Releasing latent compassion through an innovative compassion curriculum for Specialist Community Public Health Nurses

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Running head: Releasing latent compassion for SPCHNs

Keywords :
Nursing
Compassion
Self-compassion
Specialist community public health nurses; SCPHN
Health visitors
Education

Acknowledgements

The authors are grateful to participants who gave up time after work or on a day off to travel and attend focus group interviews. We thank Paula Carr (Specialist Practitioner Perinatal Mental Health) for her support.

We thank the Trust in facilitating availability of premises for the interviews.

We thank Professor Paul Gilbert (University of Derby), Professor Kristin Neff (University of Texas, USA) and members of the Compassionate Mind Foundation, in particular Chris Irons, Tobyn Bell, and Michelle Cree, for their advice in the development of the curriculum and for their encouragement.

Funding

Funding provided by a project award from the Faculty of *[to be completed pending acceptance of the paper for publication].*

Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

Criteria	**Author Initials**
Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;	AP, AM, PK-D, AS-F
Involved in drafting the manuscript or revising it critically for important intellectual content;	AP, AM, PK-D
Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content;	AP, AM, PK-D, AS-F
Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.	AP, AM,PK-D

ABSTRACT

Aims: To evaluate the impact of a curriculum based on the Compassionate Mind Model designed to facilitate the expression of compassion in Specialist Community Public Health Nurses.

Background: The Compassionate Mind Model identifies that fear of compassion creates a barrier to the flow of compassion. There is some evidence linking self-compassion to compassionate care but no previous research has explored this potential with post registration specialist community public health nursing students.

Design: Prospective, longitudinal design using focus group interviews.

Methods: 26 students (81% of cohort) agreed to participate in a wider evaluation (2014-2015). For this study, two groups were drawn from those participants (total 13 students) who attended audio-taped group interviews at the course mid- and end-points to explore their perceptions on compassion and compassionate care. Transcripts were analysed thematically.

Findings: A number of sub-themes were identified. 'Cultural change in the NHS', 'Workload and meeting targets' and 'Lack of time were barriers to compassionate care, as was negative 'Role modelling'. These were collated under a macro-theme of 'A culture lacking in compassion'. Secondly, the sub-themes 'Actualisation of compassion' and 'Transformation' were collated within a macro-theme: 'Realisation of compassion'. This theme identified realisation of latent compassion from their previous roles that in some transferred into students' personal lives suggesting a transformation beyond professional attitude.

Conclusion: The curriculum facilitated a realisation of compassion in students over the period of the course by enhancing their capacity to be self-compassionate and by actualisation of compassion that had previously been suppressed.

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SUMMARY STATEMENT

Why is this research needed?

- No other study has examined how or if compassion can be taught to post registration specialist community public health nursing students.
- The study took place at a time when student recruitment and expansion increased and so required practitioners and educators to review how the curriculum might be developed in face of such challenge.
- The situation provided an opportunity to introduce and evaluate an innovative post-registration curriculum to promote self-compassion as a vehicle for compassionate care.

What are the key findings?

- Findings identified that compassion had been suppressed in the secondary care environments from which the students had been recruited. The course promoted realisation of this attribute in the students.
- A major finding was that attitude changes extended beyond approaches to nursing suggesting that the curriculum was transformational**.**

How should the findings be used to influence policy/practice/ research/education?

- This evaluation supports realisation of latent compassion in nurses that can be harnessed through education by applying the Compassionate Mind Model.
- The findings present a positive means of raising levels of self-compassion and compassion. Findings are likely to be transferable to other health care settings.
- Further study should evaluate the sustainability of the transformational process.

IMPACT STATEMENT.

The NHS Constitution identifies compassionate care as a core value since it enhances the quality of patient experience. Facilitating compassionate care is a key consideration in the UK Nursing Strategy. This paper reports the impact of an innovative post-registration curriculum based on the Compassionate Mind model to release a latent, suppressed compassion in Specialist Community Public Health Nurses. The change was transformational appearing to change both professional and personal attitudes.

