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Caring to change

How compassionate leadership can stimulate innovation in health care

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Introduction

Only innovation can enable modern health care organisations and systems to meet the radically changing needs and expectations of the communities they serve. While adequate financial support is a necessary precondition, it is clear that more money on its own, without transformative change, will not be enough.

Improvement efforts are widespread within the National Health Service (NHS), stimulated and supported by a variety of organisations and initiatives, including The Health Foundation, the US Institute for Healthcare Improvement, the Advancing Quality Alliance (AQuA), NHS Quest and NHS Improvement. The national improvement and leadership development framework offers a powerful programme for developing structures and processes to ensure the spread of improvement skills across the whole of the sector (*see* National Improvement and Leadership Development Board 2016). However, examples of radical and sustained innovation are exceptions in the NHS landscape (Dixon-Woods *et al* 2014).

There are examples that offer hope and direction from local systems (*see* **Ham and Brown 2015**) that have triumphed over adversity through:

- whole-system redesign
- radical rethinking of organisational roles
- empowering teams to innovate
- persistently nurturing continuous improvement.

Enabling leadership and cultures are essential for ensuring that such innovation spreads and becomes a cultural norm within the NHS.

By ensuring that organisational and systems environments are conducive to innovation generally, and quality improvement specifically, attempts to meet the challenges of modern health care are more likely to succeed. Leadership is central to this and *compassionate* leadership in particular is a fundamental enabling factor that will create a culture of improvement and radical innovation across health care.

Compassionate leadership enhances the intrinsic motivation of NHS staff and reinforces their fundamental altruism. It helps to promote a culture of learning,

where risk-taking (within safe boundaries) is encouraged and where there is an acceptance that not all innovation will be successful – an orientation diametrically opposite to a culture characterised by blame, fear and bullying. Compassion also creates psychological safety, such that staff feel confident in speaking out about errors, problems and uncertainties and feel empowered and supported to develop and implement ideas for new and improved ways of delivering services. They also work more co-operatively and collaboratively in a compassionate culture, in a climate characterised by cohesion, optimism and efficacy. Compassionate leadership is seen as an enabling condition for innovation across sectors (Worline and Dutton 2017; Amabile and Khaire 2008) but is particularly salient and, we propose, a prerequisite for sustained innovation in health services. This is particularly so because of the need for coherence between the values and behaviours within health care organisations and how they engage with service users.

The evidence of the links between psychological safety, supportiveness, positivity, empathy, leadership (in aggregate compassionate leadership) and innovation is deep and convincing. In this paper, we therefore present a challenge to the prevailing perspective in economics about the factors influencing innovation, which is based on a somewhat simplistic view of human motivation, far less relevant to the NHS than it is to (at least some) private sector organisations.

In the next section, we say what 'compassion' is, we identify compassion as the core cultural value of the NHS and we show how compassionate leadership is therefore fundamental in this context. We explain what is meant by innovation and then show the importance of collective, compassionate leadership as an enabler of innovation in health care at various levels. In the subsequent section, we set out our understanding of the four fundamental elements of a culture for innovative and high-quality care:

- inspiring vision and strategy
- positive inclusion and participation
- enthusiastic team and cross-boundary working
- support and autonomy for staff to innovate.

We describe how compassionate leadership plays a key role in nurturing each of these.

In the closing section, we offer our conclusions and this is followed by an Appendix consisting of several case studies of compassionate leadership and innovation in practice, some of which were carried out as part of this research.

Compassion, compassionate leadership and innovation

What is compassion?

