Supporting Health Visitors and Fostering Resilience

Literature Review

Authors: Ann Pettit and Rachel Stephen
March 2015

Developed by the Institute of Health Visiting on behalf of Health Education England and the Department of Health
## Reader information box

### Audience
Health visitors  
Health visitor service providers  
Strategic leads health visiting practice  
Local authority commissioners  
Local authority councillors  
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 provides health visitors and organisations with evidence-based information about supporting the health visiting workforce and building resilience.

### Title

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March 2015

### Cross reference documents

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March 2016
Supporting Health Visitors and Fostering Resilience Literature Review

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 and inspired this literature review.

Thanks to all the health visitors who have shared their views and personal stories. We are creating knowledge together about how to build resilience with compassion in health visitors. Through engaging in this narrative we hope to transform culture and facilitate the development of compassionate relationships where health visitors can express their vulnerability and be responded to compassionately.

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Task and Finish Group

Martin Munro (HR Director, NELFT/iHV), Caroline Ward (Assistant 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 (Health Visitor (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 (HV, Royal Marsden), Karen Whittaker (Senior Lecturer, University of Central Lancashire), Sue Mills (Health Visiting Locality Lead, Bedfordshire and Hertfordshire).

Expert Advisors

Professor Paul Gilbert (Derby University; Director of Compassionate Mind Foundation), Professor Aidan Halligan (Director of Education UCL, 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 (University of Westminster; Centre of Resilience), Dr. Stephen Pettit (Reader, Cardiff University), Ruth Rothman (Education Manager, Family Nurse Partnership), 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 compassionate and resilient.

Ann and Rachel

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Executive Summary

Background
To support the Health Visitor Implementation Plan, the Department of Health has funded a number of interventions aimed at realising the benefits of the expanded health visitor workforce.

The work is commissioned via Health Education England (HEE), and one of the interventions is the development of a support framework for health visitors. A number of key publications provide the contextual background in exploring how to effectively support health visitors to foster their resilience. Bryar et al (2012) describe a range of components of a positive practice environment, and the factors to consider in the recruitment and retention of health visitors have been outlined by Whittaker et al (2013). The importance of organisational culture is also emphasised by the Francis Report (2010) in order for the NHS to deliver services and professional practice in line with the core value of compassionate care. Hence, resilience is not a value in its own right, but a key requisite for practitioners and organisations to deliver compassionate and effective care. The working assumptions of this review are that this places demands on the resilience of the NHS and its workforce. In order to retain an expanded and renewed health visiting workforce, this review highlights some key questions about approaches to the support of health visitors that will foster their resilience and help retain them within the workforce to deliver compassionate care in health visiting practice.

The questions considered as part of the review were:
- What models of support or mechanisms are available to, and used by, health visitors?
- What support do health visitors consider helpful?
- What types of support would health visitors like to have more of?
- What support do health visitors value from training, and what would they value in any future training?

Methodology

A systematic consultative review process was utilised (Hart and Heaver, 2013). The review includes a variety of sources which are not exhaustive due to the short research time factored into the project delivery. A broad general search using academic databases was undertaken initially using a range of terms. From this and the initial consultation process, six key themes were identified including professional identity, leadership and organisational culture, recruitment and retention, models of support, and resilience education and training. The literature review concludes with discussion of a support framework drawn from the literature, a survey of health visitors and discussions with the task and finish group and other advisors.

Key Findings

A range of models of support and concepts have been identified that could support compassionate behaviour in the workplace and enable health visitors to be more resilient when faced with challenges. These include: supervision, mentoring, coaching, courageous conversations, relationship-based models, action learning, performance feedback, interagency/disciplinary groups, peer support and compassionate resilience.
Supporting Health Visitors and Fostering Resilience Literature Review

**Supervision:** Currently within health visiting in England the picture is varied and supervision is carried out at various levels and in several different guises. If the emotional consequences of this work are not mitigated they will affect a professional’s wellbeing as well as their ability to work effectively. Professionals receiving supervision with a restorative function report an improvement in both professional and personal outcomes, including their resilience to stress whilst maintaining compassion, improved working relationships and team dynamics, managing a work/life balance more effectively and an increase in enjoyment and satisfaction related to their work. Safeguarding supervision is an important element in helping to mitigate the effects of vicarious trauma and compassion fatigue. It is recommended that organisations provide an externally run, structured and intensive debriefing session for staff following serious incidents.

**Mentoring:** The impact of high workload, staff shortages and time conflict presents mentors with consistent dilemmas in relation to managing commitments. Competing demands can lead to exhaustion and feeling of being overwhelmed. Mentoring ‘fosters talent’ in the organisation, increases productivity, improves communication, and mentoring improves retention. When managers fail to recognise the increased workload associated with the mentor role, it can result in increased mentor anxiety. It is important to distinguish between the widespread use of mentorship as part of the delivery of pre-registration nursing education, and mentoring in support of the development of practitioners in their established professional role. The latter is more relevant to the retention of the health visiting workforce.

**Coaching:** Coaching focuses on improving performance and the development of skill. It is an integral part of the NHS frameworks for leadership and professional development. Benefits to coachees include an increased sense of motivation and enthusiasm, and also an ability to deal with frustrations encountered. There is an opportunity to improve the deployment of coaching, particularly through the development of internal coaches, so that even greater benefits can be achieved.

**Courageous conversations:** Developing skills in managing ‘courageous’ conversations is one of the components of the NHS Leadership Academy training programme. Part of any professional relationship for the health visitor, be it with clients, colleagues, other professionals or managers, will involve having challenging conversations that need to occur whilst maintaining the relationship. These are a key factor in developing ‘conflict-resilient workplaces’.

**Relationship models of intervention:** “Making a difference” has been identified as a key motivating factor for health visitors. The development of the relationship with the client is held to be what makes the ‘real difference’ in improving outcomes for service users. However, there is evidence to suggest that it is increasingly difficult for health visitors to build relationships with their client. This may affect morale, job satisfaction and professional self-esteem and there is a risk of losing people from the profession if they feel unable to “make the difference”. In addition to improved outcomes for children and families, training in relationship-based models of intervention improves health visitor job satisfaction, competence, consistency, self-awareness, and relationships with clients and colleagues. This reflects the practice orientation of health visiting that needs to be aligned with service organisation (Cowley et al, 2013).

**Action learning:** Facilitation skills are crucial to ensuring that individuals feel safe to engage with the action learning process, and there are organisational challenges in supporting people to develop these skills quickly. To work well, action learning requires mutual commitment to participate.

**Performance feedback:** Feedback is important to improve understanding and review progress. *Multisource (360-degree)* feedback is a tool to help employees improve and focus on their development. It can identify a starting point for the development of new skills, measure progress as skills are worked on over time, and identify blind spots in behaviour. *After Action Review (AAR)* is a process which can provide insight into performance, team work, leadership and culture. In the AAR process staff take responsibility and this facilitates self-efficacy which is important for job satisfaction, engagement and retention of staff.
Interagency/disciplinary groups: Interagency/disciplinary groups can support the development of meaning, clarify roles and responsibilities, and contain the emotional impact of the work. Models such as work discussion groups and Compassion Circles™ are designed to offer a safe place for facilitated reflective dialogue for interagency groups. Their effectiveness has not yet been researched. Schwartz Centre Rounds® are multidisciplinary forums where health professionals meet monthly to reflect and acknowledge work-related psychological, emotional and social challenges. The evidence base for these is developing and a 2-year research study commenced in May 2014.

Peer support: Peer support relies on a trusting relationship with another individual, allows for the setting of performance goals, and involves observation and reflection. It is often seen as a key element in the delivery of quality patient care but its application is complex and variable, although highly beneficial. There can be negative results including conflict, criticism, failed social attempts, emotional over-involvement, and reinforcement of poor behaviour and diminished feelings of self-efficacy.

Potential outcomes of implementing the support models

Resilience: Resilience is not just about survival it is about learning, finding healthy ways to cope and even thriving in the face of adversity. The government strategy for mental health highlights the importance of individuals and employers recognising and building resilience. Adopting an ecological preventative approach in developing resilience-promoting environments is recommended.

Compassion and self-compassion: Compassion enhances staff satisfaction and engagement, and contributes to the performance of organisations. It can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity. The creation of resilient cultures starts with leaders who foster compassion at the individual and organisational level. Enhancing self-compassion develops our ability to be compassionate.

Development of a new concept

Synthesising the literature on support, resilience and compassion led to the development of the compassionate resilience concept.

Compassionate resilience: The concept of compassionate resilience has been progressed to incorporate three components and the skills to develop it. The components are: self-compassion, learning how to maintain resilience in order to sustain compassion, and compassionate cultures including compassionate leaders. Six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances have been identified: enhancing self-awareness, being in the now, developing acceptance, expressing vulnerability, building supportive relationships, and fostering hope.
Conclusion

There are a wide range of models or mechanisms available to provide health visitors with support. Each approach is evaluated and their key aspects outlined. Overall the following are issues for development:

1. **Professional identity**

   With the transfer of commissioning of health visiting services to local authorities this year, there needs to be clarification of roles and responsibilities, particularly in relation to inter-professional working. Values-based recruitment and taking into account the psychological contract between employers and practitioners are important considerations. There is a need to share stories of good practice in health visiting and the use of narrative to change culture and promote the complexity of work with vulnerable families and communities. Overall, it is clear that health visitors need to feel valued and feel that they have made a difference. There needs to be a clear career progression path (Whittaker et al, 2013) which has also been identified as a key motivator for staff, reducing stress and promoting wellbeing (NHS Employers 2014; POSHH, 2012).

2. **Providing access to supportive relationships**

   There is a need to provide access to supportive relationships, a key component of positive practice environments (Bryar et al, 2012). Health visitors value the support of their peers, which is an important consideration as mobile working is leading to reductions in access to informal support. Models such as the Samaritans peer support model could be considered. Sawbridge and Hewison (2011) are exploring this in nursing. Preceptorship programmes are needed. However, preceptors also need support and education for this role (Hudson et al, 2014). There is the need for a range of support mechanisms such as mentors, coaches and restorative models of support.

   Compassionate relationships are a key factor. Being open to suffering and motivated to take action to relieve this is important. Developing health visitors’ courage to acknowledge and communicate vulnerabilities is necessary. There are links with the 6Cs (DH 2012) and the four principles of health visiting i.e. search for health needs, stimulation of awareness of health needs, facilitating health and enhancing activities, and influencing policy.

3. **Emotional aspects**

   The emotional aspects of health visiting have not been well documented. Lindley (2013) highlighted how student health visitors found it difficult to cope with what they saw in practice, but this also acted as an incentive to do something about it. Openness to participate in reflective practice is a key aspect, and openness of leaders to hear and respond builds a safe place where trust can develop. Some literature exists in the nursing field e.g. Menzies Lyth (1960) who highlighted the risk of defensive behaviour if anxieties are not contained, and Sawbridge and Hewison (2011) who have highlighted the emotional labour of nursing. The limitations of comparing findings from nursing studies to health visiting are recognised. Having a safe place where people can express vulnerability and acknowledge the emotional impact of their work can prevent burnout and enhance patient care e.g. through restorative models of support on a one-to-one basis or in supervision groups, or through multidisciplinary groups such as Schwartz Centre Rounds® (The Point of Care Foundation, 2014). Further research is needed to explore the emotional labour of health visiting.
4. Organisational culture and resilience
Resilience is a complex and evolving concept. Varied definitions exist but all include the concept of adversity. Cultural considerations are important (Ungar, 2008). An ecological definition is recommended placing the health visitor in the context of the system where everyone has a responsibility. Compassionate business models need to be developed (Karnally, 2013) where the organisation’s culture and leadership, and individual’s needs are all considered. A position needs to be reached whereby individuals are not just positively coping with adversity, but transforming adversity (Hart and Gagnon, 2015) and not just surviving, but thriving (Wendt et al, 2011).

Key factors in professional resilience are professional identity and professional competence, values, support, reflection, positivity, emotional insight, work/life balance, spirituality, humour and a healthy work environment (McCann et al 2013, McAllister& McKinnon 2009; Jackson et al, 2007; Hunter and Warren, 2014). These can be planned for and developed with experience and education and training. Resilience builds over time and with experience. The feeling that someone has made a difference is important in developing resilience.

5. Education and learning
Education and learning to be resilient is not a linear process. Exposure to brief stressful experiences, which are managed effectively, leads to self-efficacy and builds resilience (Rutter, 2012). It is important therefore that health visitors face the adversity with support and do not adopt defensive behaviours such as avoidance or detachment. Continuous professional development is important; communities of practice are a good way to share knowledge and experiences, using narrative and the sharing of good practice.

Education is important. This includes education and support for influencing policies that perpetuate inequalities and promoting policies to enhance resilience, including those that address staff wellbeing (POSHH, 2012), reduce stress (NHS employers, 2014a) and build resilience (DH, 2009).

6. The Framework for Resilience
A resilience framework has been developed which provides a menu of support where there are ten models/concepts to choose from. Compassion is a key consideration. Compassionate resilience has three components: 1. self-compassion, 2. learning how to remain compassionate and resilient, and 3. compassionate cultures including compassionate leaders. The concept includes self-compassion and six resilience skills which can be learned to build resilience and compassion.
Recommendations

All staff, including senior managers, need access to supportive relationships and training in resilience skills including self-compassion.

- Further research needs to explore the emotional labour of health visiting.
- It is clear that peer support models need to be developed, especially in the light of an increasingly mobile working nature of health visiting.
- A range of support mechanisms need to be provided to health visitors:
  - Every health visitor should be encouraged to access a form of supervision that includes the restorative function.
  - As a way to developing ‘conflict resilient workplaces’, health visitors should be encouraged to undertake training in ‘courageous conversations’.
  - Health visitors should have access to relationship-based training programmes which develop strengths-based approaches and should be trained in the skills necessary to facilitate self-compassion.

Health visiting leaders and employers need to ensure health visitors are provided with resources to experience, make sense of, and respond to suffering.

- They should promote workplace compassion through role modelling and encouraging work-life balance, facilitating the nurturing of supportive relationships.
- The development of compassionate business models in health visiting warrants consideration and research.
- Practices to support compassion such as selection and socialisation processes, which facilitate noticing, feeling, sense-making and acting in a compassionate way should be implemented.
- Overall, managers need to provide support, enabling and encouragement for practitioners to develop relationships with their clients.
- There is a need to create narrative centres through the communities of practice and the Institute of Health Visiting, and for further research to enhance understanding about what contributes to health visitors’ compassionate resilience.
- There is a need for national benchmarks or a quality standard to support the implementation of these recommendations.
Introduction

The Department of Health has funded a number of interventions aimed at realising the benefits of the expanded health visitor workforce.

The work is commissioned via Health Education England (HEE) and the development of a support framework for health visitors forms one of those interventions.

The overall objectives of the project are to:

- Undertake a literature review and to scope effective models of support currently available in practice settings.
- Develop a support framework, which may make use of action learning sets, led regionally and supported by an iHV lead at regional level. To identify individual development needs locally, co-ordinate coaching and mentoring support and ensure that restorative support is made available more widely through the iHV and other channels.
- Ensure that appropriate support is in place for newly-qualified health visitors providing advice, peer-to-peer support, shadowing, mentoring and coaching in the first year of practice.
- Support cross-fertilisation between proficient and expert professionals, including practice teachers and newly-qualified health visitors.

The key deliverables of the project are:

- Provision of evaluated, effective models of support in a national support framework, with the delivery supported by iHV leads and a team of stakeholders at a regional level.
- To work with regions to identify individual development needs locally and co-ordinated coaching and mentoring support and where necessary for restorative support to made more widely available.
- To ensure appropriate support is in place across the country for newly-qualified health visitors to access advice, peer-to-peer support, shadowing, mentoring and coaching in the first year of practice (aligned with induction and preceptorship frameworks – project 2)
- Identification and development of cross-fertilisation mechanisms between proficient and expert professionals, including practice teachers and newly-qualified health visitors, including through the e-Community of Practice.
A key deliverable of the project is to undertake a literature review and to scope effective models of support currently available in practice settings.

This report assesses the literature underpinning the development of a framework to provide support and build resilience in health visitors.

This will underpin the other deliverables within the project and contribute to ensuring that a framework of appropriate support is in place for newly-qualified, as well as already qualified, health visitors including, for example, advice, peer-to-peer support, mentoring and coaching to build and support resilience.

The Department of Health (2013) has acknowledged the stress of health visiting practice. The 2013 NHS staff survey found that 41% of health visitors had felt unwell in the last 12 months as a result of work-related stress. Research has shown that there is a link between staff wellbeing and patient quality of care (The National Nursing Research Unit, 2013) indicating the importance of addressing the structural and contextual sources of stress as well as the methods that organisations and individuals may use to ameliorate or eliminate stressors.

A literature review was undertaken to identify literature concerning support available and used by health visitors as well as mechanisms used to develop resilience. The methods used to undertake the literature review are outlined below followed by discussion of the findings. The literature review concludes with discussion of a support framework drawn from the literature, a survey of health visitors, and discussions with the task and finish group and other advisors.

**Literature search strategy**

The search process aimed to identify pertinent literature to answer the questions:

- What models or mechanisms of support are available to and used by health visitors (HVs)?
- What support did health visitors consider helpful?
- What types of support would they like to have more of?
- What support did they value from training and would value in any future training?

A systematic consultative review process was utilised (Hart and Heaver, 2013). This is an iterative process in which discussions with a range of professionals in practice and educational settings established areas of interest before the literature search, with findings fed back to them following the search. The review includes a variety of sources that are not exhaustive to the short time available for the research, which was factored into the project delivery.

A broad general search was undertaken, initially using terms such as resilience, support, coping, hardiness (USA), compassion and health visitor, health visit*, nurs*, health profession* public health nurs*. From this and the initial consultation process, six key themes were identified including professional identity, leadership and organisation culture, recruitment and retention, models of support, and resilience education and training. The searches then focused on these key areas, and the three members of the literature review team each looked at separate themes. Pertinent literature was identified through searching databases including Cumulative Index to Nursing & Allied Health Literature (CINAHL), British Nursing, Medline, Google Scholar, Google and Applied Social Sciences Index and Abstracts (ASSIA). The literature included articles, research studies, books, and policy guidelines.
Positive Practice Environments

The impact of the context of practice, the organisations and environments within which health practitioners work has been acknowledged in the Positive Practice Environments (PPE) initiative supported by the International Council of Nurses and other international health bodies (WHPA, 2008). Positive Practice Environments are defined as: ‘...settings that support excellence and decent work. In particular, they strive to ensure the health, safety and personal wellbeing of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations’ (WHPA, 2008, p.1). Elements of PPE which are particularly relevant to the provision of support and development of resilience include (ICN, 2007 cited in WHPA, 2008p.2):

- Fair and manageable workloads and job demands/stress;
- An organisational climate reflective of effective management and leadership practices, good peer support, worker participation in decision-making, shared values;
- Work schedules and workloads that permit healthy work/life balance;
- Opportunities for professional development and career advancement;
- Professional identity, autonomy and control over practice;
- Support, supervision and mentorship;
- Open communication and transparency.