INTRODUCTION

The beneficial impact of compassionate care is well recognised. It is enshrined within UK Department of Health initiatives to promote a caring culture in the UK National Health Service (NHS) (Department of Health 2012, NHS England 2016). Compassion enhances quality of client care (Maben et al. 2012), builds compassionate resilience of practitioners (Pettit & Stephen, 2015) and helps to prevent staff burnout (Neff 2009). The Constitution of the National Health Service identifies it as a core value (Department of Health, 2015) and facilitating compassionate care is a key consideration in the UK Nursing Strategy (Department of Health, 2012). A pertinent contemporary question is concerned with whether or not compassion may be taught. This paper describes a research evaluation of an educational programme designed to develop attributes specifically related to compassionate care.

Background

A generic international consensus is that compassion is a relational process which involves recognising that someone is suffering and consequently being motivated to take action to alleviate this suffering (Ménage et al., 2017, Ledoux, 2015; Strauss et al. 2016). Compassion provides a base from which people can develop the capacity to not become overwhelmed by emotionally distressing situations and is achieved by working with the difficulties of the mind rather than being overwhelmed by suffering or by avoidance of the difficulties that are presented (Gilbert & Irons, 2005).

Gilbert (2010) identified six compassion attributes: motivation, attentional sensitivity, sympathy, empathy, tolerating emotional distress and non-judgement. He has argued that it is the motivation to relieve suffering that is a key defining factor and proposed a Compassionate Mind Model (Gilbert 2010; 2013) that outlines how compassion influences emotional regulation, thinking and behaviour. A key principle is that using personal reflection to understand the nature of our evolved minds helps us to gain insight into how to facilitate the development of experiences and conditions that then enable self-compassion and compassionate care (Gilbert & Irons 2005). An ecological approach is recommended as compassion can be difficult to sustain in threatening environments. For example, a public

enquiry into failings at a hospital in central England (Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry, 2013), Chaired by Robert Francis QC, concluded that *'a culture of awareness was operating in a structure where identifying systems and processes and meeting targets were the main factors of performance …..finances and targets were often given priority without considering the impact on the quality of care'* (page 65).

Compassion has been described (Gilbert, 2009) as a process which flows to others, from others and to self. Certain factors may act as a barrier so inhibiting this flow including a perception that compassion is a " weak, fluffy" attribute that leaves you open to threat , or that self -compassion is selfish (Welford, 2012), or it is connected to earlier life experiences where caring was absent (Gilbert et al., 2012) . It was recognised some years ago (Kitwood,1997) that good care teams must be open to the complexity of practice and to understanding how unresolved feelings can be projected. Failure to do so may cut off those feelings and present a personal barrier likely to relate to the development of certain psychological scripts about caregiving arising from previous experiences. Irons and Beaumont (2017) differentiate between types of barriers/inhibitors to compassion. 'Fear' of compassion is when we would like to be compassionate but are frightened of feelings that may arise, for example sadness, grief or anger about the past. 'Blocks' to compassion arise when people are not frightened of it but something gets in the way for example being too busy. 'Resistance' is when we are not frightened or blocked but we do not want to engage with it, for example if we perceive someone as not deserving of compassion or if we feel that it is something we are ashamed of.

Overcoming the barriers by promoting a compassion 'flow' from self-self is a critical part of the Compassionate Mind model. It is suggested to be promoted by enhancing the attribute, self-compassion (Neff 2009) identified by Raes et al. (2011; p250) as the '*ability to hold one's feelings of suffering with a sense of warmth, connection and concern*'. It has been linked to improved emotional intelligence in student nurses (Heffernan et al., 2010; Şenyuva et al., 2014) and to compassionate care (Gustin & Wagner, 2013). Neff (2003) suggested that the key to facilitating self-compassion is to nurture its constructs of self-kindness, common humanity and mindfulness. In their editorial, Mills et al. (2015) identified that there is an emerging body of evidence that relates nurses' self-compassion to compassionate patient care but also note that this is an under-researched focus.

