

Title: Cultivating Compassion through Compassion Circles: learning from experience in mental health care in the NHS

Structured Abstract

Purpose: This paper discusses the importance of compassion in health care and experiences of Compassion Circles (CCs) in supporting it, placing this into the national policy context of the NHS, whilst focusing on lessons from using the practice in mental health care.

Design/methodology/approach: This conceptual paper is a discussion of the context of compassion in health care and a description of model and related concepts of CCs. We also discuss lessons from implementation of CCs in mental health care.

Findings: Compassion Circles were developed from an initial broad concern with the place of compassion and wellbeing in communities and organisations, particularly in health and social care after a number of scandals about failures of care. Through experience CCs have been refined into a flexible model of supporting staff in mental health care settings. Experience to date suggests they are a valuable method of increasing compassion for self and others, improving relationships between team members and raising issues of organisational support to enable compassionate practice.

Originality: This paper contributes a conceptual discussion and practice model to a growing area of concern, namely supporting compassion in mental health care.

Research limitations/implications: The article is a discussion of CCs and their conceptual underpinnings, and of insights and lessons from their adoption to date, and more robust evaluation is required.

Practical implications: As an emergent area of practice Compassion Circles have been seen to present a powerful and practical approach to supporting individual members of staff and teams. Organisations and individuals might wish to join the community of practice that exists around CCs to consider the potential of this intervention in their workplaces and add to the growing body of learning about it. It is worth further investigation to examine the impact of CCs on current concerns with maintaining staff wellbeing and engagement, and, hence, on stress, absence and the sustainability of work environments over time.

Social implications: Compassion Circles present a promising means of developing a culture and practice of more compassion in mental health care and other care contexts.

Originality: Compassion Circles have become supported in national NHS guidance and more support to adopt, evaluate and learn from this model is warranted. This paper is a contribution to developing a better understanding of the CCs model, implementation lessons and early insights into impact.

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Keywords: compassion, Compassion Circles, wellbeing, staff support, workplace improvement, human resources.

Article Classification – Conceptual paper/case study

Disclaimer – this article represents the collected work of a community practice with experience of developing and using Compassion Circles. Andy pioneered the approach and several of the authors have experience of implementing CCs and working with him to adapt them for various contexts. Michael is an independent researcher.

Introduction

There has been concern that compassion is lacking in parts of the health care system in England with negative consequences for care, as exemplified in the scandals in Winterbourne View and the Mid Staffordshire hospitals (DH 2012; National Advisory Group on the Safety of Patients in England 2013; Her Majesty's Stationery Office 2013). These helped bring concerns about compassion deficit to wider public attention, placing it firmly centre of debates about leadership and management in the NHS. Compassion is now explicitly articulated in policy as crucial to good health care (e.g. Department of Health (DH) 2015a; Health Education England (HEE) 2019), but whilst it is recognised that to be compassionate requires an accompanying ethos to be embedded throughout organisations (NHS England 2019) there are few examples of practice developments to help in doing this.

In this article we discuss an innovative practice for nurturing compassion for self and others in workplaces and wider communities to be more populated with thoughts, feelings and experiences of compassion. We discuss this intervention, Compassion Circles (CCs), and practice evidence and lessons from experiences of its implementation in the context of mental health care. The approach has been adopted in and adapted for various contexts, resulting in a great deal of learning amongst its community of practice to guide further implementation and evaluation of CCs. This paper is a contribution to these developments, to share an emerging area of practice to help improve mental health care with a view to encouraging more reflection on and work to nurture compassion in care, and more empirical research evaluating the impact of CCs.

What is compassion?

Before discussing Compassion Circles we need to briefly discuss the concept of compassion to help set the context for understanding the CCs model.

Compassion is entwined with what it is to be human in the world (de Zueletta 2013; Spandler & Stickley 2011; Strauss et al. 2016). It has been defined as “a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action” (Sinclair et al. 2016:195). Gilbert (2017:11) defines it as “a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it”. These two definitions highlight the relational, emotional, and action-oriented nature of compassion. These interactions take place in contexts, which may have an impact on how they play out.

Shea, Wynyard & Lionis (2014:2) add to our understanding by elaborating constituent elements of compassion and their relationship to physical and mental wellbeing:

“the component parts of compassion such as kindness, empathy, attention to basic needs, attention to dignity, are crucial in alleviating pain, prompting fast recovery from acute illness, assisting in the management of chronic illness, and relieving anxiety”.