The PPE initiative recognises the importance of the context of practice and the multiple factors that impact on the delivery of care by health practitioners. In work aimed at supporting the delivery of the most effective primary health care nursing, Bryar et al. (2012) developed a model of the components needed based within the PPE requirements, illustrated in Figure 1.
As illustrated in this model, if health visitors are to provide the most effective care, which is people-centred, they need to take a public health perspective and make use of partnership and inter-professional working. Organisations need to support this through, amongst other things, the provision of appropriate leadership and managerial support that enables health visitors to work in an environment which contains the above features of PPE providing support and helping develop resilience. In the UK the Family Nurse Partnership model, discussed under ‘Relationship-based Intervention’, possesses the components of a PPE and could be considered as a working example.
Models of support

The following sections provide an overview of existing models of support that have been found to be helpful by health visitors and also models that have potential application to the profession.

Supervision

A number of stressors are associated with the health and helping professions, including time pressures, workload, having multiple roles, and emotional issues (Lambert et al 2004, Lim et al, 2011). Frequent environmental stress associated with human pain and distress in the workplace can impact on the physical and mental wellbeing of health professionals and result in burnout and, in some cases, traumatic stress-like symptoms (Stamm, 2010). These negative stress outcomes can impact not only on the wellbeing of health professionals, but also on their ability to care effectively for others (Barnett et al, 2007).

This section looks at the various types of supervision and the evidence for their effectiveness in promoting resilience and mitigating environmental stress. Supervision is considered good practice now across a range of professional disciplines and has a number of forms. In general it consists of practitioners meeting regularly with another professional, not necessarily more senior, but normally with training in the skills of supervision, to discuss casework and other professional issues in a structured way. This is often known as clinical or restorative supervision or consultation. The purpose is to assist the practitioner to learn from his or her experience and progress in expertise, to provide emotional containment to the practitioner, as well as to ensure good service to the client or patient.

The concept of managing one’s own responses to client’s emotions had its origins in the psychotherapies. Indeed supervision has been found to have benefits in psychotherapy research, improving the working alliance, symptom reduction and treatment retention (Bambling et al, 2006). Recognition and personal understanding of the practitioner’s feelings and thoughts regarding his/her client behaviours or verbalisations is seen to be central to the therapeutic relationship. Supervision provoked self-awareness, thoughtfulness, curiosity, and within that, an opportunity to think about what was being transferred to the practitioner from the client as a way of better understanding and therefore working with the client to bring about positive change and self-awareness. The idea of emotional toil or labour was also recognised: “The concept of emotion work involves the management of emotions by an individual in order to conform to the demands of the particular social situation” (Bendelow, 2009 p.156). Emotional labour is central to health visiting. Donetto et al (2013, p37) explored the views of health visiting service users. Their study highlighted the difficulty for some clients when they felt judged by health visitors or where there was no opportunity for them to explore their feelings and emotions in a way that they felt comfortable with. This demonstrates the importance of the health visitors’ ability to show empathy with the client but also the importance of them being able to mask disapproval or negative feelings even if that is what they are experiencing.

Wilfred Bion’s (1962) insights into the analytic process have had a profound influence on how psychoanalysts and psychotherapists understand emotional change and pathological mental states. This is reflected in the Solihull Approach to working with children and families (Douglas, 2010) and has been incorporated into what the Wave Trust (2013: Appendix 3) recommends as ‘Professional Reflective Supervision’ amongst the ‘core knowledge and skills’ necessary for the early years workforce to improve outcomes for young children through their work with families. One of Bion’s most influential ideas concerns the notion that we need the minds of others to develop our own emotional and cognitive capacities.
Bion used the metaphorical concept of the container and the contained – his reasoning being that the baby fills the mother (the container) with its anxiety and emotion and the mother is in turn contained by another such as the father. The question arises: what happens when there is no container for the mother? Bion suggests that the mother becomes full, saturated or overwhelmed and is no longer able to provide adequate containment for her baby. We know that a parent who can help their child manage and process their emotions contributes to the architecture of their child’s brain (Schore, 2001).

Using Bion’s model, if the health visitor is in the role of container for multiple mothers what happens if she/he is uncontained? A recent research briefing paper by the NSPCC (2013) stated that there is a personal cost to working with traumatised children and families. There are several different terms that describe the damage that can be done by being a helping professional, these include: vicarious trauma, secondary trauma, compassion fatigue and burnout. If the emotional consequences of this work are not mitigated they will affect a professional’s wellbeing as well as their ability to work effectively. Vicarious trauma can accumulate over a long period of time or it can be brought about by one-off traumatic events. The NSPCC research has found that one way to manage levels of vicarious trauma among professionals is with rigorous supervision and peer support. When particularly serious cases occur, it can be helpful to have an externally-run, structured and intensive debriefing process to ensure that the team can move on and continue to work effectively.

In the course of their literature review, McCann et al (2013) found that nurses use a number of positive coping strategies including problem-focused coping, taking time out, and giving and receiving support from co-workers. Their results suggest that positive coping might not be enough to reduce the negative effects of stress, whereas maladaptive coping (suppression and denial) might significantly increase the negative effects of stress. McCann et al (2013) suggest that in terms of resilience, there are a number of individual and contextual factors that contribute to levels of resilience in nurses, work that appears relevant to health visitors as well. These include work/life balance, hope, control, support, professional identity and clinical supervision. However, they concluded that what remains unknown is whether resilience can be strengthened in nurses. There are various types of supervision that health visitors are currently receiving and these are discussed below.

**Safeguarding supervision**

All health visitors will receive some form of safeguarding supervision, ensuring that health visitors of families where existing risks and vulnerabilities have been identified are given guidance and a forum to think about 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.
Supporting Health Visitors and Fostering Resilience Literature Review

The possibility of significant harm coming to a baby or a child within their caseload as a result of child abuse is an ever-present fear for health visitors. Health visitors will experience, witness or read in the media about incidents that have happened which heightens their awareness. While for some this responsibility acts to motivate and drive them to excellence in practice, for others it may become paralysing, or impact negatively on their emotional health. Turbitt (2012) suggests that scrutiny rather than support, and stressful working environments being accepted as normal, can impact negatively on the quality of supervision offered. From the existing literature it is difficult to assess the quality and frequency of safeguarding supervision for health visitors, or to consider whether it develops the resilience of health visitors. In her review of the literature regarding safeguarding supervision in health visiting, Botham (2013) found that there is little or no standardised guidance provided to undertake safeguarding supervision and, as a result, the content and process is open to individual and organisational interpretation.

Botham found evidence of efficacy, quality and value for health visitors and school nurses, and cites two reports (Hall, 2007; White, 2008- cited in Botham 2013) and other recent authorities in support of its benefits including Laming (2003; 2009); DCSF (2009); Ofsted (2010) and Munro (2010).

Key points: safeguarding supervision:

- Organisations should provide an externally run, structured and intensive debriefing session for staff following serious incidents.
- Use of a model and framework for safeguarding supervision would improve quality and provide effective evaluation of the supervision process.
- Safeguarding supervision is an important element in helping to mitigate the effects of vicarious trauma and compassion fatigue.
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 part of 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.

Brunero and Stein-Parbury (2008) carried out a literature review to look at evidence of effectiveness of clinical supervision. They concluded that clinical supervision provides peer support and stress relief for nurses (restorative function) as well a means of promoting professional accountability (normative function) and skill and knowledge development (formative function). This is essentially the model that was first developed by Proctor (1986) and that has been adopted widely in the UK and abroad.

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 for all’ philosophy should not be sought; individual organisations and supervisors should choose a model that suits them and their service. They state that there is an absence of supporting evidence to suggest that any model is wholly suitable, choice within service areas should be considered. Bidmead (2013) identified that the health visitors in the inner city area that she studied were not receiving supervision other than safeguarding supervision. On the other hand, 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). When asked to describe models of support that foster health visiting resilience, restorative supervision was frequently mentioned as being helpful (Institute of Health Visiting ‘Health Visiting Survey’ 2014).

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).

Table 1 sets out a list of reported outcomes of restorative supervision from Australian research (Brunero and Stein-Parbury, 2008). Many of these reported outcomes are related to resilience, and factors commonly associated with the measurement of employee resilience.
Hunter and Warren (2013) suggest that, to date, there has been limited research that has tested the hypothesis that interventions such as restorative supervision enhanced resiliency in midwives or nurses, and no report of the use of resilience theory in midwifery or nursing education. They suggest that there is thus ample scope for developing a research programme in this area.

Within the UK, South Warwickshire Foundation Trust (SWFT) has developed a programme of restorative supervision, which they state is ideal for professionals working within complex and challenging professions. Their literature emphasises that this model of restorative supervision differs from other models of supervision often used within services, as the focus of the supervision session is the supervisee as opposed to their work. The model therefore underpins managerial and safeguarding supervision by focusing on the capacity of the professional to engage in their work rather than on the work itself.

The University of Warwick is currently carrying out an independent evaluation of the SWFT model, and, although this has yet to be published, the team’s literature states that there have been numerous positive qualitative outcomes from the programme to date. Professionals report an improvement in their resilience to stress whilst maintaining compassion, improved working relationships and team dynamics, managing a work/life balance more effectively and an increase in enjoyment and satisfaction related to their work alongside many more beneficial outcomes both professional and personal.

Quantitative findings recorded as pre and post-supervision measures have shown a positive trend in the reduction of symptoms of burnout and secondary traumatic stress whilst improving the individual’s sense of compassion satisfaction, the pleasure they derive from doing their job.

### Table 1: Restorative supervision (reported outcomes of restorative supervision categorised by Brunero and Stein-Parbury 2008 based on Proctor’s model)

<table>
<thead>
<tr>
<th>Listening and being supportive</th>
<th>Empathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved coping at work</td>
<td>Sense of community</td>
</tr>
<tr>
<td>Accessing support</td>
<td>Catharsis</td>
</tr>
<tr>
<td>Better relationships amongst staff</td>
<td>Self-understanding</td>
</tr>
<tr>
<td>Engagement in the workplace</td>
<td>Improved relationships with colleagues</td>
</tr>
<tr>
<td>Safe group environment</td>
<td>Trust</td>
</tr>
<tr>
<td>Sense of security</td>
<td>Reduced conflict</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>Reduced tedium</td>
</tr>
<tr>
<td>Lower received anxiety</td>
<td>Reduced burnout</td>
</tr>
<tr>
<td>Understanding colleagues</td>
<td>Personal accomplishment</td>
</tr>
<tr>
<td>Increased interest relief</td>
<td>Personal development</td>
</tr>
<tr>
<td>Relief of thoughts and feelings</td>
<td>Coping</td>
</tr>
</tbody>
</table>
Key points: supervision

- If the emotional consequences of this work are not mitigated, they will affect a professional’s wellbeing as well as their ability to work effectively.

- “Stressful working environments being accepted as normal” can impact negatively on the quality of supervision offered.

- Currently within health visiting in England the picture is varied and supervision is carried out at various levels and in several different guises.

- Restorative supervision underpins managerial and safeguarding supervision by focusing on the capacity of the professional to engage in their work rather than on the work itself.

- Professionals receiving restorative supervision report an improvement in their resilience to stress whilst maintaining compassion, improved working relationships and team dynamics, managing a work/life balance more effectively and an increase in enjoyment and satisfaction related to their work, alongside many more beneficial outcomes both professional and personal.
Mentorship

The concept of mentoring has been used for many years within nursing and health visiting.

Within this review of the literature we aimed to explore the definition of mentoring, evidence of its effectiveness and problems with the approach. We started by exploring the broad research, and then focused on the literature around mentoring and health visiting.

In the UK, the role of formal mentoring became more established in the context of professional education and training in health and social care during the 1970s and 1980s (Downie and Basford, 2003). Continuous assessment was also introduced during this period and passing or assessing students in practice became the responsibility of the mentor in 2001 (Duffy, 2003). Prior to this, the Department of Health (DH) defined the mentor as a registrant who facilitated learning, and the assessor was another registrant (Gopee, 2008), highlighting a role and function narrowing circumscribed by the context of professional education and training.

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. This wider and more general concept of mentorship overlaps with, but can be distinguished from, mentorship as instrumental in preparation of students or trainees for professional registration in nursing or health visiting. Within the nursing professional literature, this latter function is dominant in ways that are not representative of the more general literature concerning mentoring and mentorship for career development and progression. While educational mentorship can be included in this wider concept, its dominance within the nursing literature and in practice (owing to the system-wide allocation of human resources to its provision for trainees) somewhat eclipses the wider developmental mentorship that could, in principle, be offered to health visitors established in their role to support their resilience. Bearing this in mind, the extensive literature on mentorship in nursing education is found to be, at best, tangential to the purpose of this review’s focus on fostering resilience and retention of health visitors.

Definitions of 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).

Levinson’s definition of the term (below) links it strongly with teaching and advising; he also talks about the mentor’s role in assisting the mentee to realise his or her dream or perhaps ‘goal’.

“The term mentor...generally means teacher, advisor or sponsor....The mentor has another function, and this is developmentally the most crucial one: to support and facilitate the realisation of the Dream” (Levinson, 1978, pp.97-98).
Mentoring and health visiting

Until recently, in health visiting it was possible to distinguish the role of educational mentor for trainees from a wider concept of developmental mentorship.

This is because the former role was characteristic of pre-registration nursing education, while health visitor students were supported and supervised by practice teachers (PTs) with a dedicated teaching role.

With the recent growth in the number of health visitors there has been the need to engage more PTs in training new students. Traditionally, the PT has trained one specialist community public health nurse (SCPHN) annually (Nursing and Midwifery Council (NMC), 2008). However, in view of the recent additional training requirements, this route is unsustainable in terms of capacity. The NMC revised this policy advising that PTs may now manage up to three learners (NMC, 2011). They are supported in this task by health visiting ‘mentors’ who undertake the majority of the practice teaching with the PT supervising the process and undertaking responsibility for signing-off the assessment learners’ proficiency. Anecdotal evidence both regionally and locally indicates a considerable degree of resentment and disquiet among health visiting mentors. The commitment for the training of SCPHNs runs alongside mentors’ ongoing responsibility for a caseload of children under five and their families, and the requirement to continue to maintain professional skills and knowledge.

The impact of high workload, staff shortages and time conflict presents mentors with constant dilemmas in relation to managing commitments. For many mentors, work overload was counteracted by working overtime, and some reported feeling overwhelmed and exhausted due to competing demands (Omansky, 2010). Controversially, some managers and co-workers perceived the mentor as having additional help as opposed to additional responsibility. Haydock et al (2011) identified professional ‘burnout’ among some PTs. Fischer and Webb (2008) and Kenyon and Peckover (2008) undertook community-based studies where mentors experienced different challenges, and concluded the nature of the community environment intensifies difficulties associated with planning to accommodate patients and students. The second emerging theme surrounded support from managers, colleagues and higher education institutions (HEI). Omansky (2010) noted managers failed to recognise the increased workload associated with the dual role, leading to mentor anxiety. Fischer and Webb (2008) found mentors felt undervalued by managers, evidenced by their failure to support them. The final emerging theme related to education, learning and assessment. Poor continuing professional development impacted negatively on student learning (Myall et al, 2007) and preparation of mentors was crucial to positive student outcomes. Kenyon and Peckover (2008) identified that a forum for sharing of experiences and learning would promote consistency in assessment but, due to the pressure of clinical commitments, priority is not always given to attending annual mentor updates (McVeigh, 2009). Haydock et al (2011) identified the value of good partnership arrangements with the HEI, while the need for more user-friendly and succinct documentation was highlighted as a prerequisite by Pulsford et al (2002).

Morton (2013) carried out a study to find out what support health visitor mentors required. Powerlessness was identified as the overarching theme within Morton’s data. Participants argued the role had been imposed upon them. Some participants felt coerced into the role and reported feeling taken for granted while receiving little meaningful recognition of the effort and consequence of maintaining the dual role. With reference to the managers, one participant commented: ‘They don’t seem to empathise with what we do, and how hard we really do try’ Morton (2013, p33). Inadequate staffing levels exacerbated this burden. Morton found that mentors felt unprepared for their role and some of them were less qualified than the mentees. Indeed during iHV training sessions it was identified that health visitors with only one year postgraduate experience were being asked to be mentors. Mentors...
in Morton’s study felt that they were not valued or supported to undertake the work emotionally and nor were they given time to undertake the role in the way they would have wished.

Sayer (2013) has completed a longitudinal study of health visiting students from one London university to explore managers’ views regarding issues faced by student and newly-qualified health visitors. Themes emerging from the data for trainees and newly-qualified health visitors were: the importance of personal attributes; the value of experience; the need for support; managing self and others. The analysis suggests that previous experience, either nursing/midwifery work or life experience, is a key enabler regarding assimilation into the SCPHN role and performing the role on qualification. Support from practice teachers is crucial to the socialisation process during training but preceptorship support is lacking for most newly-qualified health visitors.

Although this paints a bleak picture of health visitor mentoring in the UK, there is some evidence to suggest that, at least in some areas of the country, where it is well managed, the picture is improving. Devlin and Mitcheson (2013) carried out an evaluation of three models of health visitor practice teaching in the east of England with their evaluation including feedback from students on their experience of mentoring. They found that most of the students had predominantly positive relationships with their practice teachers and/or mentors and appreciated how pivotal this was to their development as a health visitor. Several factors were identified by Devlin and Mitcheson (2013) as being important for a positive mentoring experience these included: proximity, continuity and reciprocal positive regard, together with clinical expertise. Another factor mentioned was that mentees valued their mentor’s acknowledgment of their previous learning.

Outside the confines of nursing education, mentoring is an integral part of the of the NHS frameworks for leadership and professional development and is offered through the NHS Leadership Academy (2012). At present, the potential for mentoring as a supportive intervention is likely to be limited by a) the conflation of developmental or career mentorship with educational mentorship for professional training; b) the recent conflation of practice teacher and mentor functions in health visiting; and c) the recent, possibly short-term, pressures on capacity for mentorship within the health visiting workforce due to increased demands to deliver increased throughput of trainees. These combine to give the unfortunate perception of mentorship as part of the problem rather than a solution to the demands on professional resilience in health visiting. However, points b) and c) are arguably short-term effects of the health visiting implementation plan that can be mitigated by a clarification of the wider potential of mentoring and mentorship as adopted more widely in the NHS and other organisational contexts.

Key points: mentoring

- 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.
- The impact of high workload, staff shortages and time conflict presents mentors with constant dilemmas in relation to managing commitments. Competing demands can lead to exhaustion and feelings of being overwhelmed.
- When managers fail to recognise the increased workload associated with the educational mentor role, it can result in increased mentor anxiety.
- 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.
- Within health visiting, the role of the mentor has become associated with a form of practice teaching, to cope with the greatly increased number of students since 2011. Positive developments beyond the health visiting implementation plan include building on induction and preceptorship of newly-qualified health visitors to offer mentorship in line with wider developments in mentoring emerging leaders within the NHS. Institute of Health Visiting projects on developing a career framework and developing a cadre of Fellows offer the potential to hold on to this more promising vision of mentoring in support of resilience.
Coaching

Coaching, as opposed to mentoring, has been used less frequently within health visiting; however, there is some evidence from the training and consultation groups facilitated through the iHV that some Trusts are offering coaching to staff. Traditionally, coaching within the NHS may only have been seen as an appropriate support for personnel in senior strategic positions within organisations.