The present study centres on health visiting, an emotionally-stressful profession with an emphasis on safeguarding and long-term work with vulnerable children and families (Cowley et al., 2012). Health visitors (i.e. Specialist Community Public Health Nurses; SPCHNs), are

trained to be leaders of the UK's Healthy Child Programme (Department of Health, 2009) of which compassion is a critical attribute and therefore it is important to integrate compassion into their training. That training is delivered post-registration and to our knowledge no previous research has examined fear of compassion in post-registration nursing students or if teaching self-compassion can alleviate that fear and so enhance compassionate care. In this respect, an innovative compassion curriculum to develop students' self-compassion based upon the principles of the Compassionate Mind Model (Gilbert, 2010) was introduced to the SCPHN course in a large regional university in England.

THE STUDY

This study aimed to explore the impact of an innovative, new course for Specialist Community Public Health Nurses (SCPHN) by exploring the question: *Does this innovative curriculum model facilitate the expression of compassion by post-registration health visiting students?*

The course and ethos

In seeking to ensure the delivery of compassionate care by SCPHNs, a new psychoeducational curriculum was introduced with the aim of enabling practitioners to understand and recognise their own facilitators and inhibitors of compassion. In order to help students understand that reducing fear and resistance is a normal part of the process of developing self-compassion the course leader, author AP, was trained in Gilbert's Compassionate Mind Model (CMM) and supported by Gilbert and others in developing the curriculum (see Acknowledgements) while members of the Compassionate Mind Foundation's online forum provided an invaluable source of support in its design and delivery. The CMM was embedded into the modules and shared with practice teachers and mentors in a workshop before the course started. The assessment framework was underpinned by the '6Cs' framework of the UK Compassion in Practice strategy (Department of Health, 2012; care, compassion, competence, communication, courage, commitment) and was developed in partnership with practice teachers who were updated regularly during practice link visits. In addition practice meetings were held three times a year and all had opportunity to contact course facilitators at any time for additional one to one support. Peer review and student evaluations of their practice placement were also part of this process.

The 52-week course leads to a qualification to become an SCPHN. It is delivered by a team of academic tutors, practice teachers and mentors each with a role in delivering classroom or practice elements of the curriculum and providing student observation and assessment. The student progresses from being an observer in the first trimester to managing a caseload in the third trimester (see Figure 1).

[Figure 1 near here]

Kitwood (1997) had previously noted the importance of recognising practitioners' resourcefulness and the richness of the ecology of care. In line with this strengths-based approach the curriculum was designed to facilitate a depth of compassion by building on resources that students already had from previous experiences in managing stress and responding compassionately. Students are encouraged to progress at a comfortable pace and are encouraged to explore if their feelings may be projections from clients or their own personal unresolved issues that required addressing.

The course adopted a compassionate learning environment in the university and practice placement through enabling a trusting and supportive relationship between students and members of the practice and academic teams. Interventions such as mindfulness are applied to reduce fear of compassion by facilitating an 'inside-out' approach intended to increase students' personal awareness of occasions when they had been emotionally distressed. The intention is to help balance their emotions and so promote 'flow' and emotional regulation in the students' work with clients. In this respect, one-to-one support by practice educators, using reflection, a restorative model of supervision (Pettit & Stephen, 2015) and role modelling of compassion were key facilitators.

Additionally a student pledge and the continuous assessment of students in relation to professional nursing values (Department of Health, 2012; 2015) ensured that compassionate values were continuously reviewed. Their pledge is based on their observation of exemplary practice linked to professional values, and set a personal intention at the start of the course to develop the capacity to emulate the good practice they had witnessed. The pledge was formally reviewed in partnership with the student's practice educator and the university lecturer. At the end of the course the students presented their journey in completing the pledge to their peers, practice and university educators.