Compassion is, then, intimately connected to other higher-order concepts (such as dignity). Being compassionate has, for example, been said to involve an authentic response to others (Trzeciak, Roberts & Mazzarelli 2017), authenticity being another complex, relational and

higher-order concept (Guignon 2004). Such associations between concepts highlight the connection of compassion with a (desirable) sense of being a person, which also alerts us to a concern with a person's sense of self-identity if their ability to be compassionate is comprised.

Compassion connects, then, to identity, which brings us to a further conceptual element to compassion of interest to our discussion here, namely that of self-compassion (Neff 2003). This is showing the same compassionate qualities shown to others to oneself, but not in a self-centered manner. Higher levels of self-compassion have been linked to a range of positive outcomes (Gerber, Tolmacz & Doron 2015), and may be an important medium for better holding oneself to account. However, the evidence on self-compassion is under-developed in understanding its link to compassion towards others, impact on delivering better care and in terms of interventions to improve it in health care staff (Sinclair et al. 2017a).

A further important concept is that of compassion fatigue. The experience of finding it difficult to keep demonstrating compassion for others (fatigue) may be partly a result of not being able to care for oneself compassionately. Such a notion of 'fatigue' also resonates with that of emotional labour (Brotheridge & Lee 2002), conveying the notion of the hard work of caring and being compassionate to others. However, compassion fatigue is a contested concept, and not clearly delineated from others such as burnout (Sinclair et al. 2018). Connections between compassion, fatigue and moral distress (feeling unable to do what you see as morally right) are far from clear (Sinclair et al. 2018; McCarthy & Deady 2008; Ledoux, 2015).

Compassion is an important human concept, but, as we have seen, its conceptual boundaries and connections with other concepts are unclear. For the purposes of developing the CCs model discussed below we propose a relational view of compassion (after Fernando & Consedine 2014), in which its enacting is influenced by the environment (crucially in health care, that provided by organisations) and other actors within it. The model includes self-compassion as an important element. (See the discussion of CCs below.)

Compassion and health care

Given the foregoing discussion of compassion it is no surprise that it is often discussed in relation to the delivery of health care, given its relevance to wellbeing and relational aspects of dealing with forms of dis-ease. Indeed, compassion has been something of a buzzword in the NHS in recent years, as noted in the introduction. The sense has evolved that, as Shea, Wynyard & Lionis (2014) comment, in too many places in NHS care humanity and its expression in compassion has been diminished and requires restoration. Reports on shortcomings in the NHS (DH 2012; National Advisory Group on the Safety of Patients in England 2013; Her Majesty's Stationery Office 2013) were catalysts to a movement to make attention to compassion an explicit focus for service improvement (NHS Commissioning Board 2012; NHS England 2013; HM Government 2012).

Compassion has been defined for national policy as "how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and

is central to how people perceive their care” (NHS Commissioning Board 2012:13). This resonates with our above discussion but ignores some of the conceptual uncertainty, complexity and connection with self (compassion) and identity.

It should also be noted that a focus on ‘compassionate care’ can seem tautological (Seager 2014) as to care is generally thought to be compassionate. Taking such a view might undermine a commitment to explicitly nurture compassion in care organisations. However, the joining of ‘compassionate’ and ‘care’ is to explicitly encourage a move away from thinking of the verb ‘care’ purely as a process or transaction to be narrowly understood and measured by simplistic performance indicators, and to (re-)introduce a fundamental consideration of the people involved, the relational aspects of care and their impact on the experience and outcomes of that care.

De Zueletta (2013) discusses that there is a debate as to whether or not being compassionate is a good thing for clinicians, but notes evidence that being compassionate has been demonstrated to be beneficial for patients and clinicians, and how having compassionate care blocked can cause distress for clinicians (the link with the concept of moral distress). Risks to improvement for more compassion and the culture change argued to be necessary to improve care (e.g. DH 2015b) are that improvement is subverted or ignored as compassion is seen as not crucial or as harmful to staff and, hence, is relegated in importance to other concerns, and/or support for compassion is redirected through resilience training placing more emphasis on staff to cope with circumstances as they are.