Compassion can be understood as having four components: *attending, understanding, empathising and helping* (Atkins and Parker 2012). In the context of an interaction between a health care professional and, for example, an older patient, compassion involves the following steps:

- paying attention to the other and noticing their suffering – *attending*
- understanding what is causing the other's distress, by making an appraisal of the cause – *understanding*
- having an empathic response, a felt relation with the other's distress – *empathising*
- taking intelligent (thoughtful and appropriate) action to help relieve the other's suffering – *helping.*

Compassion is the core NHS cultural value

The NHS was founded in 1948 as an expression of a core national value of compassion: a post-war generation made a commitment to providing free health care for all those who needed it, regardless of status, wealth, ethnicity, age, gender or any other characteristic. The nation has demonstrated its commitment to this value of a free and inclusive NHS, by its fierce and sustained protection of the system over the subsequent 69 years. That value is also fundamental to the work orientation of those who deliver health care in the United Kingdom. Virtually all NHS staff have dedicated a major part of their lives to caring for others in their communities, with compassion being their core work value. When they work in organisations that mirror that core value, their motivation, wellbeing and creativity are sustained and nurtured and they demonstrate compassion in their interactions with patients (Amos and Weathington 2008). Care that is compassionate rather than uncaring or disempowering has a positive effect on patient satisfaction and health outcomes. Compassionate care is what patients want and need (**National Advisory Group on the Safety of Patients in England 2013**). The challenge, then, is to nurture a strong culture of compassion in health care.

The culture of an organisation is primarily a result of three influences:

- the founding values of the organisation
- the early experiences and thereby acquired values, norms and behaviours of those joining the organisation (via formal and informal induction and the mechanisms through which new employees gain the necessary knowledge and skills to be an effective member of the organisation – so-called 'onboarding' processes or organisational socialisation)
- the behaviour of its leaders (Schneider *et al* 2017).

What leaders focus on, talk about, pay attention to, reward and seek to influence, tells those in the organisation what the leadership values and therefore what they, as organisation members, should value.

Where leaders model a commitment to high-quality and compassionate care, this has a profound effect on:

- clinical effectiveness
- patient safety
- patient experience
- the efficiency with which resources are used
- the health, wellbeing and engagement of staff
- the extent of innovation within the health care system (Dawson 2014; Shipton *et al* 2008).

Compassionate leadership for a compassionate culture

There is a growing research focus on the concept of compassion at work, with the journal *Academy of Management Review* dedicating a special issue to the topic in 2012 (Rynes *et al* 2012) and a huge increase in publications exploring compassion in health care contexts (numbering in the tens of thousands).

In order to nurture a culture of compassion, organisations require their leaders – as the carriers of culture – to embody compassion in their leadership. There is a clear link between supportive leadership and quality of care in the NHS (Shipton *et al* 2008). The same four compassionate behaviours outlined earlier – attending,

understanding, empathising and helping – must be demonstrated by NHS leaders through their leadership of health care organisations, at every level (West and Chowla in press).

What is innovation?

Creativity is generally defined as the generation of novel and useful ideas; innovation as both the production of creative ideas and their implementation (Shalley and Zhou 2008; Amabile 1996; Oldham and Cummings 1996; West and Farr 1990). Creativity is usually taken to mean *absolute* novelty, whereas innovation includes the implementation of ideas adopted from other organisations and adapted (Anderson *et al* 2004). Researchers have distinguished between innovation in the development of new technologies, the development of new products and services, the improvement of production systems or processes and the development of entirely new business models (Bessant and Tidd 2007; Anderson *et al* 2004; West and Farr 1990). For the purposes of this paper, we consider innovation in the round encompassing any introduction or development of new ideas with the aim of improving health care.

Researchers have also distinguished between different types of innovation by reference to the radicalness, novelty or magnitude of change involved. Hamel distinguishes between incremental change and revolutionary innovation, describing the latter as changing the balance of power or redefining the parameters of an industry (Hamel 1996). Christensen distinguishes between innovations that sustain an existing business model and disruptive innovations that fundamentally challenge firms' existing models and create new markets (Christensen 1997). In this paper, we consider both incremental and more radical innovation although we do not attempt to draw a clear distinction between them.

We define innovation as *the introduction and application of processes, products, treatments or procedures, new to the team, department, ward, pathway, organisation or system and intended to benefit patients, staff, the organisation or the wider society* (adapted from West and Farr 1990).