Study design

The study was conducted in one area of England. Thirty-two students from a public-sector hospital (a National Health Service Trust) joined the course. Perhaps not surprisingly, in view of their caring background, some students considered that they were already compassionate and consequently there was some resistance to being taught compassion. Some also argued that compassion was an inherent characteristic which could not be taught, or that self-compassion was indulgent and if they opened up to the emotional influence of clinical practice then it would impact on their capacity to be professional. The transition from a qualified nurse to being a student of a profession that emphasises a facilitative approach can also leave participants feeling disempowered as 'hands-on' practitioners (Cowley & Frost, 2006; Shaw-Flach, 2014). Tutors therefore had to quickly establish a trusting and supportive relationship between students and tutors in the university and practice placement..

Enhancing a personal attribute requires a developmental process and so this evaluative study applied a prospective, longitudinal design by extending across the duration of the course. Focus group interviews were the predominant means of data collection to ascertain student perceptions of their progress through the course. These were held around the course mid-point (+6months of commencement) and at course end (+12months). In this way (see Figure 1) data were captured after classroom elements which explored theoretical components of compassion and health visiting practice and initial exposure to practice placements, and again after gaining the requisite practice experience to meet the professional outcomes of the course.

Participants

Using convenience sampling the entire course cohort were invited to join the research study. The purpose and process of the research was explained in an initial briefing session and students were then invited by email to take part. This included an information sheet and a consent form should they wish to do so. Recruitment to the focus groups was by confidential invitation included on a survey tool (n=28 participants) that had been administered during the first two weeks of the course to obtain additional context and insight. The survey is beyond the scope of this paper and will be reported separately. Thirteen students consented to join the groups.

Data collection

All participants were invited to attend the two group interviews, one conducted at the course mid-point and one at the end. The mid-point group comprised seven participants, the end-of course group six. The focus groups took place at a mutually-agreed location in a health centre away from practice. Consent was retaken and group 'rules of participation' were agreed prior to commencement to ensure that all could express opinion openly and without reprisal.

Participants were asked to give their views that explored if the publicised lack of compassion in health care meant that the 'system' was failing, if compassion can be learned, if the SCPHN programme facilitated development of compassionate care skills, their views on their course pledge, and how educators might further enhance and encourage compassionate practice. Notably, these were used as a guide and questions were adapted as necessary to expand on the discussion and ensure equitable contributions.

Interviews lasted 40-60 minutes and were audiotaped (with permission) for later transcription. Each group was attended by two facilitators, one of whom was independent from the course team and led on the group questioning and discussions. The other facilitator was the course leader (author AP) who sat out of immediate sight of the group and took field notes to supplement the audio recordings. On occasion she also clarified for the lead facilitator any queries from participants as to the curriculum and/or its delivery but otherwise played no part in the active proceedings.

Ethical considerations

The main ethical issues in the data collection were anonymity and confidentiality. The names of focus group attendees were not noted. Also, recruitment was confidential. At group meetings the participants were asked not to refer to any group member by name as the discussions would be audio-taped. Despite this there were some instances when names were mentioned and these were deleted from the transcriptions to ensure anonymity. Group rules were also established to emphasise equity and confidentiality of all discussions within it. In view of the discussion of thoughts and feelings, and perhaps experiences, participants were also encouraged to access student counselling services as needed. Consent obtained upon recruitment was confirmed on attending each meeting. The study received ethics approval from the appropriate Faculty Research Ethics Panel within the University.

Data analysis

Audio-recordings of focus group discussions were transcribed independently by authors PK-D and AS-F. Transcribing followed the approach of repeated listening and reading through the transcriptions alongside the audio recordings to ensure accuracy. Researcher insights were noted and updated in this process and informed later analysis (below). Notable statements were coded thematically by application of Colaizzi's (1978) descriptive phenomenological approach. All four authors subsequently convened in three discussion sessions, each session lasting approximately 3h, to discuss the context of the transcripts and to agree the initial and secondary coding, a process which led to identification of emergent sub-themes. These were then integrated into two agreed macro-themes (see Table 1).