What is coaching?

Coaching is centred on unlocking a person’s potential to maximise his or her own performance. A focus on improving performance and the development of skills is the key to an effective coaching relationship (Fieldon, 2005). Brandt (2013, p 56) states that “Coaching is effective because it is personal, behaviour-oriented and targeted to the individual”. Coaching is not, however, telling someone what to do and how to do it. Occasionally, it involves overseeing what is being done and advising how to do it better. Over recent years, there has been an increasing trend of individuals taking greater responsibility for their own development (Parsloe and Rolph, 2004 cited in Fieldon 2005). If individuals are to do this they need support and advice and the coaching relationship appears to provide employees with the appropriate support they need in order to achieve their developmental aims (Whitmore, 2002).

How coaching differs from mentoring

Table 2 below outlines the differences between coaching and mentoring: importantly coaching does not have to be performed by someone from the same professional background as the coachee/person being coached. It does not contain the same role-modelling expert/novice component. In addition, coaching tends to be more time limited where mentoring can continue for many years.

Evidence for the effectiveness of coaching in the NHS

“Coaching and mentoring are an integral part of the of the NHS frameworks for leadership and professional development. They are also important skills for public service managers and usually form part of management development programmes”. (NHS Leadership Academy, 2012)

Sinclair et al (2008) completed a study into the effectiveness of coaching in the NHS. They found that personal benefits to coachees included an increased sense of motivation and enthusiasm, and also an ability to deal with frustrations encountered. Most benefits identified were at the level of behaviour, or how people were going about their work. These included having a more objective and strategic approach, better work prioritisation, increased confidence, improved ability to influence key people, better team management and enhanced self-presentation in job applications. They also suggested that what coachees seemed to value most about coaching included having space to reflect on their work, having a safe environment in which to work through options, being encouraged to find the answers for themselves, having a new perspective on their situation and being able to draw on the expertise of their coach. Within their study, Sinclair et al (2008) also looked at the differences between external coaches brought in from outside the organisation and internal coaches. They found only minimal differences between them, however, they suggested that coachees would also benefit from improved information about coaching, including how coaching works and what it can be used for, as well as help in choosing a coach. They concluded that, although it is clear that when coaching takes place it is delivering benefits for the NHS, there is also an opportunity to improve the deployment of coaching, particularly through the internal coaches, so that even greater benefits can be achieved.
Coaching generally has a set duration.

Generally more structured in nature and meetings are scheduled on a regular basis.

Short-term (sometimes time-bounded) and focused on specific developmental areas/issues.

Coaching is generally not performed on the basis that the coach needs to have direct experience of their client’s formal occupational role, unless the coaching is specific and skills focused.

Focus generally on development/ issues at work.

The agenda is focused on achieving specific and immediate goals.

Coaching focuses on specific development areas/ issues.

### Mentoring

Ongoing relationship that can last for a long time.

Can be more informal and meetings can take place as and when the mentee needs some advice, guidance or support.

More long-term and takes a broader view of the person.

Mentor is usually more experienced and qualified than the mentee. Often a senior person in the organisation who can pass on knowledge, experience and open doors to otherwise out-of-reach opportunities.

Focus is on career and personal development.

Agenda is set by the mentee, with the mentors providing support and guidance to prepare them for future roles.

Mentoring focuses on developing the mentee professionally.

### Table 2: Differences between coaching and mentoring relationships. (Source: Jarvis, 2004)

Within the nursing literature, the study of the effectiveness of coaching appears to have been limited to time points in the recipients’ career where they were expected to make significant change. This includes the evaluation of its effectiveness in supporting nurses and midwives to develop clinical leadership competencies (McNamara et al, 2014). They concluded that coaching and action learning were positively experienced by participants and contributed to the development of clinical leadership competencies, as attested to by the programme participants and intervention facilitators. They recommended that, with coaching and action learning interventions, the focus should be on each participant’s current role and everyday practice, and on helping the participant to develop and demonstrate clinical leadership skills in these contexts.

Kelton (2014) evaluated the effectiveness of using coaching to work with students whose performance was reported to be marginal. Within health, working with any staff whose performance or behaviour is in question can be extremely challenging and at present this is done through the process of performance management, which is poorly defined. Managers will often cite working with difficult or poorly performing staff as particularly challenging to them, and it can affect team performance in general. In Kelton’s study she evaluated the effectiveness of a clinical coach (CC) role created by one school of nursing and midwifery in response to ongoing concerns about students’ level of competency. She found the model of clinical coaching, that was adopted for supporting marginal performer or ‘at risk’ students, was effective at developing their practice.

There is relatively little mention of coaching within the health visiting literature. However HEE (2011) in an accompanying document to the Health Visiting Plan acknowledged that, by 2015, approximately 60% of the workforce would be newly qualified and inexperienced. They stated that “Commitment has been given within the health visitor programme to supporting the newly-qualified practitioners during the first two years of practice to aid transition from theory to practice and from novice to expert” (p11). The document also acknowledged that practice teachers and mentors need to be skilled in supporting development of team members alongside delivery of development activities, using strengths-based approaches and motivational interviewing skills. The HEE suggests one way of this being realised was for health visitors to develop coaching skills in order to support inexperienced staff.
The direct relevance of coaching to resilience is not obvious without being contextualised. At a general level, coaching concerns improved performance under challenging if not adverse conditions. The analogy is drawn with coaching for physical fitness, as being the capacity to recover quickly from exertion, to perform at a high level, or to endure, for example by tolerating pain. This raises the question of which elements of performance are to be improved and which are not. Coaching is a generic skill that needs to be applied appropriately to the performance requirements of context. Coaching could improve resilience that is either emotionally ruthless or compassionate. Thus, it is important to consider carefully the alignment of individual and organisational performance requirements when determining the focus of coaching.

Key points: coaching

- In coaching there is a focus on improving performance and the development of skills.
- Coaching and mentoring are an integral part of the NHS frameworks for leadership and professional development.
- Traditionally, coaching within the NHS may only have been seen as an appropriate support for personnel in senior strategic positions.
- Benefits to coachees include an increased sense of motivation and enthusiasm, and also an ability to deal with frustrations encountered.
- ‘Clinical coaching’ can be used to work effectively with “marginal” staff with performance issues.
- Consideration needs to be given to the alignment of the performance requirements of individual practitioners and organisations so that resilience is promoted to reflect the therapeutic basis of professional-client relationships as sensitive, attuned and reciprocal (Douglas, 2010).
- There is an opportunity to improve the deployment of coaching, particularly through the development of internal coaches, so that even greater benefits can be achieved.
- Health Education England suggests developing the coaching skills of practice teachers and mentors as one way of developing them for their roles.
Courageous conversations

Within the literature related to developing resilience within health visiting, there are many reminders that good relationships are an important component of resilience.

There are, however, examples (Whittaker et al, 2013) where maintaining good relationships with colleagues whilst maintaining your integrity and need to be heard is, at times, challenging for health visitors.

In addition, Whittaker found that health visiting managers’ abilities to respond sensitively to staff was sometimes compromised. This may in part be due to pressures felt from those senior to the managers. It is difficult for professionals to develop professional resilience in a ‘bubble’ and the impact of the organisational culture is strong. Leadership training within the NHS is currently being spearheaded by the NHS leadership academy, and part of that training incorporates preparing leaders for the ‘challenging’ conversations that they will inevitably encounter. This training is being offered at band 6 and 7 level, and it is hoped that all health visitors will eventually have the opportunity to engage with the programme. This section highlights some of the key messages from the literature.

There are many different terms used to describe these conversations, such as ‘courageous’, ‘challenging’, ‘difficult’ or ‘crucial’. Patterson et al (2002) describe it as learning to communicate best when it matters most. A review of the literature reveals very little in terms of models with a clear evidence base. However, there are a wide number of best-selling titles that deal with the subject (Patterson et al, 2002; Grimsley et al, 2012).

Why it is important to consider courageous conversations

When New Zealand school leaders were asked to identify the issues that created challenging problems for them, they nearly always indicated people problems (Cardno, 2007). Furthermore, the leaders indicated that many of the problems were longstanding, difficult to resolve, and had negative consequences that spilled over into other areas of school life. Whittaker (2013) discussed some of the ongoing difficulties health visitors have with managers and seniors that result in difficult and mutually unsatisfying conversations. Part of any professional relationship for the health visitor, be it with clients, colleagues, other professionals or managers, will involve having courageous conversations that need to be had whilst maintaining the relationship. Patterson et al (2002) argue that the root cause of many – if not most – human problems lies in how people behave when others disagree with them about high stakes issues. A report by the State Government in Victoria, Australia (2011) deals with the importance of developing ‘conflict resilient workplaces’. They suggest that costs of unresolved conflict are many, ranging from individual distress, to broken relationships and strained organisational resources, mental and physical wellbeing, absenteeism, counter-culture activities and ongoing dissatisfaction, lost productivity, lost opportunities, declining trust and morale, increased disputation, time spent on case management, and difficulties with recruitment and retention. They state that a conflict resilient workplace is underpinned by strong communications and relationships, supported and demonstrated from the board level down. A conflict resilient workplace does not rely solely on formal dispute processes, but emphasises positive relationships and strong communication, so that conflict is managed early, at the lowest possible level, and with the most appropriate response. It is one that integrates strong diagnosis (‘what is the cause of the problem?’) with appropriate decision-making about the best response (‘is this best managed through adjudication by a third party, or can we resolve this better through non
confrontational approaches such as mediation, a courageous conversation or facilitation?). Facilitated approaches to resolving conflict include models such as conflict coaching and appreciative enquiry, both cited as being effective within the State Government of Victoria (2011).

They also suggest that conflict presents opportunities for people to strengthen their relationships with themselves and others. Resolving the issues is only one of the desired outcomes when people are in dispute. Behaviour change is achieved in part, by increased self-awareness and insight. With increased self-awareness, we are more likely to discover our choices and shift our behaviour.

Open-to-learning conversations

The evidence-based model Open–to–learning conversations was developed by Robinson et al (2009) at Auckland University. This draws on the theory from Chris Argyris, a social and organisational psychologist who has done extensive empirical and intervention research on the interpersonal effectiveness of leaders in real, on the job situations (Robinson and Lai, 2006; Cardno and Piggot-Irvine, 1997). Table 3 outlines the key values and strategies the model employs.

Table 3: The guiding values and key strategies of “Open-to-learning” conversations

<table>
<thead>
<tr>
<th>Guiding Values</th>
<th>Key Strategies</th>
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<tbody>
<tr>
<td>1. Increase the validity of information. Information includes thoughts, opinions, reasoning, inferences and feelings.</td>
<td>■ Disclose the reasoning that leads to your views. ■ Provide examples and illustrations of your views. ■ Treat own views as hypotheses rather than taken-for-granted truths. ■ Seek feedback and disconfirmation.</td>
</tr>
<tr>
<td>2. Increase respect. Treat others as well intentioned, as interested in learning and as capable of contributing to your own.</td>
<td>■ Listen deeply, especially when views differ from your own. ■ Expect high standards and constantly check how you are helping others to reach them. ■ Share control of the conversation including the management of emotions.</td>
</tr>
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</table>
At the heart of the model is the value of openness to learning – learning about the quality of the thinking and information that we use when making judgments about what is happening, why and what to do about it? An Open-to-learning conversation, therefore, is one in which this value is evident in how people think and talk. Do they assume the validity of their views and try to impose them, however nicely, on others, or are they searching for ways to check and improve the quality of their thinking and decision-making? Robinson (2013) cites Argyris and Schon (1974) who suggest that conversations about the quality of performance are difficult because they have the potential to threaten relationships by triggering discomfort and defensiveness. In the face of such threats, leaders often experience a dilemma between pursuit of their change agenda and protection of their relationships. Cardno (2007) found that leaders may often want to raise issues of poor performance but are concerned about the resulting stress and conflict this will bring to them and their team.

Several models, including Rosenberg’s iconic work (2013) ‘Non Violent Communication’, discuss the importance of acknowledging feelings - both our own and others’. There are inevitably many difficult emotions that arise when an individual attends to a situation and understands it as being relevant to his or her current goals (Lazarus, 1991). Negative emotions alert us to the possibility that our needs or interests are being threatened or harmed; positive emotions signal expansion and harmony and contribute to broaden and build our resources for future interactions (Fredrickson, 2001). Skills in identifying, acknowledging and managing feelings are thus seen as important prerequisites for effective challenging communication. Rosenberg (2013) also highlights as key to success the skills of observing without evaluating, and skills in communicating based on needs. He suggests these skills are related because evaluations are often masked expressions of our needs. Rosenberg cites Gibb’s (1961) suggestion that evaluation is often harmful in interpersonal communication because it generates defensiveness. He explains that when people hear an ‘evaluative or judgement statement’ they often perceive criticism. Blame, insults, put-downs (critical remark), labels, criticism, comparisons, and diagnoses are all forms of judgment, which may lead to feelings of defensiveness, self-absorption, threat and weakness.

Rosenberg suggests that learning to communicate only what we have observed, without linking it to an evaluative or judgemental statement, is a far more effective way to communicate, as it is less likely to activate the defensive arousal of the other. Observation is linked to communicating based on needs, as an observation exposed without the evaluative mask is easier to connect with one’s needs (Rosenberg, 2013). Rosenberg strives to encourage people to make a clear differentiation between communicating our observations objectively and accurately to someone without attaching a judgement to them. He acknowledges that this is difficult to do in practice as it means circumventing our instincts, however he believes it is a skill that can be taught.

**Key points:** courageous conversations

- Part of any professional relationship for the health visitor, be it with clients, colleagues, other professionals or managers, will involve having challenging conversations that need to be had whilst maintaining the relationship.
- Patterson (2002) describes courageous conversations as “learning to communicate best when it matters most”.
- Developing the skills to have effective ‘courageous conversations’ is a key factor in developing ‘conflict resilient workplaces’.
- Conflict presents opportunities for people to strengthen their relationships with themselves and others.
- Developing skills in managing ‘courageous’ conversations is one of the components of the NHS Leadership Academy training programme.
Relationship-based models of intervention

Rationale for the inclusion of relationship-based models within the framework

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

At the same time, this aspect of practice is also demanding and therefore pivotal to support needs and resilience. Crowther and Cowan (2011) studied effective relationships which help vulnerable parents and improve outcomes for children. They state that previous studies and evaluations demonstrate that the development of the relationship with the client is what makes the ‘real difference’ in improving outcomes for service users. Crowther and Cowan (2011) cite Bell and Smerdon (2011) in their literature review and suggest that human relationships are essential to effective service provision. Whitaker et al (2013) identified that the idea of “making a difference” was the key motivating factor to entering health visiting (students) and remaining in it (qualified health visitors). Whitaker et al also identified that health visitors recognised that, in order to make a difference by improving life chances, enhancing children and families’ health, protecting children and vulnerable adults, several things needed to happen. Firstly, health visitors needed to gain access to people in their home, form a relationship with them and gain information about their private lives, which then enables health visitors to offer appropriate help and support. This is complex and skilful work especially when considering that many of the clients that health visitors will be working with the most, are those that trust the least. Puckering et al (1996, p.540) state “that it is the very factors which put the children at risk that make it harder for parents to engage in support for themselves or their children”. Therefore, having the ability to engender trust in parents who are scared, angry and hypersensitive to criticism is arguably one of the most skilful within the health visitor’s role. It is what puts the ability to form and model good relationships at the core of health visiting practice. It is how health visitors define themselves and are able to derive a sense of mastery and pleasure from their work.

However, there is increasing evidence to suggest that it is difficult for health visitors in many areas of the country to develop relationships with their clients. There is also evidence to suggest that this affects morale, job satisfaction and professional self-esteem. Ausbrooks (2011) found that a sense of job satisfaction was a protective factor that allowed practitioners to withstand, endure and bounce back from the myriad of stressors they face in their working lives. She also found that what kept practitioners working with vulnerable families in their jobs was their ability to realise their “mission;” for health visitors the evidence would suggest that “making a difference” comes under this mantle. However, as a prelude to this work on resilience in health visiting, the iHV (2014) surveyed a group of 600 health visitors across the country. Health visitors were asked what was important to them about their job; the questions asked were aligned to factors that the literature has identified as being linked with professional resilience. 100% of health visitors surveyed identified that “making a difference” was a key factor for them, however only 21% strongly agreed that they felt they were currently achieving that.

Cowley et al (2013) reported on a part of the doctoral work of Bidmead (2013) who found that in inner city areas of deprivation, the size of the health visitor caseload is a very important factor in influencing the ability of the health visitors to establish relationships with parents. Bidmead found that caseload sizes in Britain are extremely variable and that it is not unusual for caseloads in Britain to be above the level recommended, and not to be linked to deprivation levels. Health visitors included in the study by Bidmead found their caseload sizes unmanageable (typically in excess of 400 under-fives to one fulltime health visitor). If we consider that this is 15 times the size of caseloads held by Family Nurses, the enormity of the pressure...
that the health visitors are under becomes evident. Bidmead (2013) also found that health visitors valued the relationship that they developed with clients; however, due to the pressure they were under and the organisational culture, this was extremely difficult in some areas. She states that the “organisational issues identified by parents and health visitors highlighted the need for parents and health visitors to have time to develop relationships in an unhurried atmosphere” (p13). Bidmead identified several organisational issues that prevented or hindered the client/health visitor relationship; amongst them were pressures of record keeping. Working with other agencies in particular this applied to children’s centre staff, who were increasingly seen to be taking over the work of health visitors in the home. This is of particular concern considering the complexity of this work and the extensive work of Olds et al (2002) who clearly identified the complex nature of this work and the high level of skill required to achieve positive outcomes for families. In addition, the obviously demoralising effect this has on health visitors may impact on their resilience. Skill mix was felt to have contributed to health visitors being left with safeguarding work, which was seen as less rewarding than more preventative intervention. Lack of management support for relationship-based work was also seen as a major issue. The Children and Young People Mental Health Coalition (CYPMHC) also suggest caseloads can pose a problem. Building trust takes time and effort that health visitors cannot spare if their caseload is too large or too complex (they cite Barlow et al, 2007; Department of Health et al, 2009; Adams 1998). There can be a ‘postcode lottery’ in health visitor provision with many service cuts, or health visitors having to delegate interventions. Additionally, the focus for delivering many interventions can be on the children’s centre workforce, rather than health visitors (Adams, 1998). Bidmead’s (2013) work reported above sets out the rationale for the later development of a suite of instruments, suitable for evaluating the parent-health visitor relationship and the extent to which organisations support them, which are now validated and available.

The CYPMHC states that if we fail to address the problems outlined above, some families will continue to be reluctant to engage with professional staff, and treat them with distrust. This means that they may miss out on valuable interventions and support, including a better understanding of the importance of attachment in their children’s development. It also means that early signs of mental health problems – whether in the infant or the parent – may be missed, increasing the risk of serious mental disorders, which are costly both in financial and human terms.