How does compassionate leadership enhance innovation?

Compassionate leadership creates the necessary conditions for innovation among individuals, in teams, in the process of inter-teamworking, at the level of organisational functioning as a whole, and in cross-boundary or systems working (*see* Table 1).

Table 1 Compassionate leadership and the processes that lead to innovation, from the individual level to the system level

Level	Compassionate leadership activities	Cognitive/emotional processes	Other processes
Individual	Listening Role-modelling reflexivity Coaching	Self-efficacy Self-worth at work Good relationships	Suggesting Noticing opportunities Trying, failing, learning
Team	Creating a psychologically safe environment Discovering meaningful differences and similarities Facilitating purpose	Psychological safety Appreciating each other Team identification	Discussion Review and implementation Team efficacy and potency
Inter-team	Exchanging information empathically Role-modelling perspective-taking Building awareness of mutual needs and interdependence	Multi-level perspectives Organisational identification Diversity matters	Lower inter-team conflict Higher inter-team collaboration Higher-quantity and higher-quality innovation
Organisational	Having a realistic vision Creating a culture of belonging Personalising purpose Using strategy as practice/ a learning process	High levels of inclusion Secure attachment/high organisational identification	Organisational agility and responsiveness Organisational resilience Faster adoption of innovation
System-wide	Showcasing compassionate leadership practice Using strategy as a reflective learning process	Embracing failure as human and an opportunity for improvement System resilience Adopting a learning perspective	System-wide learning Robustness/resilience Faster diffusion of innovation

Compassionate leadership, problem-solving and innovation

Innovation is often spurred by a challenge or problem that confronts people, teams, organisations or communities. We therefore now focus on the relationship between compassionate leadership and problem-solving in health care.

Problem-solving can be seen as having four broad stages: problem identification and exploration, ideation (the generation of ideas), evaluation and implementation. We suggest that compassionate leadership is a powerful facilitator at each stage of the problem-solving process and, by extension, innovation. Below we set out the four components of compassionate leadership and how they relate to problem-solving and innovation.

- **Attending.** Attention is vital for ensuring that the key challenges that staff face are clearly identified (a prerequisite for innovation) and that there is an awareness of the domains that need innovation and improvement (Van de Ven 1986). When leaders pay attention to accounts of difficulties, challenges and problems, they can then be explored in depth. This is the most important phase of the innovation process because a good understanding of the issues ensures that innovation attempts are appropriately directed. Leaders who actively listen, pay attention, withhold judgement, clarify, summarise, reflect and share in turn. Active listening requires a frame of mind geared towards learning and gaining insight, as well as an empathic connection to the other (Hoppe 2007). It establishes the caring and compassionate connection necessary for strong and lasting bonds among leaders and employees.
- **Understanding.** Compassionate leaders work in conjunction with staff to make sense of and understand the challenges they face. A collective, compassionate approach to leadership is not hierarchical and directive but engaging and supportive. The more staff are enabled, supported and empowered to develop a comprehensive understanding of the challenges they face, the more likely they are to develop effective innovations in response because they have an expert perspective. Leaders who engage in coaching behaviours help others to discover solutions for their problems themselves, enhance their self-discovery and in turn increase their self-awareness and self-efficacy (Ting and Scisco 2012; Strauss *et al* 2009). The enhancement of self-efficacy and self-worth is particularly important for employees who have had the experience and/or perception of being disempowered, disenfranchised or discriminated against, as all these experiences have a strong negative effect on self-efficacy and self-worth (*see* for example Hackett and Betz 1981) and, thereby, innovation.
- **Empathising.** Empathic leadership increases team member motivation, commitment and engagement, which are vital for innovation at every level of an organisation. Empathy also creates a more positive emotional environment, which is associated with higher levels of creativity and innovation and enables 'affective shift' (whereby negative emotion is transmuted into positive affect

with the by-product of creativity – Bledow *et al* 2013). People are more likely to identify problems, notice opportunities, explore new ideas and have confidence to overcome challenges by innovating. They are more likely to make suggestions proactively, knowing their voices are listened to and their perspective is appreciated. If staff feel more positive, they are likely to have greater resilience and to learn from mistakes and failure (Fredrickson 2004).