Rigour

Trustworthiness of qualitative research (Shenton, 2004) relates to credibility, dependability, confirmability and transferability. Credibility was assured by application of an appropriate data collection method (group interviews) from an appropriately-constituted sample of individuals who had insight into the topic under question. Although the sample was relatively small, as is often the case with qualitative studies, it was a convenience sample drawn from the 28/31 cohort members (81%) who had expressed interest in the study; all had been employed in a UK National Health Service hospital prior to commencing the course and the only inclusion criterion was limited to having undertaken the course for at least 6 months (all of the cohort completed and qualified as SCPHNs). All participants gave informed consent on both occasions. Dependability was assured firstly by ensuring that the group meetings were held off-site and facilitated by an experienced researcher who was independent of the course team. Group rules were agreed to ensure that all could express opinion openly without reprisal. Secondly, all discussions were audiotaped and transcribed by individuals who were independent of the course team. Both transcribers were experienced at this process. The data analysis process followed the recognised framework of Colaizzi (1978).

For confirmability it was unfortunately not possible to return transcript analyses to participants for member checking, and hence confirmation. However, any potential for error was minimised by having the initial coding reviewed by all authors collectively in three x3h discussion sessions which established the secondary coding and agreed the overall sub-themes and themes. Finally, transferability of the research outcomes was addressed by the nature of the evaluation in that it was founded on the course in promoting a process of

change in the students' compassion attribute. This is discussed again in the Discussion in relation to study limitations and conclusions.

FINDINGS

The groups had an international profile. Non-UK countries were diverse with students from Africa, Europe and North America. All had been practicing in the UK prior to commencing the SCPHN course. Also, though not an inclusion criterion, it became evident that participants included at least some students who at course recruitment had expressed doubt about the compassion-focused curriculum, noted in the Methods.

Two macro-themes were identified in the analyses of focus group discussions: (1) a culture lacking in compassion, and (2) change: the realisation of compassion. Sub-themes are summarised in Table 1, and referred to in the following narrative.

Macro-theme 1. A culture lacking in compassion.

This was a prominent macro-theme. In the wider picture, students perceived that there has been a general loss of compassion in society. For example,

"*I just feel like everything should go back to basics…. life in general has become less compassionate ….*"

The groups agreed that a loss of compassion within the caring professions had occurred, identifying a culture shift in the NHS including a more threatening culture for staff that raised anxieties over litigation and potentially unemployment:

"…there is a lot of fear about jobs….and things like litigation, speaking out…if you've been in the service long enough you can see the changing culture of the NHS….somewhere along the lines [compassion has] *been lost in..translation."*.

A significant aspect of the cultural shift was the lack of time to spend with patients that has become a hindrance to being compassionate. For example,

"....*if you can't give patients time then they don't know that you're compassionate".*

and

"..sometimes it's hard to factor in time to actually give compassion to someone else…it's hard to stop and just remember that behind the patient is a person."

These observations are echoed by a participant who reminisced on her pre-registration training when she was able to spend time talking to patients:

"*I was sitting talking to a patient and my mentor said 'you're…not gonna be able to do that'… it's going".*

Analysis further indicated that one issue for time availability was that workload and meeting targets were limiters of compassionate care. Several students mentioned workload and targets as taking priority over, and therefore being barriers to, the delivery of compassionate care. The following comments succinctly sum up this issue:

"….you try and be compassionate but if you're working all day, by the end of the day it's kind of out of you. As much as …you try to be compassionate it can just like go out and people might look at you and think, you're not compassionate, but you might have been at the beginning".

"…..*when you look at the workload that nurses' have…sometimes it's hard to factor in the time to actually give compassion to someone else you're so busy ticking the boxes…".*

"I think pleasing the CQC [UK Care Quality Commission] *tends to go higher sometimes than pleasing the patients and showing compassion actually…….".*

Negative role modelling and leadership were also perceived to have a detrimental effect of as a further barrier to compassionate care:

"…*if you are put.. where you're not encouraged..to express yourself or to be part of the team or whatever challenges come up….then you end up feeling a bit stifled, unappreciated. You can see how people can lose the compassion".*

Relatedly, feeling undervalued by senior staff was also commented upon as being a barrier to the practice of compassion. For example,

"…If people are feeling undervalued then the culture within the NHS maybe has to change and staff have to start feeling more valued".