Perhaps it is not surprising, therefore, that health visitors listed the Solihull Approach as one of the most valuable trainings they had engaged in within the iHV survey (2014). The Solihull model puts the relationship with the client as central to intervention and places great value on factors such as containment and reciprocity. There are indeed other relationship-based programmes which have been developed in the UK such as Mellow Parenting and the Family Partnership model. Within this section we have also referred to the Family Nurse Partnership (FNP) Model as this model also focuses on the relationship between the client and the nurse as a factor that is central to its success. Although it is acknowledged that this is not a model that can be adopted in its totality in health visiting, many of its features are similar to the other models. However, the attention to fidelity within the FNP programme, small case-load sizes, supervision, training and support structures and the recognition that the emotional wellbeing of the nurse is central to the success of the programme, has contributed to its continued growth. In essence, the acceptance, support and encouragement from their seniors that family nurses receive to build relationships with their clients empowers them to make use of a good model of intervention. It is arguably an extremely good example of a Positive Practice Environment in the UK and as such it will be valuable to consider factors that have contributed to its success within the context of developing resilience in health visiting.

**Solihull Approach**

The Solihull Approach was first developed in 1996 by joint working between health visitors and psychotherapists in Solihull, to work with families on feeding, sleeping and behavioural difficulties. It has now been adopted by a wide number of health visitors in the UK.
How does the Solihull Approach work?

The Solihull Approach model combines three theoretical concepts, containment (psychoanalytic theory), reciprocity (child development) and behaviour management (behaviourism). It provides a framework for thinking for professionals working with families. Containment and reciprocity underpin relationships and brain development as well as the quality of an attachment.

According to Douglas and Brennan (2004), knowledge of the process of reciprocity can help the practitioner to understand the relationship between a parent and a child and to work with the parent or family on the relationship. This can be done on an individual basis or within a parenting group. Parents appreciate this knowledge too, and are often able to change their behaviour and improve their relationship with their children when the pattern of interacting is brought to their awareness. The Solihull Approach uses the concepts of containment and reciprocity to explain how the infant brain develops within relationships. However, an understanding of the importance of reciprocity and containment within relationships is transferable to other relationships and thus contribute to a sense of connectedness, known to be a key component of resilience (Mental Health Strategic Partnership, 2013). In addition, the increased skill levels and feeling of ‘I am making a difference’ are also likely to improve professional pride and resilience.

Moore et al (2013) found that there was a substantial amount of research that has provided evidence for the effectiveness of the Solihull Approach with health visitors. Douglas and McGinty (2001) found that following training in the Solihull Approach, health visitors reported greater confidence and job satisfaction. In addition, it changed practice in 88% of health visitors trained in the approach. Douglas and Whitehead (2005) carried out a qualitative evaluation of health visitors and found that using the Solihull Approach during their work enabled them to focus more on emotions. In addition, it improved consistency in practice, and, again, health visitors reported better job satisfaction. Health visitors also reported improved relationships with other professionals, which would suggest that the relationship building skills that they utilise with clients have a wider impact.
Family Partnership Model

The Family Partnership Model (FPM) is an evidence-based method, developed by the Centre for Child and Parent Support. Its effectiveness has been demonstrated through a number of research trials which indicate positive benefits to the developmental progress of children (e.g. Davis & Rushton, 1991; Marlow et al, 1998), parent-child interaction (Barlow et al, 2007; Puura et al, 2005) and the psychological functioning of parents, families and children (e.g. Davis & Rushton, 1991; Davis & Spurr, 1998).

Its intention is to enable all practitioners to understand the processes and skills of helping so they can use their own technical expertise more effectively. This is achieved by taking into account internal processes and addressing the psychological and social issues which may present when individuals and families have problems (Davis and Day 2009).

Bashford and Seal (2012) describe the impact of using the FPM within a health visiting team using a case study. They suggest that critical to the success of the delivery of the Healthy Child Programme is the ability of staff to engage with families and to establish effective working relationships that result in measurable outcomes. The model, although originating from parents’ concerns about professionals not listening to them and not recognising them as people with skills of their own, has since developed to support all parents, both for preventive/promotive purposes and for those who may be experiencing difficulties with their children, through the use of a structured ‘helping process’. The ‘helping process’ constitutes the following phases:

- Relationship building
- Exploration
- Shared understanding
- Goal setting
- Strategy planning
- Implementation
- Review
- Ending

Bashford and Seal (2012) suggest that it is clear that mothers in their study placed significant importance on the development of the relationship and the characteristics required (trust and a feeling of ‘connectedness’ between the client and practitioner), which were all crucial in obtaining favourable positive outcomes. They state that the implementation of the FPM in Somerset has been a significant opportunity for staff to reflect, to develop and learn new skills and increase self-awareness. Relationships are enhanced as staff are able to empathise, listen and summarise while moving parents through the structured ‘helping process’. Feedback from parents demonstrated that they feel listened to, supported and able to change their behaviour. Observations of staff within home visits demonstrated an increased confidence in working with families with a more structured and focused approach. Relationships appeared to be stronger and mutual respect evident, even when working with families where traditionally engagement has been minimal. Staff reported that the use of the framework is effective when supporting problem solving, and confidence has increased considerably in setting SMART (Specific, Measurable, Achievable, Realistic and Timely) targets. The model also uses the same helping process for staff supervision in case work where staff are also listened to and empathised with, a partnership where shared understanding will support staff goals to meet the outcomes with clients. The FPM also clearly identifies the importance of providing skilled supervision and the development of an infrastructure within an organisation.
Mellow Parenting

Mellow Parenting is a parenting programme for families where the children (0-5 years) are either on a child protection plan or the extent and nature of associated risk factors for child development give significant concern that child protection might become an issue (www.mellowparenting.org).

It was developed for families where there were severe relationship problems and around 25% of participating families had a child on the Child Protection Register (Puckering et al., 1994; 1996). Seventy four per cent of mothers entering the Mellow Parenting programme reported at least one hostile or indifferent parent figure in their childhood and sixty per cent reported no current confiding friend or family member was available for them (Puckering et al., 1999). This programme offers health visitors and other family practitioners a framework by which to work with families who find relationships most difficult. There is currently an independent meta-analysis of the evidence for the effectiveness of Mellow Parenting which will be published by Edinburgh University this year. In addition Randomised Controlled Trials (RCTs) are being conducted in Belfast, and the Mellow Bumps (antenatal programme) is part of the THRIVE trials in Scotland, one of the largest independent evaluations of parenting programmes that has been conducted in the UK.

Mellow Parenting is traditionally a group intervention but also offers practitioners training in a detailed parent/infant observation system. Key components that aim to facilitate engagement, and empower parents to reflect and learn from their own experience, include the use of video feedback as a means of encouraging parents to reflect on their own behaviour and the response of their children. While time-consuming and demanding, structured observations of mother-child interaction have been shown to distinguish problem dyads (Puckering et al, 1994). The programme is thought to successfully engage parents ‘at the extreme end of the spectrum’ (Puckering, 2004). Mellow Parenting aims to reach these parents by providing a more nurturing context in which to develop their own relationships and their own skills alongside applying those to the relationships with their child (Figure 3).

Figure 3: Mellow Parenting Model (babies and toddlers).

- Transport and crèche
- Focus on strengths
- Facilitation team

- Providing a nurturing experience for parents
- Exploration of life events that impact on parenting
- Joint lunch and activity with parents and children
- Feedback on parent-child own videos using strengths-based approach
- Improvements in parent-child relationship

- Have a go at home tasks
- Build up parents’ relationship with each other
Strengths-based approach

Central to the Mellow Parenting philosophy is the concept of working with families’ strengths as opposed to lowering self-esteem and encouraging defensive behaviours by focusing on deficits.

Practitioners are supported to develop the ability to identify sometimes embryonic or brief episodes of positive interaction between parents/infants. This is not to say that weaknesses and concerns are ignored but rather they are reflected upon in a way that is empathetic to the perspective of the parent. In this way a strengths-based approach becomes a way of building relationships, developing self-esteem, motivation and hope. It does not in any way however detract from the need for ongoing assessment of risk.

Indeed there is much evidence for the effectiveness of strengths-based approaches and HEE propose that health visitors can also utilise these skills when mentoring colleagues. In mental health there is a strong focus on recovery and positive psychology – an inherently strengths-based perspective. Petersen and Seligman (2004) state that “The relationship is hope-inducing”. A strengths-based approach aims to increase the hopefulness of the client. Having a sense of hope is also believed to be a factor which builds resilience. Further, hope can be realised through strengthened relationships with people, communities and culture. Researchers have found that by encouraging pride in achievements and a realisation of what people have to contribute, communities generate increased confidence in their ability to be producers not recipients of development (Foot and Hopkins, 2010). Strengths-based models have also been shown to help change entrenched and destructive behaviours, family justice research using this model has been shown to reduce drug use, lower rates of arrest and conviction and improve higher levels of social functioning (Shapiro, 1996). In a pilot study of people with serious mental health issues, people were asked to identify the factors that they saw as critical to recovery. The most important elements identified included the ability to have hope, as well as developing trust in one’s own thoughts and judgments (Ralph et al, 1996). Strengths-based approaches are shown to be effective in developing and maintaining hope in individuals, and consequently many studies cite evidence for enhanced wellbeing (Smock et al, 2008). Much strengths-based practice has an internal component, which is therapeutic in nature, and which involves locating, articulating and building upon an individual’s assets or capabilities. It also aims to assist with finding solutions for current problems based on currently available resources. Similarly, MacLeod and Nelson (2000), in a review of 56 programmes, found evidence to support the view that an empowerment approach is critical in interventions for vulnerable families. A strengths-based perspective shows how the practitioner can work positively towards partnership, by building on what parents already possess. As Graybeal (2001) explains, ‘the identification of strengths is not the antithesis of the identification of problems. Instead, it is a large part of the solution’ (p.234).

Programmes such as Mellow Parenting, which have a philosophy of strengths-based working with clients, present an opportunity for health visitors not only to build resilience in their clients, but the resulting shift in focus from deficits to strengths may also impact on their own resilience and the resilience of the colleagues that they mentor.
Lessons from the Family Nurse Partnership Model (FNP)

The FNP was developed in the USA (Olds et al, 2003) and is one of the most popular and well-researched home visitation parenting programmes (Browne and Jackson, 2013).

It is also cited as a prevention strategy to reduce child abuse and neglect as well as promoting maternal and child health (Olds, 2002). Positive findings from the evaluative research carried out in the USA, in the absence of a universal health service, have led to the cross-party government decision to use the NFP (known as the FNP in the UK) as a targeted, secondary prevention service offered to ‘every vulnerable, first-time young mother who meets the criteria and wants to join’. The current criteria are that the mother is recruited at under 28 weeks gestational stage of pregnancy and is 19 or under at the date of their last menstrual period. As a result, the FNP in England is designed to act as a support system to work alongside the universal Healthy Child Programme. One of the largest randomised-controlled trials as to the effectiveness of this programme is currently underway in England, with the findings expected later this year. What is of particular interest to the current project is whether there is evidence of greater resilience within family nurses, many of whom have come from the field of health visiting.

In a study of the Family Nurse Partnership workforce by Robinson et al (2013) they reported that 80% of nurses and supervisors rated their job as ‘better’ or ‘much better’ than their previous job. This is perhaps not surprising when one considers their training, resources and low client caseload. However, are there lessons that can be learnt from the FNP model, which could support resilience within health visiting? Robinson et al (2013) found that family nurses rated the quality of their supervision highly. In turn, supervisors were very positive about the support they had received from the FNP National Unit. The supervisors said that they feel ‘part of the FNP family’ indicating a strong sense of belonging, and compassionate and available leadership. In addition, nurses spoke about the “high quality” of their training and were extremely clear about their role.

Support framework for Family Nurses

The Family Nurse Partnership is a highly targeted model which has a number of fidelity measures that are rigorously applied in order to maintain optimum outcomes. The fidelity process begins during the set up and recruitment of the teams and the measures put in place which facilitates support and resilience are shown in Table 4.
Table 4: Support and resilience features of the Family Nurse Partnership Programme

**FNP fidelity measures**
- Interviews for team supervisors are attended by a member of the FNP National Unit (interviewing includes considering emotional intelligence and personal characteristics such as personal warmth).
- Nurses and supervisors attend residential study days where they are given the theoretical framework and clinical tools to prepare them for the work.
- FNP nurses carry a caseload of no more than 25 cases and supervisors carry a caseload of no less than 2/3 families.
- The supervisor provides clinical supervision for each nurse on a weekly basis.
- The supervisor receives supervision from a psychological consultant allocated to the programme once a month.
- The team receive psychology supervision once month.
- There are at least 4 team meetings per month facilitated by the supervisor: two to discuss programme implementation and two case-based meetings to identify client challenges and solutions. This will include skills practice and role play to give nurses an opportunity to practice approaches before the client visit.
- The supervisor makes a minimum of one home visit every 4 months with each nurse for field supervision purposes.
- The supervisor uses programme reports to assess and guide programme implementation, inform supervision, enhance programme quality and plan team-based learning.
- Family Nurses receive one day training based on the Compassionate Mind Approach.
Robinson et al (2013) also report that the family nurses described the work as intense and the phrase “emotional labour” was used on several occasions. One nurse commented: “We thought it would be easier, with a lower caseload, but it wasn’t. I never got up to full capacity... but it felt as though I did – it was very hard work. We’d be writing things up at 8pm, asking each other, ‘How are we going to cope?’” (p.7).

Family nurses work intensely with clients and the development of the therapeutic relationship is central to the work. However the finding that fewer than 25 vulnerable clients was a considerable pressure to contain and manage perhaps puts into perspective the enormous strain and expectations put on health visitors who hold on average in excess of 400 clients in their caseloads (Bidmead, 2013), many of whom will be extremely vulnerable with complex needs and multiple children in their families. It is perhaps not surprising that 41% of health visitors in the NHS survey (2013) stated that they could not deliver the care to which they aspired.

Robinson et al (2013) have been able to use the NHS survey 2011 and their own survey of family nurses to make direct comparisons between family nurses, other nursing groups and health visitors. Figure 4 below outlines the results with regards to areas relating to professional resilience. It is striking that the family nurses and supervisors report feeling better in relation to all of the issues, which include feeling valued and supported. In addition, health visitors are shown to feel they have least opportunity to use their skills in comparison to the other nurses.

**Key aspects of the FNP Support Model**

- Job satisfaction is inextricably linked with the ability and time to form therapeutic relationship with clients.
- The tight framework of supervision and support allows the nurses to cope even with high levels of “emotional labour”.
- Family nurses are confident and able to use their skills as they have the time, resources and practice opportunities to enable them to.
- The fidelity measures interwoven into the programme including joint visits with supervisors, regular skills practice training, case analysis sessions allows for rich personal development and client engagement.
- The National Unit brings a sense of belonging and security to the teams making it feel like a “family”.
- Family nurses struggle to cope with caseloads of fewer than 25 clients who will vary in vulnerability. Health visitors are routinely managing caseloads in excess of 400; this, in conjunction with other issues identified by Bidmead (2013), makes forming therapeutic relationships with clients (central to the work of the health visitor) impossible.
- FNP supervisors carry out regular joint visits with their nurses allowing them to identify strengths and areas for growth. This will also allow supervisors to identify when staff are ready to undertake mentoring roles for others.
There is now overwhelming evidence to suggest that the first 1001 days of life (conception to the 2nd year of life) are critical to improving outcomes for children (Wave Trust, 2014). Indeed there is now a cross-parliamentary agreement to focus support and resources on this period of life. The Family Nurse Partnership focuses on providing intensive support to parents in this period of their baby’s life. Their role is clearly delineated with a clear cut-off point at two years, which allows a focusing of resources and agreement around priorities. This may indicate that a smaller more boundaried role delivered within a PPE would bring the greater job satisfaction to health visitors and improved practitioner resilience. It could also be argued that this would in time bring improved outcomes for children and families in addition to added value for the organisation.
**Key points: relationship models of intervention**

- The development of the relationship with the client is what makes the ‘real difference’ in improving outcomes for service users.

- "Making a difference" has been identified as a key motivating factor for students’ decisions to enter health visiting and health visitors’ rationale for remaining in the profession.

- Having the ability to form and model good relationships is at the core of health visiting practice.

- It is difficult for health visitors in many areas of the country to develop relationships with their clients. There is also evidence to suggest that this affects morale, job satisfaction and professional self-esteem.

- There is a risk of losing people from the profession if they feel unable to “make the difference” and thus lose a key motivator to remain engaged with the demanding but most critically important therapeutic basis for practice.

- Overwhelmingly large health visitor caseload size is a very important factor inhibiting the ability of the health visitors to establish relationships with parents.

- Pressures of record keeping, less qualified staff being deployed to take on work with families, lack of support from managers to take on relationship work are also inhibiting factors.

- Where health visitors are unable to establish relationships with clients, valuable interventions and support, including a better understanding of the importance of attachment in their children’s development, will be reduced. It also means that early signs of mental health problems – whether in the infant or the parent – may be missed, increasing the risk of serious mental disorders, which are costly both in financial and human terms.

- Training in relationship-based models of intervention improves health visitor job satisfaction, competence, consistency, self-awareness, and relationships with clients and colleagues, in addition to improved outcomes for children and families.

- The fidelity measures, values and structures of the Family Nurse Partnership model have contributed to its success and place it as an example of a ‘positive practice environment’.
Supporting Health Visitors and Fostering Resilience Literature Review

Action learning

Action learning is a commonly used approach for leadership development and has been discussed in a wide range of academic literature (see for example O’Neil & Marsick, 2007; Marquardt et al, 2009; Raelin, 2008; Cho and Egan, 2009). It is a popular method of developing an organisation’s human resources and has been driven by perceived outcomes and relevance to organisational issues (Marquardt, 2004; Bolt, 2005; Raelin, 2007).

Action learning has been defined as ‘a process of reflecting on one’s work and beliefs in the supportive/ non-confrontational environment of one’s peers for the purpose of gaining new insights and resolving real business and community problems in real time’ (Dilworth and Willis, 2003, p.11). Action learning has been widely discussed in academic literature and Cho and Egan (2009) detail a wide range of academic literature dedicated to action learning.

The use of action learning can contribute to improved performance and helping staff to learn by reflecting on their practice and decision-making (Jackson and Thurgate, 2011). Both individuals and organisations can benefit from action learning, as when used correctly at an organisational level, it can help improve communication, work environments, cooperation, shared vision and development. It has also been suggested as being a useful approach for developing human resources through individual learning and development (Willmott, 1994; Vince, 2003, 2004; Reynolds & Vince, 2004; Pedler, et al 2005; De Loo, 2006; Marquardt et al., 2009;). However, there is a need for participants in an action learning process to strike a balance between action and learning (Revans 1971, 1998, Pedler, 2002; Kuhn and Marsick, 2005; Raelin & Raelin, 2006; Tushman et al., 2007).