Moreover, to the extent that those offering leadership are able to empathise with those they lead, the more motivated the latter will be to take action to help find solutions to the challenges they face (Worthington and Scherer 2004; Brown *et al* 2003; Batson *et al* 1995). Feeling valued, respected, understood and supported by leaders is associated with higher levels of engagement and innovation (West and Richter 2007). And compassion creates a sense of being valued at work (Dutton *et al* 2014). This sense of being valued and worthy is not a given in work organisations; rather, it is something that is either created or destroyed, by the way that people interact with one another at work (Dutton *et al* 2014).

When leaders empathise with those who face challenging problems at work, they experience some measure of the frustrations, anxieties and pain of others. That provides the motivation to offer practical support to change the situation (Gilbert in press). A compassionate approach to dealing with failure can help employees to take safe risks and explore new ideas, particularly when they see failure as a necessary step in learning and innovation.

- **Helping.** The fourth component of compassionate leadership is taking thoughtful and intelligent action to help – leaders working with those they lead, to support them in their work. Of course, most leaders believe that what they do is to help, but thoughtful and intelligent action that engages and involves staff is different from merely telling others what to do. It includes the innovation processes of ideation, evaluation and implementation. Compassionate leadership involves helping staff to develop ideas for new and improved ways of doing things, be it providing health care, completing administrative tasks, supporting patients and their families or overseeing financial probity within the organisation. Such leadership also helps staff to evaluate options in a non-threatening environment where leaders do not impose or reject solutions because of their hierarchical position. Compassionate leadership manifests in leaders finding the time and resources for innovation and removing the obstacles to implementing new and improved ways of working.

Collective leadership

The arguments above imply a collective approach to leadership: leadership of all, by all, for all. This means:

- everyone taking responsibility for ensuring that there is high-quality, continually improving and compassionate care
- shared rather than dominating leadership in teams
- continual development of teamworking (West 2012)
- interdependent leadership with leaders working together across boundaries, prioritising patient care overall, not only in their area of responsibility
- a consistent approach to leadership across organisations, characterised by authenticity, openness, curiosity, kindness, appreciativeness and, above all, compassion (West *et al* 2014a).

Research into cultures of high-quality care internationally suggests that dominant, hierarchical and top-down approaches to leadership are the most ineffective ways of managing health care organisations (West *et al* 2014b).

In summary, we suggest that collective leadership creates a culture in which high-quality, compassionate care can be delivered because all staff accept the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within the organisation. That in turn stimulates individual, team and cross-boundary innovation.

In this section we have described in general terms how the elements of compassionate (and necessarily collective) leadership combine to facilitate the major stages of the problem-solving process and, by extension, innovation. In the next section we show how there are important links between compassionate leadership values, the core cultural values of high-performing health care organisations and the key elements necessary to nurture a culture of innovation. Our review of the research literature on cultures of high-quality care (Dixon-Woods *et al* 2014), cultures of innovation in health care (West *et al* 2014b; Charles *et al* 2011) and compassionate leadership (West and Chowla in press) reveals a powerful synchronicity, which argues for the importance of developing compassionate leadership for a high-quality and innovative culture in health care.