The importance of role modelling was further emphasised in perceptions that positive role modelling had been an important faciltitator of compassionate care for some participants in their previous practice. For example,

"*She* (mentor) *does it anyway….. I see it in her all the time. And …. some of the things I picked up for my pledge, I picked up from her…watched her and I think this is a good thing. I wanna be like that".*

Other students noted receiving of compassion from others as another means of becoming compassionate:

" *I think…compassion is coming from the top of the organisation….. . the ward I worked in .. was known for being one of the best wards because the team leader was compassionate to her staff.*

and

" ….*they* [managers] *were compassionate to me, like colleagues were compassionate to me. That has enabled me to be more compassionate to myself. Because, I've received it".*

Macro-theme 2. Change: the realisation of compassion.

Despite some expressions of anger at being treated as novices to caring (see Methods) students did acknowledge that the course had led them to gain a deeper understanding of self and others. Predominantly in the end-course focus group interview, they spoke in terms of going through a transition to higher self-awareness,

"…. *there has to be a break in the cycle and that can come in compassionate understanding of people…that has changed in me definitely…I'm pretty compassionate anyway. But I think it's really highlighted…if that was me. .how would I want to be treated? …. I'd want someone to have a compassionate look at me*".

and becoming less judgemental,

"But it's- it's changed me.. 'don't be so judgemental'. How can ..people be empowered? How can they get a better quality of life? 'cause there has to be a break in the cycle and that can come in compassionate understanding of people…that has changed in me definitely.."

They described how these qualities have been utilised with others and described situations in which compassion is 'triggered' such as overcoming a difficult personal experience. These expressions support an actualisation of latent or dormant compassion within the students which was triggered and realised through education/practice experience from the course:

" *I've come from a hospital background so with my new life [*in health visiting*] since I've done the course I feel the compassion's come back into me"*.

Further comments identified that students not only actualised latent compassion but the process had instigated transformational personal change and growth during the course, illustrated in the following extracts:

"…*when I started this course I felt I was very compassionate and it felt strange that we were going to be looking at it again. And I think it's the depth isn't it? ….But there is that sort of a deeper understanding and I suppose it's about being self-aware it's about awareness of others"*.

"I think you can't help but be changed..the subject matter and the fact that we're working with families and mothers and children and that whole life experience it makes you reflect on yourself as a person, yourself as a parent. You reflect on your own parents and how they did things and I think ..it's being more compassionate to other people around you…stepping back and listening rather than making pre-judgement."

"I think compassionate care …. shouldn't be part of our practice only. [It] should be part of our individual life anyway. Because to build a community, it's not just an easy thing..So if we take up compassionate care not only at work, but even in your home..then we can take it to know your neighbours, to know your community, to be (kind) to the people that come your way.

The student's pledge had a significant role to promote transition. The pledge was revisited at points throughout the course when students were asked to comment on achieving what they had put forward and its impact on them personally. For example:

.."*my pledge.. was to be non-judgemental and just to be open-minded. I found there's loads of shades of black and grey and white so it's just coming up to that point where you step back…And it's also so funny because I realise that I was so judgemental..about other people but more so about myself*"..

DISCUSSION

Compassionate care is considered an essential skill of health professionals in providing person-centred care. This study evaluated the perceptions and experiences of students attending an innovative 12-month post-registration course designed around the Compassionate Mind philosophy that flow of compassion from self to others commences, and is influenced by, compassion for self (Gilbert, 2013). Self-compassion therefore is suggested to be a precursor in fostering compassionate care (Neff,2009; Gustin & Wagner, 2013; Beaumont et al 2015).