In addition, De Zueletta (2013) discusses the debate as to whether or not being compassionate is a good thing for clinicians or brings them harm, but notes evidence that being compassionate has been demonstrated to be beneficial for patients and clinicians, and how having compassionate care blocked can cause distress for clinicians (the link with the concept of moral distress). The risk with ideas of compassion as being obviously a part of care, or as potentially harmful to staff is that it is relegated in importance to other concerns.

Policies for developing compassion in the NHS have been broad and lacking in concrete detail of means of doing this. Compassionate practice is seen as requiring leadership in organisations if they are to nurture it in the face of many pressing demands (NHS England 2014). Other guidance on compassion in nursing and midwifery (West, Bailey & Williams 2020), for example, has added more breadth, connecting it to core needs of people in care work - autonomy, belonging and contribution - along with some areas of focus, such as working conditions and schedules (including workload), teamworking, culture and leadership, management and supervision, and learning. In national guidance then compassion is portrayed as an essential concept to good care, but concrete examples of models of intervening to nurture compassionate practice are few.

Whilst compassion is important to high-quality care, the stress and burnout that care staff may face potentially hinders the ability to deliver compassionate care (Sinclair et al. 2017b). A response has been a focus on improving self-care to build resilience amongst staff in health care to enhance the compassionate delivery of care to patients (Sinclair et al. 2016 & 2017b). Questions to be asked about this include to what degree it brings attention to the

relational aspects of care and places an onus on the organisation to develop a supportive environment, and, hence, how effective such an approach is to delivering more compassionate care. Seager (2014), for example, argues that thinking simplistically about training for compassion, like filling an empty vessel, is wrongheaded. Rather, we need to consider that people in caring roles have the ability to be compassionate and that training plus congruent relationships and context are more likely to support better compassionate care. Thoughtful and sensitive approaches, that focus on relationships and operate over time are required to nurture compassionate care, rather than approaches limited in terms of focus or time.

One approach to support compassion across health care that has been widely promoted and adopted is Schwartz Rounds. Developed over 20 years ago, these are created spaces in which caregivers come together to discuss the emotional, social and human issues involved in their roles (Maben 2018). A Round is formally organised in terms of its timing (perhaps 1 hour, monthly) and structure (a panel presenting narratives of the experience of delivering care for someone). A facilitator guides the discussions of the issues people feel about the narratives. They support local exploration of compassionate practice, including between colleagues.

Schwartz Rounds have been successfully implemented in the NHS (Maben et al. 2018). Including in mental health care (e.g. Qadri et al. 2017; Farr & Barker 2017). However, implementation is difficult in terms of resources and cultures and they may not work in some settings and organisations (Farr & Barker 2017). Indeed, no one approach to supporting compassionate care is likely to be the panacea (Mannion 2014), meaning there is a need to develop a range of approaches which work to support compassionate care giving, and understand how and in what settings they work best. Schwartz Rounds themselves have been adapted as 'Team Time' for use in the COVID pandemic, for example.

Compassion, organisations, leadership and culture

We have seen, then, that compassion in care is an important though complex subject that requires consideration to aspects of the organisation environment in which it is expected to occur. It is one that is too easily superficially discussed, given its commonsensical links to caring for people. Compassionate organisations can be created (Poorkavoos 2017; National Forum for Health and Wellbeing at Work (n.d.)), but the process of doing so is multifaceted. Seager (2014), for example, writes that compassion (and its absence) in care is not so much an issue of teaching techniques but of organisational culture. However, organisational culture is a contested concept (Goodwin 2019). It may be broadly defined as the basic assumptions, values and beliefs that its members share (Davies & Mannion 2013; Mannion & Davies 2018). However, rather than seeing an organisation as having a uniform culture it is best to think of culture in such contexts as continuous processes or 'a dynamic cultural mosaic' (Mannion & Davies 2018:2). Overly simplistic notions of culture may hinder endeavours to improve health care by implying that it can be easily manipulated in a desired direction.

Whilst organisational culture is complex and difficult to grasp, and the link between culture(s) and performance is complex, there is evidence that organisations do better at the activities that are explicitly valued and celebrated (Davies & Mannion 2013). Hence, leadership actively promoting, modelling and valuing compassion is likely to be a key element in improving compassionate cultures and practice in health care organisations (West et al. 2014; West et al. 2015; Rafferty et al. 2015; Poorkavoos 2016).