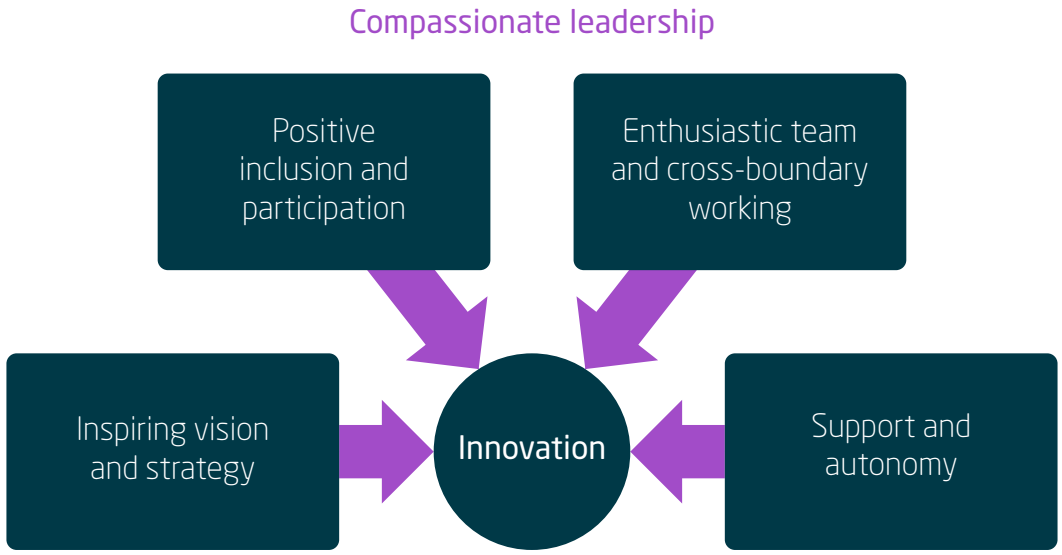
The key elements of a culture for innovative and high-quality care

The NHS context is one of very high levels of work demands. This significantly influences innovation because people innovate partly in response to such demands. Among NHS staff, high work demands predict both individual innovation (West 1989; Bunce and West 1996, 1995) and team innovation (Borrill *et al* 2000). Where teams function well, there are higher levels of team innovation, particularly in highly demanding contexts (such as areas with high levels of deprivation). Research involving top management teams in NHS hospitals (West and Anderson 1996, 1992) also suggests that external demands have a significant impact on organisational innovation.

What is intuitively apparent is that the relationship between work demands and innovation is not linear. Excessive work demands have detrimental effects on stress levels, absenteeism and staff turnover (Wall *et al* 1997) and are likely to produce 'learned helplessness'. Either very low or very high levels of demands will be associated with relatively low levels of innovation. All the more important to ensure compassionate leadership that supports staff in dealing with their highly demanding work environments (Worline and Dutton 2017).

Based on our review of the research literature on innovation generally, and on innovation in health care specifically, we have identified four key elements of culture that need to be in place within organisations and across systems for innovation to take place under compassionate leadership and these are described below (and in Figures 1 and 2).

Figure 1 Key elements of a culture of innovation



Inspiring vision and strategy

Organisations and systems that have an inspiring vision and strategy focused on high-quality, continually improving and compassionate care are likely to innovate in pursuit of that vision and strategy. Fundamentally, all leaders must demonstrate an unwavering daily focus on the vision and strategy and nurture optimism and a sense of efficacy about progress towards the goals inherent in them (Schneider *et al* 2017; Dixon-Woods *et al* 2014). Compassionate leadership necessarily implies that leaders within health care will be focused primarily on providing high-quality care for people in their communities. The innovation literature makes clear that such clarity of vision and strategy in practice (as contrasted with merely espoused visions) is associated with higher levels and quality of innovation and improvement (West and Richter 2007).

Staff in the English NHS report often feeling overwhelmed by tasks as well as unclear about their priorities, and there is robust evidence showing that this leads to stress, inefficiency and poor-quality care (Dixon-Woods *et al* 2014; Wall *et al* 1997). Compassionate (and skilled) leadership involves helping translate the vision and strategy into a limited number of challenging but manageable priorities, with clear, aligned and challenging objectives for all teams at all levels in the organisation (West 2013). Such conditions also facilitate innovation. Compassionate leaders facilitate teams and ensure agreed rather than imposed objectives, based on a shared understanding of the work context faced by the team. This is quite different from

the institution of target-driven cultures – an approach that has limited success (**Ham 2014**). Compassionate leadership requires leaders who listen to, understand and support staff both to set and achieve challenging objectives.