The basis of action learning is the premise that people learn more effectively when working on real-time problems occurring in their own work setting (Day, 2000; Reynolds & Vince, 2004) and that they learn best when reflecting together on real problems occurring in their own organisation (Raelin & Raelin, 2006; Vince, 2004). Senge (1990) suggested that teams (otherwise known as learning teams or action learning sets) are the fundamental learning unit in an organisation. Participants in action learning environments learn as they work by reflecting with their peers. This reflection helps individuals gain insights into their, and their colleagues’, workplace problems (Raelin, 2008).

The ‘action’ in action learning provides the pathway to learning with the consequence that any given task will be a vehicle for learning (Raelin, 2008). The ‘learning’ can occur at individual, team, or organisational levels (Marquardt, 2004). However, addressing an issue is useful only if there is learning from the experience (Rooke et al., 2007; Raelin, 2008).

Balanced approaches

Revans (1971, 1982, 1998) emphasised the importance of taking a balanced approach, where action learning is regarded as an optimal method for connecting learning and work (de Haan & de Ridder, 2006). Thus learning is focused on learning for more effective action (Marsick & O’Neil, 1999). Through a balanced process of action and learning, people can develop skills to learn from their experiences and personal development may occur from reflection on action (Pedler et al., 2005; O’Neil & Marsick, 2007). Action learning balances working on a problem and learning through that process (O’Neil & Marsick, 2007). Balanced action learning programmes have been shown to enhance both individual and organisational outcomes (Tushman et al, 2007). Cho and Egan (2009) show that key success factors in a number of balanced action learning studies include the effective use of project or learning teams for organisational learning, deliberate reflective practices and management support, and participants being provided with adequate time for reflection.
Unbalanced approaches

Action learning programmes can, however, develop ‘action’ at the expense of ‘learning’ (Raelin, 2008). Action is not the goal but the means by which learning is achieved; however, ‘learning-oriented action’ instead of balancing ‘learning with action’ is often what takes place (Rooke et al., 2007). Imbalances between action and learning can only be overcome by reflective practices which are required to convert experience into knowledge and which is fundamental to learning to provide a basis for future action (Raelin, 2008). Thus action learning is ‘the process of stepping back from experience’ (Coghlan and Brannick, 2005) to process what the experience means, with a view to planning further action. An unbalanced approach is unproductive, as ‘action without learning’ is unlikely to return results and ‘learning without action’ does not engender change (O’Neil & Marsick, 2007). Thus action learning must balance action and learning (Pedler, 2002; Kuhn & Marsick, 2005; Raelin & Raelin, 2006; Tushman et al., 2007). Where learning oriented action learning practices occur and are deemed to be successful they tend to be aimed toward personal learning but not organisational learning, as there is a less clear process for transferring personal action learning into organisational contexts (Willmott, 1994; De Loo, 2001, 2002, 2006; Donnenberg & De Loo, 2004; Vince, 2004; Pedler et al., 2005). Pedler et al (2005) suggests that individualised approaches can result in employees focusing on their own job-related issues but be isolated from the wider organisational context (Cho and Egan, 2009).

Action learning sets

Action learning sets (ALS) are used widely for organisational and workforce development. Action learning sets (usually comprising six to eight 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 about 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.

Action learning has often been used in the health sector, particularly in relation to nursing and midwifery (see for example: Learmonth, 2005; Bell et al, 2007; Board and Symons, 2007; Wilson et al, 2008; Edmonstone, 2008; Richardson et al, 2008; Walia, 2014). A multi-faceted educational pilot programme for new nurses and midwives was implemented in Scotland in 2010 to accelerate their clinical practice and leadership development (Machin et al, 2014). The use of facilitated action learning sets by nurse consultants at two NHS trusts in Brighton to support their development of strategic leadership skills is discussed by Young et al (2010). Here, the settings, process and outcomes, including benefits to patients, of the organisations were assessed. One further example used online action learning sets as part of a national pilot development pathway for Advanced Nursing Practice in Scotland (Currie et al, 2012). In this study a range of benefits and limitations of online ALS was identified. While flexible access and sharing experiences with others was emphasised, issues of multiple commitments and lack of group cohesiveness interfered with the process. The need for face-to-face sessions to provide getting-to-know-you opportunities and to enhance commitment to the group process was identified.
There are many definitions and variants of action and examples include business-driven action learning, inter-organisational action learning, critical action learning, auto action learning, self-managed action learning, project action learning, developmental action learning, work-based learning, and internet-based action learning (Cho and Egan, 2009). Action learning is more often used for personal development than organisational growth and is more predominant in this context in the education and public sectors (De Loo, 2001, 2002, 2006; Donnenberg & De Loo, 2004; Pedler et al., 2005; Vince, 2004; Willmott, 1994).

Within the literature reviewed there can be no firm conclusions of a direct relationship between action learning or learning sets and resilience. The primary focus of action learning is learning in, through and for action. However, it is reasonable to infer that the benefits of action learning are likely to contribute to resilience through fostering such outcomes as improved self-efficacy and control, a positive set of group relationships and a sense of empowerment to align individual actions with organisational goals. At the time of writing the University of Birmingham, Institute of Health Service Management is researching action learning sets to support hospital clinical leaders in delivering compassionate care. Outcomes of such work may be of interest to health visiting services as an example of action learning focusing on ‘support’ and ‘compassionate care’.

**Key points:** action learning

A number of aspects have been identified as crucial to successful action learning (Leadership in Compassionate Care Programme Team, 2012):

- Facilitation skills are crucial to ensuring that individuals feel safe to engage with the action learning process;
- There are organisational challenges in supporting people to develop these skills quickly;
- To work well, action learning requires mutual commitment to participate;
- Participants can find it problematic to attend action learning sets as part of their working day;
- Action learning and action learning sets may contribute to some of the determinants of resilience although their primary concern is with learning.
Performance feedback

The importance of feedback 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) has been documented.

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 proving the feedback are important considerations.

The principles of effective feedback

Constructive feedback is timely and starts with the positive, is specific, refers to a behaviour that can change, offers alternatives and choice (King, 1999; Svinicki and McKeachie, 2011). Sadler (1989) suggested that to benefit from feedback the person needs to understand the standard or goal to be achieved, be able to compare their level with this, and take action to address the difference. Accuracy and specificity is important (Wilson 2008). This is supported by King (1999) who suggests that recognising the person’s efforts, enabling them to express their views and supporting their development, will enhance motivation.

Developing practitioners’ skills in self and peer assessment and providing feedback can facilitate effective learning (Svinicki and McKeachie 2011). Encouraging self-assessment as part of the process facilitates responsibility and develops skills. Building on the person’s self-assessment and having a dialogue is important (Wilson 2008).

Models for providing feedback

Two specific models have been reviewed in considering support for health visitors to foster their resilience. These are multisource (360-degree) feedback and after action review (Collison 2014).

Multisource (360-degree) feedback

There are several domains to professional competence, and multisource (or 360-degree) feedback is designed to assess in particular the relational and humanistic competencies (Sargeant, Mann, Ferrier 2005). It is a tool to help employees improve and focus on their development. It uses the combined perspective of a manager and several peers – from four to ten people looking at the teamwork, communication, leadership and management skills of an employee. It can identify a starting point for the development of new skills, measure progress as skills are worked on over time, and identify blind spots in behaviour and its impact (Vanek 2013). It also provides a means to recognise strengths and build on them.

360-degree reviews alone will not change a person. However, there is some evidence that facilitated feedback enhances successful behaviour change (Nowack 2005).
A meta-analysis of 26 longitudinal studies indicates significant but small effects sizes (Smither et al, 2005). When using these findings it may be unrealistic to expect large performance improvement after 360-degree feedback. A lower number of raters undermines reliability of the responses. Eight to ten raters maximises the reliability (Nowack 2005), with the NHS Leadership Academy (ND) recommending 12 raters as optimum.

The employee will need support to carry out the changes identified, which will take time. There is some evidence that coaching coupled with 360-degree feedback can facilitate behaviour change (Smither et al 2003). Smither and Walker (2004) found that 70% of written feedback was generally positive and favourable comments are associated with improved performance. Managers who received a small number of unfavourable comments showed greater improvement. However managers who received a large number of unfavourable behavioural comments declined in performance. It is important to note that a meta-analysis on over 3,000 studies found that one third of all studies showed declines in performance (Klugar and DeNisi 1996). This is important when considering effective support to build health visitors’ resilience.

360-degree reviews are for the benefit of the individual not the team or the organisation, therefore it is crucial the individual accepts the concept and process. Preparation for the 360-degree review should involve ensuring that employees are happy to engage in the process, and consider what to do with those who are not able to participate in the review for whatever reason (Vanek 2013). The process of completing the 360-degree feedback can take six weeks (NHS Leadership Academy ND) – a lengthy period that may be time intensive for organisations. Scale feedbacks are quicker for the person completing the review but open texts have more meaning. User fatigue should be considered (Vanek 2013), particularly if individuals are expected to complete these for a number of colleagues.

How the feedback is delivered is important, as individuals may perceive them negatively, and they should not be used as a substitute for good leadership and management (Nowack 2005, Vanek 2013). Starting 360-degree reviews from the top down in an organisation can be helpful. Performance issues should be addressed directly and immediately and not left for the 360-degree review (Vanek 2013). If the individual has not received regular feedback from their manager this is unlikely to be a positive experience. Acceptance of the feedback is influenced by perceptions of objectivity, credibility of the process, relevance of competencies being assessed and the way the feedback is delivered (Sargeant et al, 2005). Nowack (2005) advises caution in the way feedback can be given and the profound impact upon the individual’s wellbeing of being compared to others. He cites neuroscientific evidence from Dickerson and Kemeny (2004) which showed that when stress is interpersonal, i.e. due to being compared with or judged by others, the effect on cortisol is three times greater than when stress is impersonal, and takes 50% longer to reach baseline. The compassionate model (Gilbert 2010) is helpful in understanding this response and considering how to facilitate a compassionate process in providing feedback and building a person’s resilience.

Often the questions in 360-degree reviews are pre-set, however they can be customised to meet the specific needs of the organisation or the group of employees being reviewed. Technical or performance skills should not be evaluated or rated with this tool. It is recommended that individuals are in post for more than one year before using the 360-degree review. Administering 360-degree reviews is a skill, and is best learnt by observing and working with someone else with experience before doing it alone (Vanek 2013). Thus, the use of mentoring to support feedback, reflection and learning can enhance the acceptability of feedback thereby facilitating change (Sargeant et al, 2005).
After action review

The after action review approach process considers the use of four simple questions which people can easily remember, so that they become embedded in their practice and in the organisational culture. These have been described by Collison (2014) and illustrated in Figure 5 below

**Figure 5: After action review model**

<table>
<thead>
<tr>
<th>i) What was supposed to happen?</th>
<th>ii) What actually happened?</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii) Why was there a difference?</td>
<td>iv) What can we learn from this?</td>
</tr>
</tbody>
</table>

Agreed Facts

Shared Opinions

At University College Hospital a significant number of staff from across disciplines have trained in the after action review (AAR) process (Halligan 2012). The process is embedded in the organisational culture and used to facilitate effective teamwork and enhance performance (Walker et al 2012). It has been used to analyse significant events as well as being on the agenda for routine team meetings. It is designed to use a blame-free approach and facilitate long-term learning. This approach seems very relevant to building health visitor resilience as McCann et al (2013) found that opportunities for feedback and debriefing contributed to nurses’ resilience.

AAR can provide insight into performance, teamwork, leadership and culture. All of these are important components of a positive practice environment (Bryar et al, 2012). Although it appears a simple process, conducting an AAR involves exploring values, beliefs and principles, and requires skills including leadership, courage and effective communication in having challenging conversations. This links with the findings of Whittaker et al (2013) on the importance of the psychological contract, exploring expectations and engaging staff.

AAR has been used predominantly in analysing specific events to increase awareness, generate understanding, facilitate behaviour change, learn and develop an action plan. Learning from adversity and sharing experience is a key factor in building resilience (McAllister and Kinnon, 2009). Rutter (2012) suggests that a reflective style, commitment to relationships, and personal agency are characteristics of resilient individuals. Applying this to the AAR process would suggest that this could contribute to building resilience. However, it could also be applied in the context of a shared experience in providing feedback. It can be used to examine a situation where performance could be improved or to celebrate and publicise a situation with excellent outcomes. This is in keeping with the strengths-based approach used by health visitors in working with clients. Once good practice has been identified it is important to share expertise and learning, as this is influential in building resilience and enabling practitioners to thrive in practice (Wendt et al, 2011).

Walker et al (2012) describe the implementation of AAR through multi-professional training using experiential methods, with the aim to develop leadership skills. The
process requires protected time, a safe environment and a skilled trained facilitator. It is important that participants are clear about the purpose and the four key questions are used. All participants explore and verbalise their expectations so it is important that they feel psychologically safe. A solution is generated by the team, which creates ownership of the change. Involving staff in decision-making and sharing values are important in creating a positive practice environment (Bryar et al, 2012). In the AAR process staff take responsibility and this facilitates self-efficacy which is important for job satisfaction, engagement and retention of staff (Whittaker et al, 2013) and for developing resilience (Rutter, 2012). The AAR process is also said to benefit patient care and the Trust by enhancing listening skills and communication and building resilience during stressful times (Walker et al, 2012).

Key points: performance feedback

- Feedback is important to improve understanding and review progress.
- Barriers to feedback may include a fear of upsetting the person, compromising their self-esteem and their relationships.
- Multisource (360-degree) feedback.
  - 360-degree feedback is a tool to help employees improve and focus on their development.
  - 360-degree feedback can identify a starting point for the development of new skills, measure progress as skills are worked on over time, and identify blind spots in behaviour.
  - 360-degree reviews will not change a person. However there is some evidence that facilitated feedback enhances successful behaviour change.
  - 360-degree reviews are for the benefit of the individual not the team or the organisation.
  - Acceptance of the feedback is influenced by perceptions of objectivity, credibility of the process, relevance of competencies being assessed and the way the feedback is delivered.
- After Action Review.
  - AAR can provide insight into performance, team work, leadership and culture.
  - AAR has been used predominantly in analysing specific events to increase awareness, generate understanding, facilitate behaviour change, learn and develop an action plan.
  - In the AAR process staff take responsibility and this facilitates self-efficacy that is important for job satisfaction, engagement and retention of staff.
Interagency / disciplinary groups

Opportunities for professional development, peer support and sharing values are important elements of positive practice environments (Bryar et al, 2012).

Resilient strategies can be developed through building positive professional relationships (Jackson et al, 2007) and positive learning experiences (McAllister and McKinnon, 2009). Coming together regularly in an interagency/disciplinary group can support the development of meaning, clarify roles and responsibilities, and contain the emotional impact of the work. Clarifying roles, responsibilities and accountabilities is important in a complex system such as children’s services (DH, 2013a). Inter-professional learning can facilitate integration and collaboration (CAIPE, 2012). Sharing experiences of vulnerability and resilience facilitates learning, emulating strengths and preventing pitfalls (McAllister & McKinnon, 2009). Acknowledging strengths promotes pride in professional practice. Through story-telling fresh insights are developed, creativity is enhanced and groups can respond more effectively to change (Allen et al, 2001). Developing integration improves the quality of services and enhances the experiences of staff (NHS Confederation, 2014).

Three models of interagency/multidisciplinary support were examined. These are work discussion groups, Schwartz Centre Rounds® and compassion circles.

Work discussion groups

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). An experienced-based learning approach is utilised. The group has approximately five members, is held in a stable setting and 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).

Through exploring the experience and reflecting on the implication of what has been seen and experienced in the group, participants develop their understanding of institutional and interpersonal dynamics and the possible emotional meaning of communications (Tavistock and Portman, 2015). An understanding is developed of unconscious emotional reactions or psychological defences, which may be preventing them from noticing painful feelings in themselves or others. The process of ‘containment’ is a key component (Bion, 1962). Menzies Lyth (1960) described how nurses used detachment in managing anxiety and that a certain amount of this is healthy. However, the sustained use of defensive strategies can exacerbate stress and increase the risk of burnout (Gray and Smith 2009). Work discussion groups provide a safe place where emotions and the use of defensive behaviours can be explored. The emotional labour of health visiting is not widely discussed in the literature, although the demands of supporting families experiencing distress, tragedy and suffering is a significant component of health visiting practice. Having the opportunity to enhance understanding of the use of defensive strategies could prevent sustained use of these behaviours which may contribute to burnout.

Jackson (2008) describes the use of work discussion groups in educational settings which enabled teachers to manage the challenges of their work, their role and their relationship with the students. This resulted in a learning environment in which personal, professional and whole school development was enabled. Work discussion groups can be applied in different settings, but there are some considerations to bear in mind. For example, participants need to acknowledge and be sensitive to unconscious processes, and understand that the work discussion is about exploring their personal experiences and relationships. A clear differentiation between the work discussion group and supervision or psychotherapy needs to be made. Jackson (2008) describes the importance of the facilitator clarifying their role and task when working in different settings. The facilitator does not provide solutions to problems, and this can lead to frustration if participants are expecting to find an immediate answer. In addition, participants
may be anxious about sharing their problems in front of colleagues or managers who might judge them. Jackson (2008) suggests that effective working relations can be established between participants when management hierarchies are not represented. The work discussion group is designed to enable a participant-observer to cope more effectively with their working setting and facilitate reflective practice (Rustin, 2008).

Schwartz Centre Rounds®

The Francis Report (2010) 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). A range of professions and specialities share their experiences and gain support from colleagues. Each round lasts for an hour and starts with a case presentation by the team who cared for a particular patient. They describe the impact that the case had 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 (Kings 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). A two-year evaluation commenced in May 2014 and is led by Professor Jill Maben. This national UK study aims to evaluate the effect of Schwartz Centre Rounds® on staff wellbeing at work, the relationships between staff and patients and the provision of compassionate care.

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. A host and facilitator work together to create a space for reflection (Frameworks for Change 2014). The host invites people to join the circle and the facilitator runs the group. The benefits are reported as providing time to reconnect with core values, to consider self-compassion and make plans for maintaining boundaries and personal wellbeing, and time to reflect on culture in the workplace. Compassion circles have been well-received by those who have participated in their implementation (Frameworks for Change 2014). Frameworks 4 Change is now actively seeking partners to research the benefits of compassion circles to staff wellbeing, team working and patient experience. They have just started a project called Sustaining Compassion in High Pressure Environments with a Central London Community Trust which is drawing on the work of the Westminster Centre for Resilience.

Key points: interagency groups

- Interagency/disciplinary groups can support the development of meaning, clarify roles and responsibilities, and contain the emotional impact of the work.
- By using work discussion groups, exploring experience and reflecting on the implication of what has been seen and experienced in the group, participants develop their understanding of institutional and interpersonal dynamics and the possible emotional meaning of communications.
- Schwartz Centre Rounds® are multidisciplinary forums where health professionals meet monthly to reflect and acknowledge work-related psychological, emotional and social challenges.
- Compassion circles are offered to people connected through health and social care and are designed to offer a safe place for facilitated reflective dialogue for groups of up to 12 people.
Peer support

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; McCann et al, 2013; Hunter and Warren, 2014).