However, we have a shortage of robust and practical interventions to support health care organisations to move to more compassionate cultures and care. Schwartz Rounds have a place, but as noted provide some significant challenges for implementation. Given the complexity of nurturing compassionate cultures, we are in any case likely to require a range of interventions rather than rely on one. Compassion Circles are proposed as another intervention to support more compassionate care.

What are Compassion Circles?

The first Compassion Circle took place in 2013 and the practice has evolved since (Bradley 2016). They were developed recognising the importance of compassion to care, its multifaceted nature, and the need for means to explicitly nurture it rather than presume its presence and persistence.

Writing in 2016 Bradley discussed how CCs then felt ‘counter-cultural’ in terms of inviting people into a circle to think about, discuss and share awareness of their own and each other’s compassion, thoughts and needs. However, as we have seen, a policy movement discussing compassion and implementation of Schwartz Rounds in the NHS may have moved the culture.

Related to our discussion of the concept of compassion above, the understanding of compassion built into CCs is:

- of compassion as a positive thing that we are seeking to nurture as a human value needing to be sustained across time, and not merely based on deficit models such as the need to overcome compassion fatigue at a specific time;
- a relational model of compassion, which requires consideration of the individual who is expected to display compassion in their practice, the other individuals involved and the context of care and how this shapes practice.
- based on a spirit of mutuality and collaboration – supporting each other
- specifically focused on also increasing self-compassion as a value in its own right and a basis for caring for others.

Compassion Circles, and their variations (see below), follow a common set of principles and a similar structure. These principles are a foundation and apply across contexts, though with some adaptability for variations on the original model of CCs. A paradox is that, rather than being restrictive, a structure for CCs creates a space (the Holding Space), engendering the feeling of safety, from which can emerge open dialogue, connection, creativity and equality of listening. Developing good listening skills and dialogue (Kline 1999) are key

elements and outcomes of CCs. The foundational *personal principles* (or Compassion Habits) for CCs are:

- Listening with a quiet mind
- Asking questions that matter
- Appreciating from the heart

Closely linked are a set of *organising principles* to enable these, namely:

- Making compassion a priority – the organisation explicitly valuing compassion and actively seek to nurture it by generating holding spaces for each other and ourselves
- Creating a warm, appreciative spirit to encourage a positive frame of mind
- Taking turns to speak and listen, in a circle if people are physically together
- Having equal time to speak so that all are heard, and no one dominates
- Offering the option not to speak – people know it's ok to pass when it's their turn and holding space for silence as well as talking. This is especially important as people may have past traumas that they are managing
- Using respectful, inclusive and non-judgmental language
- Ensuring the practices are accessible so that they can be widely used; creating inclusive spaces and using inclusive language so that all feel welcome
- Encouraging self-care – turning towards our challenges in resourceful ways, whilst bringing compassion to ourselves

Following these principles, a CC then provides a supportive space for participants to consider the complexity of routinely being compassionate, and specifically:

- i) Self-care and compassion for oneself (mindful self-compassion);
- ii) Compassion for others;
- iii) Local inhibitors and facilitators of compassion for self and others;
- iv) The interactions of i-iii for each other and for the collective work they do (Being in A Community).

CCs aim to explore and engender amongst participants a spirit of collaboration, being courageous (to share and discuss experiences), humility, discipline, inclusion and justice as all are interlinked to the concept of compassion underpinning the model. Inclusiveness is encouraged through a warm welcome to everyone joining the Circle, meeting as equals and celebrating difference. There is an emphasis on identifying nourishing or joyful things (such as naming one thing that is going well for you and appreciating the contribution of others) to enable creating spaces for raising more difficult issues. Whilst the Circle is shared as space for contemplation, there is also commitment to action amongst participants after the CC has completed.

The practice of a CC entails facilitating through the prepared script, a framework for the Circle. The script includes time to welcome everyone together, for personal thought, for paired and group work. The extensively tested script enables robust facilitation providing 'the structure that holds the space safely'.

CCs share some of the characteristics that Maben et al. (2018) identify in Schwartz Rounds. For example, they focus on creating a safe space for sharing experiences and they are not primarily concerned with specific problem solving; open and honest communication is encouraged; and they provide a place for giving and receiving peer support for anyone in the care setting who wants to participate. They also both allow exploration of self-care and supporting others.