Compassionate leadership also addresses the problem of work overload, which both damages employee health and inhibits effective innovation. When there is leadership recognition that staff are unacceptably overloaded, compassionate action ensures that there is clarity about priorities as a result of dialogue, negotiation, exploration and a shared commitment to high-quality outcomes. Teams that have agreed a limited number (five or six) of challenging, clear and motivating objectives or goals are both more effective and innovative than other teams without such clarity of direction (West 2012).

Positive inclusion and participation

Compassionate leadership is inclusive in ensuring that the voices of all are heard in the process of delivering and improving care. It is also marked by humility, a key trait of many of the most effective leaders (**Ou *et al* 2015**). Compassionate leadership creates psychological safety and encourages team members to pay attention ('listen with fascination' to each other), develop mutual understanding, empathise and support each other (West and Markiewicz 2016). In such psychologically 'safe' team environments, there are higher levels of learning and innovation (Edmondson 1999). Empathic responding by leaders that mirrors emotions, creates the sense of psychological safety that Edmondson (1999) and others have shown is vital for developing innovation in health care teams – what she calls 'learning when it's safe'. Psychological safety also ensures that the benefits of diversity are realised more effectively. Others have highlighted the importance of engaging staff across an organisation, in particular those with different perspectives, in the process of identifying opportunities for radical innovation (*see* for example Hamel 1996).

Diversity contributes to the magnitude of the total pool of task-related skills, information and perspectives. The size of the pool represents the potential for more comprehensive or creative decision-making via 'informational conflict' (when different team members have varying information that bears on the decision, they must collectively process it carefully to enable high-quality decision-making) (Simons *et al* 1999; Milliken and Martins 1996). Compassionate leadership is associated with a valuing of all voices in a team. And this results in informational conflict being processed in the interests of effective decision-making and high-quality patient care, rather than on the basis of a motivation to win or prevail, or because of conflicts of interest. This in turn generates improved performance and innovation (Paulus 2000;

Tjosvold 1998, 1991, 1985, 1982; De Dreu 1997; Porac and Thomas 1990; Pearce and Ravlin 1987; Hoffman and Maier 1961). Groups that work in a positive emotional environment coupled with diverse but overlapping knowledge domains and skills are particularly creative (West 2002; Dunbar 1997, 1995).

Diversity of people, inputs and voices must be complemented by consistently positive attitudes to difference (of opinion, professional background, experience and demographic features). Positive inclusion must exist in every team not simply as an organisational aspiration, but in order to ensure that difference and all voices are valued, thus stimulating psychological safety, trust and engagement. Compassionate, collective and inclusive leadership promoting positive attitudes to diversity, to inclusion and to creativity and innovation must be nurtured in every team and department and at every level of the organisation.

Such compassionate leadership will apply also to the involvement of patient groups and the wider community in the development of treatment options and the design and delivery of health care services. The voices of service users are powerful stimulants for innovation – we know that extensive patient and carer involvement in organisations is associated with higher levels of innovation and improvement leading to radical change (West and Richter 2007). And patients' and citizens' groups that model compassionate leadership in their organisations and when they are designing services with health care organisations create the basis for productive and innovative partnerships.

Compassionate leadership offers a fundamental and powerful contribution to enabling organisations to identify strategies that truly begin to change cultures so that the voices and contributions of all are valued, be they black and minority ethnic staff, disabled people, religious groups, patients, carers and the wider public. The NHS has grappled unsuccessfully with issues of inclusion and diversity throughout its history, but there is a growing recognition that these issues must be dealt with decisively. Inclusion and diversity are powerful forces for innovation when successfully integrated into a wider innovation strategy.