It has been described as ‘a voluntary, non-evaluative and mutually beneficial partnership between two practitioners of similar experience who have participated in training and who wish to incorporate new knowledge and skills into practice’ (Waddell and Dunn, 2005, p. 84). Alternatively, Dennis (2003, p. 323) defines peer support as ‘the giving of assistance and encouragement by an individual considered equal’ while recognising that this may be over-simplistic. Peer support relies on a trusting relationship with another individual, allows for the setting of performance goals, and involves observation and reflection (Brooks and Moriarty, 2009). During times of need, individuals turn to social relationships for support in response to barriers or deficiencies encountered in the healthcare system. In this context, the enhancement of supportive relationships and strengthening social relationships for health promotion is important (Stewart and Tilden, 1995; World Health Organization, 1998). In the patient environment, peer support has been recognised as having a positive impact on the health outcomes (Lakey and Cohen, 2000). Peer support has also become significant in the delivery of quality healthcare (Cox, 1993; Eng and Young, 1992). As such, it is important that the health visiting profession has a clear understanding of this concept. However, delivering peer support is complex and its application can be vague and variable, although its benefits continue to be sought (Dennis, 2003).

Peer support is often seen as a key element in the delivery of quality patient care but its application is complex and variable, although highly beneficial (Dennis, 2003; Lloyd Jones, 2005). The concept of peer support has been used extensively in teacher and medical education, as well as with health educators (Gingiss, 1993; Lam et al, 2002; Sekerka and Chao, 2003). However, in healthcare the application of peer support has been limited, and only a few studies discuss the benefits and difficulties (Cheate, 2001; Aston and Molassiotis, 2003). The concept was initially introduced into teacher education and developed to aid the transfer of new skills from the classroom into the workplace (Joyce and Shower, 1982).

Peer support can be delivered in many ways, for example individual one-to-one sessions; self-help/support groups; online computer-mediated groups; and educational environments. Such support can take place in a wide range of environments (e.g. home, hospitals and clinics), and can be provided in many ways (e.g. professional programmes, volunteer organisations). Peer support can be provided by educators, advocates, leaders and counsellors and can be delivered as a primary intervention or part of a comprehensive programme. Dennis (2003) identified three attributes which appear regularly in peer interventions and which support peer relationships: emotional, informational, and appraisal.

Emotional support is needed when individuals encounter situations that damage self-esteem and create doubts about ability and performance (Wills, 1985). Having someone available to discuss personal difficulties helps to counteract the effects of such threats. Such emotional support (Wills and Shinar, 2000) can include caring, encouragement, listening, reflection and reassurance, while avoiding criticism or advice-giving (Helgenson and Gottlieb, 2000). This interaction helps to foster, for example, the experience of feeling accepted or being cared for despite having personal difficulties (Cobb, 1976; House, 1981). Informational support might be sought to resolve problems and can include advice, suggestions, facts and feedback (Wills, 1985; Burleson et al., 1994). Informational support provides knowledge to the individual to solve problems and includes: relevant resources; independent assessments regarding the problem; alternative courses of action; and guidance about effectiveness (Wills and Shinar, 2000). Appraisal or affirmational support affirms the appropriateness of the individual’s emotion and behaviour (House, 1981). Specific approaches include encouragement, reassurance, assistance and communication of optimism (Wills, 1985). Together, these help generate positive future expectations.

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 known as direct, buffering, and mediating effects (Cohen et al., 2000; Helgesson and Gottlieb, 2000). The direct effect suggests that peer support directly influences health outcomes through mechanisms such as social integration. Incorporation into peer relationships can enhance social integration, which may reduce feelings of isolation, a condition associated with increased negative affect and sense of alienation and diminished feelings of control and self-esteem (Cohen et al., 2000). The buffering effect model of peer support either protects individuals from potentially harmful influences of stressful events or determines individual responses to potentially stressful events (Cohen et al., 2000; Cohen and Syme, 1985). The mediating effect of peer support intervenes indirectly to influence health through emotions, cognitions, and behaviours (Stewart and Tilden, 1995).

Peer support in practice

Peer support is a model that has been adopted within a range of health-related professions. For example, it is included as a component in the national induction and preceptorship frameworks for health visiting (iHV, 2015). The Health Visitor Implementation Plan outlines a career path for newly-qualified health visitors that begins with a period of preceptorship and consolidation and results in specialisation after two years. Newly qualified practitioners are able to access preceptorship programmes which include peer support opportunities to discuss caseload concerns with health visitors who are in a similar situation (Morris-Day, 2014). Hudson, Hart & Dodds (2014) highlight the role of the preceptor in building professional resilience and the need for preparation and support for preceptors.

The Royal United Hospital, Bath, developed a preceptorship pathway to support a high number of newly-registered nurses as soon as they took up their roles. This workplace preceptorship programme included peer support, and evaluation indicated that the pathway provides a high standard of support (Chapman, 2013). Rotherham Doncaster and South Humber NHS Foundation Trust’s children and young people’s mental health service employ peer support workers, who have been recognised as bringing benefits to the organisation (Oldknow et al, 2014). Sawbridge and Hewison (2011) describe how peer support in an ambulance service provided an informal opportunity to debrief. When the service was reorganised this informal support was lost and there was a subsequent increase in staff feeling stressed and an increase in their sickness levels. They highlight the fact that such models of support are not as visible or well understood. This is an important consideration with the increase in mobile working in health visiting and the potential reduction in accessing peer support.

The recognition that teams in healthcare organisations are crucial to their success (West 2013) has informed a programme of work focused on harnessing the potential of the nursing team to provide staff support. An analysis of the factors contributing to the well-publicised ‘failures’ in care including those itemised in the Health Service Ombudsman’s report (Abraham 2011), events at Maidstone and Tunbridge Wells (Healthcare Commission 2007), and Mid-Staffordshire NHS Foundation Trust (Francis, 2010 [and later 2013]) found that attention to the needs of staff, if they were to provide compassionate care, had been largely overlooked (Sawbridge and Hewison, 2011). There was no acknowledgement of the emotional component of nursing work and the impact this could have on the provision of compassionate care (Hewison and Sawbridge 2014, Sawbridge and Hewison, 2013). In view of this, an action research study was undertaken to explore the feasibility of using a model developed by the Samaritans organisation with ward teams in three NHS acute Trusts in England (Sawbridge et al 2014). Although it was not possible to implement the model, a number of key lessons were learned which have informed subsequent work. Identification of the issue (Hewison and Sawbridge 2012; Sawbridge and Hewison, 2012) has led to interest in, and support for further work in this area. Currently a ‘co-production’ approach (Hewison et al, 2012) is being taken in a project with an acute and a community trust to enable ward teams to develop ‘self-managed’ approaches to staff support, and to evaluate the impact of leadership development on the delivery of compassionate care. A further study to examine these issues in mental health care settings is in the process of being commissioned.

Hamrin et al (2006) evaluated peer-led support groups in the nursing education environment. Anxiety in this environment is well documented with stress greater during the initial period of clinical practice (Admi, 1997; Beck & Srivastava, 1991; Kleehammer et al, 1990; Pagana, 1998; Jones, and Johnston, 1997; Martyn, 1997). Kless (1989) suggested that enduring stress in nursing education can impede students’ success, resulting in attrition. Methods used to reduce nursing students’ perceived stress during their education include supervision and team meetings, advice seeking, and discussion of problems with supportive colleagues (Leary et al, 1995). Becker and Neuwirth (2002) evaluated peer social support by asking senior nursing students to act as teaching assistants to augment clinical experiences for
junior students. Reported benefits of this intervention included a decrease in junior students’ anxiety, an appreciation of the availability of additional role models, and an increase in collegiality among students. Such peer support groups were used to mitigate occupational stress in healthcare workers in Sweden. Staff assessed as being at risk met in weekly group sessions to reflect on work stress and provide peer support. (Peterson et al, 2008) Gillard et al (2014) considered peer worker roles in mental health services. They found that there were specific mechanisms that would benefit peer workers, these were: (i) building trusting relationships based on shared lived experience; (ii) role-modelling individual recovery and living well with mental health problems; and (iii) engaging service users with mental health services and the community.

Informal support

In a recent iHV online survey, health visitors were asked ‘How do you get support with pressure and stress at work?’ The frequently reported source was ‘informal support from colleagues sharing an office’ (n=1002, 85%). This underlines that regardless of any formal support measures, peer support is well established within the professional culture of health visiting. Indeed, ‘formal/ scheduled peer support’ was the least-frequently cited source of support at 14%. This may reflect little more than that formal / scheduled peer support is not routinely available, while a key advantage of informal support is its accessibility in the workplace, which suggests the impact upon staff experience of work environments and routines needs to take into account any unintended, adverse impact upon peer support. Rather, the ‘team around the health visitor’ should be positively valued and recognised.

Adverse outcomes

While peer support has numerous favourable consequences, less attention has been paid to potential adverse outcomes. Negative results 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). 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 professional services (Giblin, 1989).

Key points: peer support

- Peer support relies on a trusting relationship with another individual, allows for the setting of performance goals, and involves observation and reflection.
- It is often seen as a key element in the delivery of quality patient care but its application is complex and variable, although highly beneficial.
- There is evidence to suggest that peer support positively affects psychological and physical health outcomes in several ways known as direct, buffering, and mediating effects.
- Specific mechanisms can benefit peer workers: (i) building trusting relationships based on shared lived experience; (ii) role-modelling individual recovery and living well with mental health problems; and (iii) engaging service users with mental health services and the community.
- There can be negative results including conflict, criticism, failed social attempts, emotional over-involvement, reinforcement of poor behaviour and diminished feelings of self-efficacy.
- Preparation and support for preceptors is an important consideration.
- ‘Informal support from colleagues sharing an office’ is widely valued in health visitor professional culture and should be recognised and positively cultivated.
Supporting Health Visitors and Fostering Resilience Literature Review

Potential outcomes of implementing models of support

Providing support to health visitors, using a range of the models described, has the potential to foster their resilience and compassion. The concepts of resilience, compassion and compassionate resilience are examined below.

Resilience

The concept of resilience is complex and interlinks with the concept 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. Context and process are important considerations (Cowley 2008). The context of health visiting practice can contribute to an increased risk of adversity and therefore it is important to understand what contributes to health visitors’ resilience. Cultural norms are an important consideration as they influence how vulnerability is expressed, which responses are regarded as effective, and which 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. 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).

The iHV practitioner survey (2014) found that 89% of health visitor respondents thought that learning how to personally develop resilience was important. However only 12% agreed strongly that they were currently able to achieve this, whilst 50% reported not having enough time to reflect and develop self-awareness. Thus individual motivation was constrained by practical time constraints highlighting the importance of considering how the system is contributing to this.
Definition of resilience

Resilience is a dynamic, developmental process that involves an interaction between individual and environmental factors (McCann et al 2013, Cicchetti, 2010, Rutter 2012).

It is a complex and evolving concept with varied interpretations, some of which are at odds with deeper understanding of the concept, derived through research. Resilience is described as an ability to overcome difficulties and bounce back from adversity, or a process of adaptation to adversity (McAllister and McKinnon, 2009). Rutter (2012) describes resilience as a process, which is supported by Hunter and Warren (2014). He suggests that it is built through the development of self-efficacy following successful coping with repeated brief stress experiences. Resilience is not just a reactive process, and a preventative approach can be utilised. Potentially stressful events can be identified, planned for and practised (McCann et al, 2013).

Hart and Gagnon (2015) describe the lack of consensus in defining resilience and highlight that the only common factor in all definitions is the idea of adversity. They define resilience as overcoming adversity whilst potentially changing or significantly transforming aspects of that adversity. This is supported by Wendt et al (2011) who describe how social workers and teachers have thrived in demanding work contexts. Hart and Gagnon (2015) argue that there is a highly individualised notion of resilience prominent in policy, and the wider political and economic context in which the concept of resilience, and resilience research and practice, sits should be considered. Thus a strategic, ecological approach, which takes into account interactions between the person and their environment, is recommended, a premise supported by Adamson et al (2012) and Hudson et al (2014). This includes uniting resilience and practice development with a social justice approach to address health inequalities (Hart and Gagnon, 2015). Such an approach is congruent with the goals and principles of health visiting including reducing health inequalities and influencing policy. The DH (2009) suggests that, by investing in the emotional resilience of staff, employers play a role in tackling health inequalities. An ecological definition of resilience therefore incorporates individual, societal and environmental interaction and the capacities of individuals to change structures through emancipatory actions.

Professional resilience

An important factor in fostering professional resilience is exploring the personal and professional values of practitioners (Wendt et al 2011). Recruiting staff with values that are aligned with those of the role and the organisation warrants consideration. Such values-based recruitment processes are now used by many employers. Skills for Care (2014) has developed guidance to support values-based recruitment, and values related to the NHS Constitution are being embedded in NHS recruitment processes (NHS Employers, 2014b). Values-based recruitment is reported to contribute to creating positive work environments and to staff feeling more valued (NHS Employers 2014b).

There is a limited but growing body of research on professional resilience. In a review of the literature across five professional groups (nurses, social workers, counsellors, doctors and psychologists) professional resilience is defined as “the ability to maintain personal and professional wellbeing in the face of ongoing work stress and adversity” (McCann et al 2013, p61). Work/life balance was identified as a consistent influencing factor across all professional groups. Other factors included beliefs and self-reflection, insight gained through peer support and supervision and professional identity. Contextual factors were predominantly relational including work colleagues, mentors and role models and client connectedness. The limitations in comparing studies using different professional groups, definitions and measurements of resilience are recognised.

Adamson et al (2012) propose an ecological approach to professional resilience, which considers the interplay between self, the practice domain and the space in between (i.e. mediating factors such as supervision and peer support). Hudson et al (2014) support this model and highlight the importance of examining the “space in between” and the need to grow professional resilience through addressing common adversities. These include workplace incivility and bullying, role strain, workload and lack of time. Newly-qualified and inexperienced
practitioners have been identified as particularly vulnerable. Thus it is important to prepare and support preceptees and consider supportive models that may alleviate organisational constraints.

**Education and training to build resilience**

The government strategy for mental health (DH, 2011) highlights the importance of individuals and employers recognising and building resilience. The public health responsibility deal (DH 2011) pledges to provide all staff with the environment, knowledge and tools to maintain and develop wellbeing and resilience. NHS Employers has developed a strategy to address this pledge (NHS Employers 2014). Boorman (2009) concluded improving staff health is an enabler to high quality care, patient satisfaction and improved efficiency. This has been supported by Maben et al (2012) who found that where staff are supported there are higher levels of job satisfaction and patients’ rating of their care. Hart and Gagnon (2015) suggest that developing resilience can involve building individual and environmental assets or changing the restrictions to both. They question how much social adversity should be tolerated before social arguments should be made rather than targeting individuals for interventions. They suggest knowledge of oppression and addressing inequalities should be included in understanding adversity and resilience. Considering how practice spreads in organisations and co-producing knowledge with researchers and practitioners and clients to enhance understanding of resilience is recommended. Creating communities of practice could potentially offer the medium to facilitate this process.

Resilience is influenced by the interaction between individual and environmental factors (McCann et al, 2013). Individual factors include personality, gender, attachment style, stress, coping skills, emotional regulation, professional experience and knowledge, as well as personal histories and life story. Individuals who are able to develop secure attachment styles are more able to access support in times of need and to show support for others (Dutton et al, 2014). Vulnerable groups include newly-qualified and inexperienced practitioners, those in poor health or those whose roles cross different work environments (Hudson et al, 2014).

Environmental factors include culture, area, team working, supervision and resources. The perceived level of “bad events” and perceived social support or a sense of connectedness is most influential (Tusaie and Dyer, 2004). Whittaker et al (2013) highlight how the perceptions and beliefs that employees and employers hold about each other (the psychological contract) can be influential. Feeling valued was particularly important. When this informal and unwritten contract is perceived to be breached, it can influence motivation and engagement (Maben, 2008).Thus employers need to be proactive in understanding these expectations. Clear roles and responsibilities are important particularly in the light of inter-professional working and the future transfer of commissioning of health visiting services to the local authorities. Transparent processes, which engage employees in decision-making and are responsive, adopting supportive management styles and creating learning opportunities, are important considerations (Whittaker et al, 2013). These factors have also been identified as important features of a positive practice environment (Bryar et al, 2012).

As a result of the interaction between individual, environmental and contextual factors, resilience is not fixed. Adopting a preventative approach in developing resilience promoting environments is recommended (McCann et al 2013). Rutter (2012) suggests that protective factors may be built through successful coping with adverse experiences. Exposure to stresses may increase vulnerability through a sensitisation effect or decrease vulnerability through a steeling effect. What seems to be influential in building resilience is success leading to self-efficacy, rather than overcoming minor stresses. Hunter and Warren (2014) support the importance of self-efficacy and active coping techniques in developing resilience. There is a correlation between parental overprotection, which leads to a lack of successful accomplishments and emotional regulation, and lower psychosocial resilience (Tusaie and Dyer 2004). Exposure to brief periods of stress increases resistance to later stress (Rutter 2012), such that there is a steeling effect of successfully coping with challenges. Lindley (2013) supports this highlighting the importance of an open supportive relationship in facilitating this process. The availability of supportive relationships is recognised as increasing resilience (DH 2009, NHS Employers 2014).

In addition to addressing the environmental and contextual issues, intervention can also be offered at an individual level. Jackson et al (2007) propose five strategies for developing professional resilience including:

1. Maintaining life balance and spirituality
2. Understanding personal strengths and vulnerabilities
3. Using reflection to assist in meaning making
4. BUILDING POSITIVE PROFESSIONAL RELATIONSHIPS
5. Maintaining positivity
These components are common to many resilience-building programmes, as well as noticing and changing negative automatic thoughts, mindfulness, and developing an understanding of values and beliefs and resilient thinking (McDonald et al., 2012, Chade-Meng Tang, 2012, Riley and Gibbs, 2013, NHS Elect, 2014; Action for Happiness, 2014, Wickremasinghe, 2014). Resilience thinking is closely related to Cognitive Behavioural Therapy (CBT), namely the fact that it is not an adversity itself that triggers our emotional response and subsequent actions; it is our beliefs and interpretations about the adversity. For example, we say things like “she made me so angry” but in fact it was our beliefs about/interpretation of her behaviour which led us to become angry. One approach to learning to be resilient is the A-B-C model (Ellis and Dryden, 2007) of resilient thinking (where “A” is the adversity, “B” is our beliefs and “C” is the consequences - e.g. how we feel and act). A doesn’t simply lead to C, there is always a B in between and our Bs are often based on unhelpful or inaccurate thoughts. It is important to learn how to look out for unhelpful “thinking traps” (e.g. mind-reading, blaming others, blaming self, believing it is permanent etc.) - these are vital life skills that can be taught.

Through sharing experiences of resilience and vulnerability, health professionals can learn from one another and facilitate prevention of future adversity (Jackson et al., 2007). This is supported by McAllister and McKinnon (2009) who recommend that education and training programmes should include three components. These are:

1. Including discussion of resilience within undergraduate education – covering issues such as identity building, coping and strengths development, learning leadership for change.