CCs are, though, different from Schwartz Rounds in key aspects. They are less structured and resource intensive in terms of supporting panelists i.e. identifying and preparing them for each Round. There is, however, an expectation that attendees will contribute to at least some degree in a CC, unlike in a Schwartz Round, though the contribution may be as brief as a person desires and is generally in response to the structured script. CCs, then, offer an invitation to hear from all participants, thereby creating a somewhat more inclusive environment with greater distribution and sharing of “voice” for all participants than is generally expected in a Schwartz Round. There is always an option to ‘pass’ as the Circle is underway, as importantly they are optional spaces, not mandated. The structure of the CC is the crucial aspect of creating and holding the space, within which the role of the facilitator is important in engaging people’s involvement as they straddle being in the circle but also guiding it. Facilitating is not seen as a hugely complex organising task, especially compared to Schwartz Rounds, and can be a role which is quickly and more flexibly adopted.

In addition, CCs tend to operate at a smaller scale in terms of the number of participants (most likely 6-24 people) compared to a Schwartz Round (potentially 10-100). This obviously relates to the point about voice and participation above.

Two final differences between CCs and Schwartz Rounds that we would highlight are i) that CCs are intended to be more flexible in their implementation – not necessarily to be organised on a routine basis, potentially being more spontaneous, and not being focused on a panel; and ii) our sense is that CCs contain more of a specific focus on self-compassion and connecting with others in the Circle than do Schwartz Rounds as it is built in to the CC script.

Experience of using compassion circles in mental health care

Whilst Compassion Circles have been used in many care settings, we are focused here on the experience of their use in mental health care settings in the NHS. We will describe some of this experience and some key lessons we draw from it.

In the Aneurin Bevan University Health Board in South East Wales, practitioners have adopted the CC model across the organization, including within the Mental Health and Learning Disability Division. They have re-labelled it as ‘Taking Care, Giving Care’ (TCGC) rounds in response to feedback from participants in early Circles (Flowers et al. 2018) but the essence is the same as CCs. The name change was in response to concern that people were weary of openly discussing ‘compassion’ and that ‘circle’ was off-putting. The new name was intended to convey the intentions of the practice and, in the word ‘round’, to connect to the Schwartz Rounds that had been instigated in the organisation. Across 25 of the TCGC Rounds, including over 300 staff, feedback from participants was positive (Flowers

et al. 2018). The work has been integrated into a wider Employee Well-Being strategy that seeks to be proactive and systemic as well as responding to individual needs as they arise. Data collected in the Trust in 2020 shows that over 100 TCGC rounds have been undertaken, reaching over 1000 staff. A more recent evaluation of just under 200 staff suggested insights into the rounds which we have incorporated in the lessons section below.

In the West Midlands region in 2017/18, Compassion Circles formed part of a regional programme of work seeking to enhance integrated working and trust relationships between individuals and organisations across a Sustainability and Transformation Partnership (STP) footprint, including a focus on mental health care. Attendance at the initial CCs and training was multidisciplinary, including clinicians and facilities staff sharing space with senior leaders. Outputs included a commitment to collaboration in the partnership (ultimately leading to a new shared programme of work), and continued CC delivery in organisations.

Based on this West Midlands' initiative, some mental health teams trialed CCs following two development days. The first of these days brought together an invited group of potential advocates for CCs from a diverse set of organisations across the region. The second day focused on bringing together colleagues from within one NHS Trust, with a group of people from the regional NHS England. Each development day provided different insights into how CCs might be used in mental health care, which are incorporated in the next section. The second of these days has led to continuing compassion support groups/pods in a participating organisation, including during the COVID-19 pandemic (see box 1).

Box 1: Experiences of using Compassion Circles in one Mental Health Commissioning Team

It's almost 12 months since we undertook the Compassion Circles training. When the first COVID-19 pandemic national lockdown began in March 2020 we started running weekly virtual circles within the Mental Health & Personalisation Team. Those have continued ever since and been of huge benefit to participants. We've had a number of team members dealing with bereavements and other difficult life circumstances and for them the circles have been incredibly helpful.

In the summer we began to use CCs to run some of our partnership meetings across the local mental health care system and with people with lived experience of mental health issues. Participants have really enjoyed this approach. As more of us have begun to challenge ourselves in relation to inclusion and diversity the approach has helped to create spaces in which people feel included and can quickly engage with others. The approach has also been used in *ad hoc* sessions covering a range of issues, including ones raised by members of the team.