Enthusiastic team and cross-boundary working

Good team leadership ensures connection and compassion across boundaries so that health care staff work together across professions to deliver high-quality care (West 2012; West and Lyubovnikova 2012). Compassionate leadership of teams involves ensuring a climate that encourages team members to listen carefully to each other, understand all perspectives in the team, empathise and help and support each other. Such teams are considerably more innovative than teams that

do not practise these simple teamworking skills (West 2012). These are precisely the conditions for team innovation (Sacramento *et al* 2006). Meanwhile, other research consistently emphasises the importance of interaction between professional groups and across traditional boundaries in order to generate and exploit new opportunities for innovation (Eisenhardt and Martin 2000).

Supportive teams, with compassionate team leadership, have significantly lower levels of stress than dysfunctional or pseudo teams in health care. The more that staff work in such teams, the lower the levels of stress, errors, staff injuries, harassment, bullying and violence against staff, staff absenteeism and (in the acute sector) patient mortality (West and Markiewicz 2016; Lyubovnikova *et al* 2015; Lyubovnikova and West 2013; Carter and West 1999). Teams with these characteristics ensure greater role clarity for team members, provide higher levels of social support and buffer members from the negative and depleting effects of wider organisational pressures – all conditions for innovation.

Inter-teamworking. Teamworking implies inter-teamworking as well. A core objective of any team in modern health care must be to demonstrate enthusiastic cross-boundary co-operation such that supportive inter-team, cross-boundary and systems working is the norm (Richter *et al* 2006). Members of both (or more) teams should adopt a mindset that each team has equal relevance and value. Their perspective of the organisation should expand to include the other team's needs, their value for achieving the organisation's goals and their interdependence with each other. Such a mindset leads to a dual identification with one's own team as well as the other team and the organisation(s) at large.

Compassionate leadership raises awareness within teams about how multiple parts of the organisation work together and depend on one another, strengthens organisational identification and increases the fundamental belief that diversity matters for organisational innovation as well as individual wellbeing. This, in turn, ensures:

- lower inter-team conflict
- more collaboration and compassionate communication
- a higher quantity and better quality of organisational innovation (Richter *et al* 2006).

Compassionate system leadership. Sustainability and transformation plans (STPs) are the main vehicle for transforming health and social care services in England in line with the *NHS five year forward view* (NHS England *et al* 2014). Health and social care

and other services must be integrated in order to meet the needs of patients, service users and communities both efficiently and effectively (Ferlie *et al* 2010; Huerta *et al* 2006; Lemieux-Charles *et al* 2005). The success of STPs will depend on high levels of collaboration across and between organisations that historically have little experience of working together, to deliver change at the scale and pace that now seems essential. This means that leaders need to work together collectively and build a collaborative leadership culture. This requires a shared vision of:

- high-quality, compassionate and continually improving care
- frequent and supportive contact across boundaries between leaders
- a long-term commitment to co-operative working
- quick, creative and fair resolution of conflicts
- an orientation of helping the other.

These are elements of cross-boundary working that are fundamentally underpinned by compassion.

Compassionate inter-organisational working (a form of leadership) requires frequent face-to-face contact to ensure attention, understanding, empathy and helpful support. Perhaps the most important element of compassionate cross-boundary leadership is agreeing a primary orientation of focusing on helping the other organisation(s) make their contribution to the shared mission of high-quality care – in effect, always beginning with the question 'How can we help you?'

Support and autonomy for staff to innovate

Staff engagement is higher in health care organisations where leaders create a positive emotional climate for staff, and where they show compassion and support for staff and help them to cope with the inevitable negative experiences of health care that patients have, such as fear, suffering, anger or grief. When leaders take the time to do this, they enable staff to experience positive affect and this leads to greater work-focused creativity (Bledow *et al* 2013). Staff feel involved and have the emotional capacity to be compassionate towards others.

