care	3.68	3.68	4.02	3.70	1073	0.014
The CiPVS Strategy has promoted a culture of compassionate care for nurses, midwives and care staff in my organisation	3.52	3.68	4.05	3.65	1060	0.000
The CiPVS Strategy has supported staff development	3.51	3.67	4.16	3.65	1069	0.000
The CiPVS Strategy has supported me as a nurse/midwife/care staff	3.48	3.57	4.17	3.58	1074	0.000
The CiPVS Strategy has made a positive difference to my overall experience as a nurse/midwife/care	3.44	3.54	3.81	3.53	1063	0.010

staff						

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