The wider organisation has begun to show an interest in this work. In November we ran a few open sessions as part of Stress Awareness Week. A number of teams are now running circles themselves, one using CCs across their whole team of almost 100 staff, and a local BAME Support Network use CCs. In response to positive feedback and enquires from members of staff, the organisation's CEO is asking the Human Resources Department to explore how CCs might be more widely adopted across the organisation.

All of us who were involved in that initial training look back on that day with huge fondness and with thanks for this practice that has been so helpful to all of us.

Lessons learnt about the adoption and adaptation of Compassion Circles

Here we reflect on key lessons learnt about the use of compassion circles in mental health care discussed above, drawing on the experiences of the authors who have organised and participated in many CCs, in several training and development initiatives, and who now form a community of practice focused on wider implementation of CCs. We also draw in the following on the experiences of organisation-wide development of CCs discussed in Flowers et al. (2018).

- 1) CCs are short and fast-paced and very practical to implement; they provide a non-threatening space that quickly make participants feel at ease and reduce any anxiety they may have felt about participating. As such they provide a viable organisational means of nurturing compassion and supporting staff as they are highly flexible in many regards, can be rapidly deployed for specific support as well as part of general culture change, staff support and practice improvement, and require relatively few resources to develop, implement and maintain.
- 2) Organising and facilitating your first CCs may be daunting for some. It can be helpful to have experienced a CC and/or attended training and/or to have support from a colleague who understands the approach, but the script is designed to be easily picked up and used by beginners to the practice. Support from a network of practitioners is desirable to build critical capacity in an organisation. Facilitators in one organisation were positive of the experience and reported they liked that CCs are highly portability and quick to run, with minimal preparation, a focus on balancing individual and system compassion, and they could see benefits even when circumstances for a CC were less than ideal.
- 3) Difficult emotions and experiences can be surfaced during CCs and facilitators need to be ready to support people and address these situations.
- 4) Participating in your first CC can be an anxiety provoking experience at first for most people, but with clear messages beforehand and a good facilitator equipped with the CC script people can be made to feel at ease and participate very quickly. Staff who have experienced CCs have reported they like the structure, pace, sense of safety, the positive atmosphere, and the focus on practical issues.
- 5) Having a protected space to reflect on the complex nature of compassion (to self and others) was valuable to participants whose work is generally overloading in many ways.
- 6) They are a novel and positive experience, validating individuals and the work they do. CCs provide an opportunity to share and reflect on the values underpinning people's work.
- 7) They provide teams with an opportunity to connect with each other and reflect on the compassion they show to themselves, each other and the people they care for. They can prompt an appreciation of people not explicitly made before; staff can connect with each other by, for example appreciating each other; hearing from and about colleagues is positive, being variously described as "inspiring" and "great". CCs

help to reduce power differentials and reduce hierarchies in teams, helping people to more honestly connect as humans.

- 8) It is possible to develop organisation-wide implementation of CCs. There are growing experiences of developing CC practice communities across wider organisational and geographical networks, including larger multi-site and multiple organisation areas. In particular the experience of the Aneurin Bevan University Health Board is that implementing CCs is a highly sustainable means of nurturing compassion in health care.
- 9) Positive outcomes reported by participants include experiencing CCs as energizing, increased positivity, and improved team morale.

In one health care organisation (including mental health care) from which we have drawn some of the experiential-based evidence behind this paper, CCs have been used as part of an organisational culture shift to more actively support people's psychosocial needs at work, rather than only reacting when things are going wrong for them. In reviews of this work, members of staff report a more relational sense of work, such as feeling part of a team rather than isolated, and the things that have helped this have been spending time together in a Circle communicating better with each other. Amongst other things this has led to recognition of the importance of even the small acknowledgments of each other, as this person commented:

“We are going to look at each other in the mornings and say hello.”

In ongoing monitoring of the CC meetings, the organisation now has feedback from over 142 people after they have participated in a CC. They have commented that the CC made them more aware of compassion towards patients (82% of respondents), toward themselves (85%) and made them think about how to embed compassion more in their work (86%). 89% of the respondents said that participating in the CC would help them to work better with colleagues.

Perhaps best signifying the impact of the CCs is the quotation from one member of staff in the organisation:

“This was something unique and different. It was about us as people”

Developing that shared sense of humanity and of being valued as a person is a core ideal of CCs, and if people feel it towards themselves and their colleagues they are likely to have an increased sense of it towards the patients as well.