2. Including discussion of resilience within practice contexts - opportunities to reflect, practise and learn from one another, positive role models, sharing coping strategies.

3. Professional culture generativity. This can be facilitated through dialogue where resilient practitioners share stories and lessons from their experience through seminars and publications, and using creative media such as art and film.

In describing a resilience undergraduate education programme, Lindley (2013) outlines how surprised health visiting students are by what they see in practice and how difficult they find this emotionally. There is a difference between their expectations and the reality of their experience. In order to be resilient the individual needs the capacity to contain and tolerate negative emotion. This enables them to think about it (mentalise) and if it is too much to manage alone then to share with compassionate others (who provide a secure base). When an individual feels an excessive demand to carry negative emotion alone, she may become detached from her feelings and work perfunctorily or become depressed, anxious or ill (Menzies-Lyth, 1960). Practitioners may retreat into the safety of routines and tasks to escape the emotional distress of clinical practice. Experiencing the anxiety can provide an opportunity for growth if the anxiety is contained.

Resilience is not just about survival, it is about learning and finding healthy ways to cope and even thrive (Wendt et al., 2011). Resilience fluctuates across time, developmental stage and context (Tusaie and Dyer, 2004). It is a continuous process incorporating a recognition and acceptance of challenges, identifying our reactions to challenging situations and having strategies to stay in control and enjoy life. Dobbin (2014) suggests that by learning about resilience and developing the skills to relieve their own stress, practitioners can integrate these skills into their clinical practice, thereby facilitating the development of these skills in clients.

Characteristics of resilient individuals

Most research on resilience has focused on examining children in adverse circumstances. Protective factors which facilitate resilience have included social connection with family and other adults including peers, positive role modelling, discreet monitoring of wellbeing and coaching to facilitate goal setting and elevate expectations (McAllister and McKinnon, 2009). The limitations in applying findings from research with children to adult populations are acknowledged. The characteristics of resilient adults include an internal locus of control, prosocial behaviour, empathy, positive self-image and optimism. These enable them to build supportive relationships and adapt to change (Friborg et al., 2003). Factors that have influenced the ability to cope with stress have been identified. These are meaningfulness (the stressor makes sense and thus coping is desirable), manageability (identifying and searching out the resources needed to meet the demands of the situation), and comprehensibility – the view that the world is understandable and meaningful (McAllister and McKinnon, 2009).

Research on resilience has focused on learning not just from people who survived following extreme adversity...
but those that thrived i.e. post traumatic growth (Linley and Joseph, 2004). An example is the holocaust survivor Victor Frankl (Frankl, 2006). Wendt et al (2011) have explored how social workers and teachers have thrived in demanding work contexts. They identified the importance of self-awareness in balancing personal and professional lives. Personal values, beliefs and life experiences including the desire to make a difference and seeing the day-to-day work as being connected to a bigger cause, having and being a role model and enjoying the challenge were also influential. They recommend that insights into these personal domains should be included in education strategies. They suggest that more research is needed to understand these personal domains and how they interact with professional factors including professional identity, context and work culture.

Managing stress and building health visitors’ resilience is a complex issue which requires an in-depth understanding of the cultures within which it operates, combined with preventative, strengths-based approaches to working with organisations, groups, teams and individuals. Developing compassionate cultures is an important factor to consider in this process.

**Key points: resilience**

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

The Francis Report (2013) highlighted a lack of transparency and a culture of intimidation within the NHS and led to the governmental drive to create a culture of compassion.

However, competition between services and targets are continuing to create challenges in enabling this process. The Department of Health (DH, 2012) emphasised the importance of addressing the burden of bureaucracy; however the largest ever study of NHS culture has found that quality of care is often compromised by too much regulation, excessive box ticking and highly variable staff support (Dixon-Woods et al, 2013). They recommend developing person-centred rather than task-centred cultures, which is in line with the components of a positive practice environment suggested by Bryar et al (2012). They argue that there are strong links between staff experience and patient mortality rates. This is also echoed by Maben et al (2012) and emphasised in the NHS Constitution (DH, 2013).

Compassion enhances staff satisfaction and engagement and contributes to the performance of organisations (Karamally, 2013). Frost et al (2005) argue that although compassion contributes to the financial success and performance of organisations, adopting compassionate practices for strategic means can weaken the integrity of such practices. DeZulueta (2014) argues that external rewards may reduce intrinsic motivation and make people less altruistic. The DH (2012) outlines the importance of creating a compassionate organisational culture where the emotional impact of caregiving is recognised and staff feel valued and cared for. The implementation plan for this vision includes supporting positive staff experiences and developing a cultural barometer to enable staff to reflect on their organisational culture.

Compassion can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity (Cosley et al, 2010). It can also prevent empathic distress, strengthen resilience and prevent burnout (Klimecki et al 2013). Both self-compassion and compassion are associated with improved emotional resilience (Neff, 2011). Compassion is an essential health professional attribute identified in the NHS Constitution (DH, 2013) and is one of six key nursing values, the ‘6Cs’ (DH 2012), which also apply in health visiting (NHS England 2014). It is defined as “a sensitivity to the suffering of self and others, with a deep commitment to relieve it” (Dalai Lama 1995). It involves an engagement with suffering, and action to prevent or alleviate suffering (Gilbert 2010). Compassion is described as “intelligent kindness” and is central to how people perceive their care (DH 2012), and involves searching for things we can do and not waiting to be asked (DH 2013). This requires that we notice the person is suffering and have the time to care. Lack of time to build relationships has been identified in the iHV survey (2014) as a concern for health visitors which may signify that they are prevented from being able to show compassion. Gilbert (2010) outlines six core attributes of compassion: attentional sensitivity, motivation, empathy, sympathy, distress tolerance and non-judgemental positive regard. Chambers and Ryder (2009) describe the importance of dignity and respect in providing compassionate care. These are supported by the Department of Health (DH, 2012) and are described as core values in the NHS Constitution (DH 2013).

Compassion involves a dynamic interpersonal process, which unfolds at three levels: personal, relational and organisational (Dutton et al, 2014). The ability to contain emotional distress is a key attribute of compassion (Gilbert, 2010) and develops in the context of a trusting relationship. Lindley (2013) identified openness as a factor that built a safe place for reflection and promoted resilience. This included individual openness to participate in reflective practice, team openness and team leaders’ openness to see what was happening and respond sensitively. This, in turn, enables people to express their vulnerability. Brown (2012) describes how it is the capacity to face, name and share these negative emotions, which makes it possible to work with them. It is natural to want to keep things positive, but this is best achieved after negatives have been accepted as inevitable, faced and named. Ohholzer and Roberts (1994) describe helpful examples of working with individual and institutional suffering in The Unconscious at Work. Compassion involves an acceptance that life brings suffering and, by turning towards this suffering, it is hoped that developing positive coping strategies will build resilience.

White (2013) recommends that organisations invest in meeting employees’ core needs so they are motivated to bring more of themselves to work, which in turn contributes to sustainability. This is supported by Maslow’s (1971) hierarchy of needs and attachment.
theory (Bowlby, 1988). Once a secure base is established by responding compassionately to the individual’s needs then they are more able to explore, learn and develop. Dutton et al (2014) support the importance of meeting core needs, saying a sense of being valued is created through the interactions that people experience at work. Feeling valued was identified by Whittaker et al (2013) as influencing engagement and retention of health visitors. Compassion from others is important in preventing or reducing compassion fatigue (Dutton et al, 2014). Compassion fatigue may arise when people are unable to do what they consider is the right thing. Forty-five percent of health visitors in the iHV survey (2014) expressed concern that they could not deliver the care they aspired to, and 45% said stress was affecting their health. These figures suggest that there are a large number of health visitors at risk of compassion fatigue.

White (2013) suggests that the creation of resilient cultures starts with leaders who foster resilience at the individual and organisational level. However, Karamally (2013) argues that everyone has a responsibility for creating culture. Compassionate leadership is a skill and a way of being which can be developed. Undertaking compassionate mind training can enhance the ability to respond compassionately (Gilbert, 2010). This develops the capacity for self-compassion and for understanding how to support people through difficult situations by understanding the pressures people experience and how this activates their threat system, how people respond when they feel threatened and how to support people to develop more productive ways to solve problems (Gilbert, 2010).

Edinburgh Napier University and NHS Lothian’s (2012) Leadership in Compassionate Care project involved embedding the principles of compassionate care in the educational curriculum, supporting newly-qualified nurses, facilitating the development of leadership skills and identifying beacon wards as centres of excellence in compassionate care. They found integrating compassionate activities with other organisational processes and quality initiatives was important.

Organisations can develop shared values through sharing stories about compassionate events or through formal polices such as the Chief Executive (CE) being informed in the event of a significant employee event. Frost et al (2005) also suggested that narratives capture the lived experience, and how people feel about the organisation creates a collective experience and organisational identity. They describe how the caring response of the CE of Reuters after the 9/11/2001 crisis was told and retold, creating a shared recognition of the value placed by the organisation on its employees. Greenhalgh (2013) supports the use of narratives in creating a compassionate culture, saying that a compassionate organisation facilitates narrative practices, contextualises challenges and develops future-orientated stories. In this way a compassionate ethic becomes institutionalised and resilience enhanced. She argues that, rather than tightening procedures, the solutions to a lack of organisational compassion centres on interpersonal relationships and developing collective narratives.

Atkins and Parker (2012) argue that organisational efforts are ineffective if individuals do not have the capacity or motivation to engage in compassion. For example, developing managers’ emotional regulation abilities enhances coping self-efficacy rather than emotional distress in the face of suffering, facilitating a compassionate response. Modelling compassion by managers and leaders can create the contexts where people can express their values and learn to be more compassionate. They recommend providing individual training programmes incorporating these two components in order to increase organisational compassion.

**Key points:** compassion

- Compassion enhances staff satisfaction and engagement and contributes to the performance of organisations.
- Compassion can increase the ability to receive social support, which may result in more adaptive profiles of stress reactivity.
- Compassion involves a dynamic interpersonal process which unfolds at three levels: personal, relational and organisational.
- Organisations need to invest in meeting employees’ core needs so they are motivated to bring more of themselves to work.
- The creation of resilient cultures starts with leaders who foster resilience at the individual and organisational level.
Indeed many would argue that all three are so closely interlinked it would be impossible to separate them. Neff (2011) would suggest replacing the term self-esteem with self-compassion. Self-compassion involves a comparison between the self and other which can be perceived to have a competitive thread, whereas self-compassion is acknowledging people’s common humanity. Self-compassion involves turning towards suffering and taking action to alleviate it. It is a multidimensional concept that includes self-kindness (to treat oneself with care rather than harsh self-judgement), common humanity (recognition that imperfection is a shared aspect of human experience), and mindfulness (holding one’s experience in a balanced perspective) (Neff 2011).

Self-compassion fosters connectedness rather than separation or self-centeredness, and is a skill that can be taught (Neff and Germer, 2013). When teaching self-compassion it is important to consider that for some people self-compassion can feel very threatening and they may be fearful of it (Gilbert et al, 2011). Germer (2009) suggests the self-compassion process occurs in stages where there is a progressive softening of resistance. From an initial aversion, comes curiosity about the problem, then tolerance develops and feelings are allowed to come and go until finally suffering is embraced, seeing its hidden value. Wickramasinghe (2014) likens the process of self-compassion to one of grief with the person going through stages similar to those described by Elizabeth Kubler Ross (1969) i.e. denial, anger, bargaining, depression and acceptance. Thus people need to be aware of this painful process and the possibility of defensive behaviours. Taking time to develop a trusting relationship and proceeding at the person’s pace is important. There is a growing body of research on self-compassion which links self-compassion and enhanced wellbeing (Neff and Germer 2013), motivation (Persinger, 2012), personal accountability and coping (Neff and Lamb, 2009) and resilience.

Condon et al (2013) suggest that enhancing self-compassion develops our ability to be compassionate. They found that practising compassion and mindfulness exercises resulted in people being five times more likely to have a helpful response to suffering. These results are based on a small sample size and further research is needed before they can be generalised. Epstein and Krasner (2013) suggest developing self-awareness and looking after ourselves improves the quality of care; which means that practitioners are less likely to commit errors or leave practice, all of which are costly to the NHS.

**Key points: self compassion**

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

Synthesising the literature on support, resilience and compassion led to development of the compassionate resilience concept.
On reviewing the literature, it became evident that, by adding self-compassion as a route to resilience, to more mainstream approaches, we could help build a sustainable workforce, which will have the capacity to remain not only resilient but compassionate and nurturing, to both themselves and others. After integrating and synthesising the evidence, we have developed the compassionate resilience concept. De Zulueta (2014, p 2) describes compassionate resilience as incorporating two components:
1. Self-compassion, as a key to resilience
2. Learning how to maintain resilience in order to sustain compassion, even in challenging situations.

Thus, compassionate resilience is the ability to respond compassionately to adversity, using effective coping strategies. Responding compassionately can be challenging, particularly if we feel threatened or dislike the source of this adversity. Developing an understanding of the neurobiology of emotions and how we relieve our distress is an important component in learning how to respond compassionately and remain resilient in these circumstances. Learning how to maintain compassionate resilience is a dynamic, continuous process incorporating a recognition and acceptance of challenges, identifying our reactions to challenging situations and having compassionate strategies to stay in control and enjoy life. A supportive, nurturing environment is crucial for developing compassionate resilience (De Zulueta 2014). Thus, in developing this concept we suggest adding a third component, to DeZulueta’s proposed two components, which is compassionate cultures, including compassionate leaders.

We have also developed DeZulueta’s definition of compassionate resilience in considering the learning component. Compassion can be cultivated with training (Weng et al, 2013) as can self-compassion (Neff & Germer 2012). There is a growing body of research on the science of compassion, its link to early attachment experiences and the difficulties people have in experiencing it (Irons, 2013). Gilbert et al (2011) describe fear of compassion to self, from others and to others. Practitioners may find it difficult to engage in activities that improve their self-compassion as they may have difficulty responding to their own needs (Epstein and Krasner, 2013). Adamson et al (2012) highlight the importance of lifelong learning to support resilience.

On reviewing the literature and a variety of resilience education and training programmes (e.g. McDonald et al (2012), Chade-Meng Tang (2012), Riley and Gibbs (2013), NHS Elect (2014), Action for Happiness (2014), Wickramasinghe (2014), we identified six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances. These include enhancing self-awareness, being in the now, developing acceptance, expressing vulnerability, building supportive relationships, and fostering hope.

Enhancing self-awareness

Understanding our emotional tendencies and recognising early warning signs can prevent us from getting caught up in stressful responses. Recognising that it is not an adversity itself that triggers our emotional response and subsequent actions; it is our own...
beliefs and interpretations about the adversity that is important. Looking out for unhelpful “thinking traps” (e.g. mind-reading, blaming others, blaming self, believing it is permanent) is valuable. Considering whether our core psychological needs for competence (to feel effective), autonomy (to feel in control) and relatedness (to feel connected to others) are being met is also important (Ryan and Deci, 2000).

The compassionate mind model offers insight into how our complex brain functions and how our environment shapes it. It offers an easily understood explanation (the three circles model – Gilbert, 2010) of the brain’s complicated emotional systems. Understanding the three key emotion systems in the brain, i.e. the threat and self-protection system, motivation and achieving system, and soothing and relaxing system, can develop self-regulation. This requires us to pay attention, notice our emotional, cognitive and behavioural responses. Learning how to shift attention and balance our emotional systems can contribute to more effective coping with stress. It also enables us to understand how fear can activate our threat system and have dehumanising consequences. Being aware of this potential within all human beings enables us to respond compassionately. McGonigal (2013) suggests it is not the event that is stressful but what we tell ourselves about the event.

Self-awareness of somatic, emotional and cognitive experience of stress can be developed through mindfulness and informal practices. These could include developing the habit of pausing and breathing before seeing the next client. Using reflective questions such as “what am I assuming about this situation that might not be true? In what ways are prior experiences influencing me? What might a trusted peer say about the way I managed this?” The use of work discussion groups can build self-efficacy as individuals become aware of emotional reactions, biases and countertransference that might influence (Epstein and Krasner, 2013). Hunter and Warren (2014) support the importance of self-efficacy and active coping techniques in developing resilience. Self-awareness can also include developing an understanding of strengths. Effective feedback can be used to build people’s strengths.

**Being in the now**

Being present in the moment is challenging as the human brain is designed to look out for threats, and so we spend a lot of time thinking about the past and worrying about the future. Compared to animals we have the capacity to ruminate, plan, imagine and reflect (Sapolsky, 1994). Recognising and naming negative automatic thoughts and feelings can reduce our stress. These skills can be developed through mindfulness.

Mindfulness increases the likelihood of noticing our negative automatic thoughts and our suffering (Atkins and Parker, 2012). It can help to reduce personal distress as it lessens emotional reactivity and enables us to make sense of our experience (Dutton et al, 2014). We can shift our attention and train our brains to calm us down. There is a growing body of evidence for mindfulness programmes. NICE (2009) recommends Mindfulness Based Cognitive Therapy for preventing relapse in those with three or more previous episodes of depression. Holzel et al (2011) have demonstrated how mindfulness can change the structure of the brain. A mindfulness leadership course has been developed by the King’s Fund (King’s Fund, 2014). The benefits of mindfulness include physical and psychological stress reduction; positive changes in wellbeing; reduced likelihood of becoming stuck in depression and exhaustion; and better able to control addictive behaviour (Oxford Mindfulness Centre, 2014). Berry (2014) recommends mindfulness is taught to nurses, GPs and teachers. However, there are limitations to mindfulness which also warrant consideration. Evidence suggests mindfulness can lower mood and cause emotional distress (Rocha, 2014). Therefore, it is important that the potential risks are explained to clients and that educators are appropriately trained and competent to deliver mindfulness. An interesting radio documentary has debated whether mindfulness can simply be used on the individual level or whether it should be fused with a critique of the context when needed (BBC, 2014).
Developing acceptance

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

Expressing vulnerability

Life is unpredictable and one of the ways we deal with this is by numbing our vulnerability. Expressing vulnerability can facilitate growth and success (Brown, 2012). The ability to express vulnerability is a process that begins with an awareness of our vulnerability and proceeds to acceptance and expression. Expressing vulnerability in the context of a supportive relationship can develop the ability to tolerate emotional distress, name feelings and, recognise bodily reactions. This can facilitate growth and success (Brown, 2012). Individual differences warrant respect and enabling the person to proceed at their pace is important.