The group interviews during and at the end of the course evidenced a developmental process through which participants perceived themselves becoming more compassionate

over the course duration. Participants especially reflected on what they had observed in their previous roles and identified a lack of compassion operating within the culture between nurses, managers and in society generally. A concern is that a 'culture lacking in compassion' (macro-theme 1) is likely to prevent person-centred care. This was noted over 20 years ago (Kitwood, 1997) in relation to the culture of organisations and our findings confirm this view. One barrier put forward by students was an impact of increasing workload on the time available. Newton & McVicar (2014) also identified work and time pressures as barriers for palliative care nurses to enable their 'connection' with patients which, together with current findings, suggests that attributes at the core of nursing care are increasingly at risk in todays pressured environments in health care. Negative role modelling by senior colleagues was also a perceived barrier. Mills and colleagues (2015) reinforce the need to provide a compassionate environment and the importance of positive role modelling and leadership by nurse leaders in order to inspire others to demonstrate compassion was a strong sub-theme from this study.

The significance of these observations is firstly that participants acknowledged that they appreciated just how much more compassionate they had now become. Secondly, and relatedly, whilst students were indeed fully capable of being compassionate the ward culture and work environment in their previous roles had acted against any natural inclinations they had towards demonstrating it to a high degree or on a consistent basis, either with colleagues or patients. There have been calls for education to '*reawaken empathy*' (Dean & McAllister, 2018) and for nurses *'to recover elements of self-care and self-compassion'* (Mills et al., 2015). Our respondents' comments are enlightening in this respect as they strongly support a release of latent attributes within a process of self-actualisation during the SCHPN course. Actualisation was further evident in their application of a pledge made at the onset of the course and its influence on their approaches to care. Further, it is also striking that some participants identified a 'realisation of compassion' (macro-theme 2) with transference of compassion into their lives outside of work. This suggests a genuine transformation to a compassionate personal attribute of individuals expressed in both their professional and personal lives.

Limitations and Relevance to Practice

This research evaluation has a number of potential limitations. Firstly, findings might be open to constraints of a single-site context. Nevertheless the curriculum was designed with the intention to enable a process of development of a compassionate attribute. The implication of the findings from this study that nurse education can release suppressed or blocked

expression of compassion suggests that the developmental process should be transferable to other healthcare settings. Secondly, the focus group participants from a single cohort may have introduced positive selection bias. However, the interviews identified at least some participants who at recruitment had been negative as to any suggestion that they were not compassionate even after lengthy prior employment in secondary care. Thirdly, although the focus groups were facilitated by someone independent of the course team, it was considered important that a member of the course team should also attend in case of ambiguities or misinterpretations about the course and this potentially might have impacted on the facilitation process. To reduce any bias from social desirability that individual sat away from the group out of eye-line and only commented when asked directly by the facilitator. Fourthly, a risk of interpretation bias by course team members in the study was minimised by ensuring that authors who were independent of the team also took part in the transcription and analysis of audio-recordings.

CONCLUSIONS

This innovative curriculum based on the Compassionate Mind Model offers a process for guided discovery, personal experimentation and practice in cultivating a compassionate orientation. Participants perceived their capacity to express compassion to others had increased and they indicated that this attribute was realised as a consequence of undertaking the course. Role modelling and reflection reinforced by the introduction of a personal pledge by participants appeared key to that realisation. The students' courage in being honest about their initial concerns and doubts and how the curriculum supported transformational change in itself was inspirational and confirmatory of the safe learning environment provided by the course.

In keeping with Kitwood (1997) our approach recommends respecting the uniqueness of every person and enabling them to flourish in their own particular practice. This model therefore could be integrated more widely into both pre- and post-registration nurse training. This is particularly pertinent in the light of the publication of the new educational standards recently released by the UKs Nursing and Midwifery Council (2018) which require Higher Educational institutions to work in partnership with practice organisations to consider the development of new nursing curricula that reflect the new standards including promoting compassion.

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Table 1 Summary of sub-themes and macro-themes

Macro-theme	Sub-themes
Culture lacking in compassion.	**Loss of compassion in society** **Culture shift in the NHS** **Lack of time to be compassionate** **Workload and meeting targets** **Role modelling**
Change: Realisation of compassion	**Actualisation of compassion** **Transformation**

Figure 1. The new SCPHN curriculum