CCs have continued to evolve, and distilled versions exist including 20minute Care Space (Jones, Waites, & Werrett, 2021) and Pause Spaces (see [10 minute pause spaces – Our NHS People](#)). This latter version was particularly developed in response to the current pandemic context as a ‘pop-up’ means for small groups, pairs and individuals to connect to a central inquiry of ‘what does caring for yourself mean to you’. This inquiry specifically seeks to avoid phrasing of questions that have the potential to trigger trauma, or that assume individuals have a default self-compassion psychology. They were also designed with inclusive language and for anyone to run, without the need for training or external

facilitation. The inquiry also builds upon the evidence and risk of reluctance to seek wellbeing and mental health support; the hope is that these Pause Spaces encourage people to identify some of their individual needs for additional support and seek to meet those. Pause Spaces are described as 'delicate and powerful' by Professor Michael West, endorsed by the NHS Mental Health Taskforce, and are part of the wider award-winning NHS offer of support to staff. Whilst evaluation is optional for these self-run Pause Space practices, feedback has provided a rich source of data, which demonstrates very high satisfaction, though some have highlighted that running these practices is counter-cultural in their teams or departments. A hybrid approach of self-led and facilitated options, might help to overcome these barriers. The Pause Space design included input from the CC originator, and other expert colleagues including a registered nurse, a leadership consultant, an inclusion practitioner and a mindful self-compassion practitioner, who is both therapist and spiritual care lead. This provides an example of a typical multi-disciplinary lens on this emerging field of practice.

A new venture, the Compassion Practice Collective, has been established with the aim and ethos of liberating compassion globally, making compassion practices available to all. A supporting website (www.CompassionPractices.net) houses all of the practices previously described, plus others. Importantly, the distilled Compassion Practice Principles allow people to design bespoke practices for their own contexts. The resources are freely available, and the Collective also offers opportunities for people to connect with others who are using the practices, share evaluation and learning, and join events. The Collective has growing international connections.

Limitations of this paper

The intention of this paper has been to share understanding of an emerging area of concern and practice (i.e. developing more compassionate cultures and practice in mental health care organisations) and thereby stimulate more understanding and consideration of compassion and related concerns. We particularly aimed to highlight an emerging model of practice to support nurturing compassion, supporting individual members of staff and improve care (i.e. Compassion Circles). We have sought to share the extensive practice wisdom about that model from a community of practice that has been engaged with using it in mental health care (and other contexts) for several years, and to relate this to a wider body of writing about compassion in health care. We have also sought to draw on some empirical evidence from local exploration of the impact of CCs to help illuminate the practice in context.

We recognise that more empirical evidence is required about the practice of CCs and their actual and potential impact. In particular, more evidence framed by understanding CCs as complex interventions would be helpful (Craig et al. 2013). This requires more explicit articulation of the theory of change underpinning the approach and of what outcomes are thought to be delivered, in which contexts and through what mechanisms. Such an articulation would then guide planning of methods to robustly evaluate the impact of CCs. Examining implementation issues and the economic impact of CCs would ideally also be integral to this research agenda.

Conclusion

We have discussed that although compassion is seen as an underpinning concept for good care, it is a highly complex relational phenomenon – relating to individuals, relations between people, and the environment in which they live/work. It includes consideration of self-compassion as well as being able to enact compassion to others. Improving compassion in a specific organisational context means nurturing resources, leadership and culture to support it. Such a complex endeavour will require several interconnected interventions. However, care organisations are somewhat short of robust interventions to assist them to do this. In this context we have sought to describe a model of practice, Compassion Circles, designed to be one element in developing more compassionate care. This collaborative work on CCs has evolved over several years. We began writing this article in the full force of the COVID-19 pandemic lockdown of society. This has also influenced the evolution and take up of the ‘family’ of compassion practices that have been distilled from CCs, including the example described above, and demonstrated the potential and flexibility of CCs (e.g. some of the practice described above used technology to hold virtual CCs to support staff during the pandemic).

There is more to do to understand the impact that CCs and compassion practices more broadly, can have, including the longer-term outcomes for participating staff (as individuals and as members of teams) and the impact on the delivery of care and outcomes for service users. This learning may help to frame a new narrative on compassion that invites new interest and applications for wider impact.

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