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

Building supportive relationships

Establishing supportive relationships that provide a sense of acceptance and support is a key factor in building resilience. A reliable network of trusted individuals can help you through difficult times. When life is difficult, your stress response releases oxytocin which motivates you to seek support (McGonigal, 2013). The American Psychological Association (2014) suggests that resilient-building relationships include:

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

Relationships develop through a series of interactions over time and in different contexts. The development of trusting relationships requires attunement and sensitive, timely and appropriate compassionate responses. Observation, listening and containment are key skills in building trusting relationships. Frost et al (2005) suggest open listening enables three aspects of compassion, i.e. noticing, feeling and responding. Time is necessary to build such relationships and has been raised as a concern by health visitors. With the increasing number of health visitors it is hoped that there will be more time to build supportive relationships. Chosing to connect with others under stress can build resilience (McGonigal, 2013). Building relationships and connections also gives purpose and meaning to our lives (Brown, 2012), which also contributes to building resilience.
Fostering hope

The capacity for hope has been identified as a contributory factor in resilience. Fraiberg et al (1975) demonstrated the importance of hope in breaking the intergenerational cycle of maltreatment. The psychiatrist Viktor Frankl found prisoners at Auschwitz who had hope and a sense of meaning and purpose lived longer (Frankl, 2006). Hope can be increased through the use of an ABCDE model, which stands for adversity, belief, consequences, disputation, and energisation (Ellis and Dryden, 2007). Adversity is examined by asking the question “what happened?” Beliefs are explored by reflecting on how you explain things to yourself. The consequences are considered and through disputation alternative interpretations are offered. Finally through energisation you explore how things could be better in relation to that problem in the future.

Hope can be enhanced through looking after our physical, mental, social and spiritual dimensions. This increases our capacity to handle the challenges that life brings. Gratitude can enhance our sense of hope and mental and physical health (Emmons and Stern, 2013). Developing the ability to be grateful may contribute to more effectively managing life demands (Konig and Gluck, 2013) and help to build supportive relationships (Algoe et al, 2013). We can cultivate gratitude by noticing positive events, or by keeping a gratitude journal. Writing supports the development of gratitude as it organises thoughts and facilitates integration and meaning (Konig & Gluck 2013).

Key points: compassionate resilience

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

- Six skills that will support practitioners in developing their ability to remain resilient and sustain compassion even in challenging circumstances have been identified: enhancing self-awareness, being in the now, developing acceptance, expressing vulnerability, building supportive relationships and fostering hope.
Towards a resilience framework

In this review, models and concepts relevant to support have been discussed, drawing upon a range of literature of variable character, quality and application.

Some are more directly related to the core concerns and context of health visiting as a profession and as a practice. Others are more reflective of broader contexts such as organisational learning. The heterogeneity of these models and concepts of support and the literature reviewed require caution in proposing a valid synthesis of these diverse elements. However, this review has not been conducted in isolation from current practice. Rather, a consultative approach has been adopted in a spirit of appreciative enquiry and being informed by live consultation with the health visiting profession. Arising from multiple conversations, surveys, workshops and an expert Task and Finish Group, a resilience framework for health visiting has been drawn together incorporating a menu of ten models of support with compassion at its centre. Health visitors’ professional values and principles are also key.

Figure 6 represents the menu of support for employers and individuals to consider in supporting health visitors and fostering resilience. Enabling the emotionality of practice to be expressed through the medium of art can be effective in providing opportunities for learning (Warne and McAndrew, 2008). Words cannot always capture the particular experiences of health visitors and a picture facilitates individual interpretation. Art is an effective medium in facilitating mental health (Mental Health Foundation, 2007), and enabling creativity fosters resilience. The dark night is representative of the stresses in health visiting, which can result in health visitors worrying night and day about vulnerable children and families. Health visitors may feel alone with their responsibilities and the picture also represents the fact that they are part of a system. The stars, the moon and the planets represent the key support components to foster resilience. Understanding the components of support available facilitates implementation of proactive, strengths-based compassionate strategies to foster resilience.

This framework is reflective of the diversity of what can be meant by ‘support’, without having established a bounded definition. What is clear is that there is a ‘parallel process’ evident between what support and resilience mean at the level of the practice of health visiting, engaging with children and families to promote their health and wellbeing, and at the level of practitioners and their professional effectiveness and resilience. Cutrona’s (2000) research on family support has articulated two broad forms of family support: ‘nurturant’ support that affirms the worth and strengths of families regardless of what specific stresses may impact upon them; and ‘instrumental’ support which is tailored to specific stresses or problems, for example in the form of practical help or advice. Cutrona (2000) recommends optimal matching between stress and social support. In situations that are controllable with readily available solutions, “instrumental” support is highly valued by families. However, when this is not the case instrumental support may be ignored as worthless or rejected as inappropriate, adding ‘insult to injury’. However, emotional nurturing support seems acceptable in any circumstance. If this is used to help a family gain more sense of self-control, then specific expertise may be valued and accepted subsequently. This reflects Robinson’s (1982) seminal research that demonstrated that health visitors adopt relationship-oriented and problem-oriented approaches to their practice, with skilful practice being concerned with combining these in ways that are appropriate. What is clear is that ‘nurturant’ or ‘relational’ support is a necessary precondition for effective ‘instrumental’ or problem-oriented support. More recent research provides contemporary evidence in support of the criticality of this practice-orientation to relationships and the extent to which this is aligned with service organisation. (Bidmead, 2013, cited in Cowley et al, 2013). This explains why ‘relationship’ based forms of intervention are strongly represented within this review. While in many healthcare contexts effective relationships are a means to effective intervention, in health visiting they often constitute the core of effective intervention in themselves. Moreover, this is why ‘compassion’ is placed centrally within the proposed framework, being the heart that supplies the life blood for health visiting practice for clients and practitioners alike. From this secure base, there is a diversity of models of support that can be drawn upon to enhance the resilience of health visitors within the workforce.
Figure 6: The resilience framework

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage
6. Commitment

- Interagency/Disciplinary Groups
- Supervision
- Action Learning Sets
- Peer Support
- Coaching
- Performance Feedback
- Mentoring
- Relationship Based Models
- Courageous Conversations
- Compassionate Resilience
- Professional Principles/Ethos

Compassion
Conclusion

This review has reported key findings on models and concepts of support and used these to propose a framework for resilience. The findings may be considered for their potential to support resilience that is compassionate and aligned with the relational basis of much health visiting practice, working with children and families to promote their health and wellbeing.

**Supervision:** The effectiveness of supervision for improving practice and reducing stress is now well established (Palsson et al, 1996; Walsh et al, 2003). Restorative supervision now brings a greater focus on the “emotional work” of the health visitor. Restorative supervision underpins managerial and safeguarding supervision by focusing on the capacity of the professional to engage in their work rather than on the work itself. It is also recognised that if the emotional consequences of health visiting work are not mitigated they will affect a professional’s wellbeing as well as their ability to work effectively (Barnett et al, 2007). Professionals receiving restorative supervision report an improvement in their resilience to stress whilst maintaining compassion, improved working relationships and team dynamics, managing a work/life balance more effectively and an increase in enjoyment and satisfaction related to their work (SWIFT, 2015). Currently, within health visiting in England, the picture is varied and supervision is carried out at various levels and in several different guises (Bidmead reported by Cowley, 2013). Stressful working environments being accepted as normal can impact negatively on the quality of supervision offered (Turbitt, 2012).

**Mentoring:** 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. A review of the literature reveals some worrying issues surrounding mentoring in health visiting that almost exclusively concerns mentorship of students/trainees. The impact of high workload, staff shortages and time conflict presents mentors with constant dilemmas in relation to managing commitments. Competing demands can lead to exhaustion and feelings of being overwhelmed (Omansky, 2010). When managers fail to recognise the increased workload associated with the mentor role, it can result in increased mentor anxiety (Omansky 2010). The literature clearly indicates the need for mentors to have adequate preparation for the role in addition to adequate clinical experience, so that they can facilitate the mentee to begin the process of transformation from novice to expert (Myall et al, 2007, Morton 2013). The mentoring process has been particularly challenged in health visiting in recent years, by being conflated with a form of ‘assistant practice teacher’ role, as a means of managing large student workloads, rather than mentoring as a longer-term support role in the workplace. More recent research in the east of England demonstrates a more positive picture when the process is managed well. This research does, however, highlight the importance that proximity, continuity and reciprocal positive regard, together with clinical expertise, are important elements for the success of mentor/mentee relationships (Devlin and Mitcheson 2013). The dominance of mentorship focused on student support has the unfortunate unintended consequence of adversely colouring attitudes to, and understanding of, the potential value of mentorship in support of the development of practitioners established within the workforce, as is more widely recognised, for example, in leadership programmes.

**Coaching:** In coaching there is a focus on improving performance and the development of skills. The NHS Leadership Academy website states that “Coaching and mentoring are an integral part of the NHS frameworks for leadership and professional development”. Benefits to coachees include an increased sense of motivation and enthusiasm, and also an ability to deal with frustrations encountered (Sinclair et al, 2008). Traditionally, coaching in the NHS has only been offered to senior managers; however, there is some anecdotal evidence that this may be changing. ‘Clinical coaching’ has also been used to work effectively with “marginal” staff with performance issues (Kelton, 2014). Health Education England (2011) suggests developing coaching skills as one way of preparing practice teachers and mentors for their roles. In addition, Sinclair et al (2008) suggest there is an opportunity to improve the deployment of coaching, particularly through the development of internal coaches, so that even greater benefits can be achieved.
**Courageous conversations:** Part of any professional relationship for the health visitor, be it with clients, colleagues, other professionals or managers, will involve having courageous conversations whilst maintaining the relationship. Patterson (2002) describes it as learning to use effective communication when it matters most. Developing professionals’ skills to enable them to engage in effective ‘courageous conversations’ is a key factor in developing ‘conflict resilient workplaces’ (State Government of Victoria 2011). Conflict presents opportunities for people to strengthen their relationships with themselves and others. Developing skills in managing ‘courageous conversations’ is one of the components of the NHS Leadership Academy training programme.

**Relationship-based models of intervention:** The development of the relationship with the client is what makes the ‘real difference’ in improving outcomes for service users (Crowther and Cowan, 2011). “Making a difference” has been identified as a key motivating factor in influencing students’ decisions to enter health visiting (Whitaker et al, 2013). Having the ability to form model good relationships lies at the core of health visiting practice, but there is evidence that organisational factors mean that it is difficult for health visitors in many areas of the country to develop relationships with their clients (Bidmead reported in Cowley 2013). There is also evidence to suggest that this affects morale, job satisfaction and professional self-esteem. There is a risk of losing people from the profession if they feel unable to “make the difference”.

Overwhelmingly large health visitor caseload size is a very important factor inhibiting the ability of the health visitors to establish relationships with parents (Bidmead reported in Cowley 2013). Bidmead found that pressures of record keeping, less-qualified staff being deployed to take on work with families, lack of support from managers to take on relationship work are also inhibiting factors The CYPMHC state that, where health visitors are unable to establish relationships with clients, valuable interventions and support, including a better understanding of the importance of attachment in their children’s development, will be reduced. It also means that early signs of mental health problems — whether in the infant or the parent — may be missed, increasing the risk of serious mental disorders, which are costly both in financial and human terms. Training in relationship-based models of intervention improves health visitor job satisfaction, competence, consistency, self-awareness, relationships with clients and colleagues, in addition to improved outcomes for children and families (Douglas and McGinty, 2001; Bashford and Seal 2012). The fidelity measures, values and structures of the Family Nurse Partnership model have contributed to its success and identify it as an example of a “positive practice environment”.

Relational or nurturant support is a precondition for the effective deployment and acceptability of specific problem-oriented or instrumental support at the level of practice and at the level of promoting practitioner resilience. This precondition is summed up in the central position afforded to ‘compassion’ within the proposed framework for resilience.

**Action learning:** A number of aspects of action learning have been identified as important to its effectiveness. Facilitation skills are crucial to ensuring that individuals feel safe to engage with the action learning process, but there are organisational challenges in supporting people to develop these skills quickly. If it is to work well, then action learning requires mutual commitment of each team member to participate. It should however be noted that participants can find it problematic to attend action learning sets as part of their working day and additional space may need to be created for them to work successfully. The prime focus of action learning is learning from, through and for action and only derivatively related to support and resilience.

**Performance feedback:** This is important to improve understanding and review progress. There can, however, be barriers to feedback as individuals may fear being upset, and having their self-esteem and relationships compromised. Within performance feedback, multisource (360-degree) feedback can be used to help employees improve and focus on their development. As such, it is a starting point for the development of new skills, and as skills are worked on over time, progress can be measured. It may lead to successful behaviour changes within individuals, although it is not seen to benefit a team or organisation. After Action Review provides insights into performance, team work, leadership and culture and has been used predominantly in analysing specific events to increase awareness, generate understanding, facilitate behaviour change, learn and develop an action plan. In this process, staff take responsibility and this facilitates job satisfaction, engagement and retention for review their actions and making changes.

**Interagency/disciplinary groups:** These can help to clarify roles and responsibilities and contain the emotional impact of work. By using work discussion groups, Schwartz Centre Rounds® or compassion circles experiences can be explored and reflected upon and participants can develop their understanding of
institutional and inter-personal dynamics and the possible emotional meaning of communications. Multidisciplinary forums where health professionals meet monthly to reflect and acknowledge work-related psychological, emotional and social challenges should be considered.

**Peer support:** Within the healthcare environment, peer support has become a significant element in the delivery of quality care. However, it has rarely been defined in the literature and its diverse application presents serious methodological issues including difficulties in interpretation and comparability. If the health visiting profession is to effectively incorporate peer relationships into support-enhancing interventions as a means to improve quality care and health outcomes, it is essential that this concept be more clearly explained. In the IHV survey (2014), health visitors identified their peers as a significant source of support. This includes informal/unscheduled peer support, indicative of a strength of health visiting’s professional culture. Peer support attributes in health visiting can be emotional, informational and appraisalal. The mechanisms and benefits of peer support in health visiting and the impact of mobile working on this source of support warrants consideration.

**Resilience:** Resilience is a dynamic, developmental process (Rutter, 2012, Cicchetti, 2010) which can be defined as the ability to adapt, cope positively (Hunter and Warren 2014), transform (Hart & Gagnon 2015) and even thrive in adversity (Wendt et al 2011). It is a dynamic process, which can be planned for, developed and practised. Context and process are important considerations (Cowley 2008). Although the context of health visiting practice can contribute to an increased risk of adversity, many health visitors remain resilient, and understanding what contributes to their resilience is important. Key factors include professional identity, supportive relationships, supervision, work/life balance, spirituality, self-awareness including emotional insight, self-compassion, hope and learning opportunities. Culture is an important consideration in understanding resilience (Ungar 2008). Cultural norms influence how distress is expressed, which responses are regarded effective and which values and beliefs underpin these responses (Dutton et al, 2014). An ecological approach to resilience incorporating individual, societal and environmental interaction and the capacities of individuals to change structures through emancipatory actions is recommended.

**Compassion, self-compassion and compassionate resilience:** There has been some research exploring resilience in nursing and other professions (e.g. McCann et al. 2013; Hunter and Warren 2014, Adamson et al, 2012; Wendt 2014) but research relating to health visitors is limited (Lindley 2013, Hudson et al 2013). A consultative literature review, national survey and scoping exercise led to the development of a resilient framework for health visiting. While resilience programmes for individuals can be effective it is important to consider the context of health visiting practice and address the structural and contextual sources of stress that contribute to adversity. The idea of self-compassion as influential to professional resilience is a new development and one that is central to the compassionate resilient concept of support. Building health visitors’ resilience is a complex process, which requires a preventative, compassionate, strengths-based approach.

**The resilience framework:** The resilience framework is underpinned by compassion, and the principles of health visiting and 6Cs are key components. An ecological approach to resilience incorporating individual, societal and environmental interaction and the capacities of individuals to change structures through emancipatory actions is recommended. Key factors which contribute to resilience include professional identity, supportive relationships, supervision, work/life balance, spirituality, self-awareness including emotional insight, self-compassion, hope and learning opportunities. A range of models of support are included and provide a menu of support to choose from. The framework is effectively delivered through compassionate and resilient leadership, interagency education and practice, and a skilled compassionate workforce. Through the process of developing the framework, the need for further research has been identified. This includes the need to understand how health visitors process experiences that are significant or traumatic and what helps them cope. The impact of the work environment, particularly in the light of an increase in mobile working, warrants further study. This framework will facilitate resilience with compassion such that health visitors thrive in their dynamic workplaces, develop a strong professional identity and model resilience and compassion in working with clients. Supporting the development of resilient health visitors who model compassion will contribute to maximising health outcomes and experiences for children, families and communities, building their own resilience.
Recommendations

- Policy makers, educators, managers and practitioners need to work together to identify, introduce and evaluate strategies to promote resilience and compassion, and supportive practice environments. This includes the development of compassionate business models.

- Create narrative centres through the communities of practice and the iHV to enhance understanding about what contributes to health visitors’ compassionate resilience.

- Leaders should promote workplace compassion through role modelling and encouraging work/life balance, facilitating nurturing, supportive relationships.

- Implement practices to support compassion such as selection and socialisation processes, which facilitate noticing, feeling, sense-making and acting in a compassionate way.

- Support the development of self-compassion in staff at all levels in an organisation using a strengths-based approach and providing education and training programmes.

- Managers need to provide support, enabling and encouraging practitioners to develop relationships with their clients.

- The development of internal coaching should be considered.

- As a way to developing ‘conflict resilient workplaces’, health visitors should be encouraged to undertake training in ‘courageous conversations’.

- Mentors working with student health visitors should be supported and prepared to undertake their role, and have adequate clinical experience to be confident to undertake the role.

- A clear distinction should be made between the role of mentorship with students and the potential of mentorship for supporting resilience and development of established health visitors within the workforce, drawing upon work undertaken to develop mentorship for leadership development.

- Every health visitor should be encouraged to access a form of supervision that includes the restorative function.

- Health visitors should have access to relationship-based training programmes which develop strengths-based approaches.

- The Family Nurse Partnership Model should be embraced as an example of a positive practice environment from which we can learn.
Future research

In common with research on family support (Cutrona, 2000), this review has highlighted the diversity of support mechanisms of potential value to the resilience of health visitors, but also the difficulty of establishing ‘direction’ within the diversity of approaches available. The centrality of relational support and compassion as a renewed concern in nursing is promising in providing ‘direction’ within this diversity. Hart and Gagnon (2015) argue that there is a need to bring resilience research and practice development together. Understanding how practitioners process and understand significant or even traumatic experiences gives insight into coping styles and capabilities and how to strengthen these. A solutions-oriented approach to research on how healthy work environments contribute to resilience is needed, as much research is problem-oriented, e.g. does providing relaxing spaces enhance the quality of interaction between practitioners, does peer mentorship increase work satisfaction? Further research should be conducted on issues such as:

- Evaluation of the effectiveness of resilience education programmes.
- Evaluation of a bespoke compassionate resilience education and training programme.
- The short and long-term impact of compassion on staff engagement, job performance and health outcomes.
- Evaluation of how health visitors learn from compassionate experiences and how to apply this to future situations.
- More research on organisational mechanisms and how individuals communicate their suffering.
- The alignment of health visiting practice orientation with service organisation to build on the strengths of professional culture and the potential of support mechanisms to enhance protective factors.
- Examination of cross-cultural differences at work, and consideration of whether all cultures are equally perceptive in noticing suffering and what is deemed acceptable to discuss at work.
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