Compassion is affectively positive and research shows that positive leader affect (or mood) is associated with more positive affect among employees (Cherulnik *et al* 2001), enhanced team performance (George 1995) and higher rates of behaviours that benefit others (George 1990). It is also associated with higher

levels of creativity and innovation (Amabile *et al* 2005; Isen and Baron 1991). However, how leaders behave affects not just the individuals they interact with. The affective states of individual group members can influence the general mood of the whole team, a phenomenon known as *mood linkage* or *emotional contagion* (Totterdell 2000; Totterdell *et al* 1998; Hatfield *et al* 1992). So beyond the impact of compassion on individuals, compassion has the potential to spiral out, directing caring and supportive behaviours towards others (Lilius *et al* 2011). For example, such compassion can replenish the emotional resources that caregivers need and cushion them against stress and burnout (Dutton *et al* 2014; Lilius *et al* 2011). The positive ripples of compassion can also affect witnesses and bystanders (beyond patients and carers), who may experience a feeling of pride about the way staff in the organisation behave, encouraging people to act more for the common good (Dutton *et al* 2014; Lilius *et al* 2011). And all this in turn affects both the motivation and capacity for developing new and improved ways of delivering health care.

At the same time, for innovation and quality improvement to be the texture of NHS organisations, command-and-control leadership has to give way to a model of collective leadership such that all staff embrace and aspire to leadership responsibility. Research into individual-, team- and organisational-level innovation consistently shows the importance of autonomy as an enabling condition for innovation (Hirst *et al* 2011). Coupled with this, given the importance of diverse perspectives to innovation, is the need to develop emerging and diverse leaders via strategies such as the new national improvement and leadership development framework, which has compassionate leadership at its core (National Improvement and Leadership Development Board 2016).

Creating the conditions for innovation requires giving frontline teams the autonomy to experiment, discover and apply new and improved ways of delivering care (Liu *et al* 2011; Somech 2006). Compassion involves creating space and freedom for the other by providing attention, understanding, empathy and support.

Where staff understand and are committed to the vision, aims and objectives of the organisation they work for and of their areas of work, giving them the freedom to decide their work methods, scheduling, time management and objectives ensures that they introduce significantly more new and improved ways of doing things to their work. This in turn increases productivity and efficiency. Similarly, teams engaged in complex work report that a high level of autonomy is more productive and generates a high quantity and quality of ideas for new and improved ways of doing things and leads to more high-quality innovations in practice (measured in terms of magnitude, radicalness, novelty and effectiveness). And organisations

that have a climate characterised by low levels of formalisation, bureaucracy and hierarchy and high levels of autonomy and discretion are significantly more innovative in relation to new services, products, technologies, processes and administrative procedures (West and Richter 2007). Compassionate leadership is contrasted with hierarchical and directive leadership in providing precisely these enabling conditions for innovation. Caring for others, helping them grow and develop and giving them the freedom to explore and experiment within safe boundaries is characteristic of compassionate leadership. Staff are more likely to challenge the status quo and be innovative within safe boundaries when they work in teams with compassionate and shared leadership.

The national NHS Staff Survey, which has been conducted annually for 12 years, shows that if staff are to treat patients with compassion, respect and care, they themselves must be treated with compassion, respect and care. Where health service staff report that they are well led and they are satisfied with their leadership, patients report being treated with respect, care and compassion (Dawson *et al* 2011). Directive, brusque managers dilute the ability of staff to innovate and to make good decisions; they deplete their emotional resources and hinder their ability to relate effectively to patients, especially those who are most distressed or difficult (West 2013; Mickan and Rodger 2005; Carter and West 1999).

Figure 2 Compassionate leadership and key cultural elements

Compassionate leadership: Four key elements needed for innovation			
Inspiring vision and strategy	**Positive inclusion and participation**	**Enthusiastic team and cross-boundary working**	**Support and autonomy**
• Unwavering focus on high-quality continually improving compassionate care • Inspiring and meaningful vision • Shared understanding • Clear, aligned, manageable challenges and tasks • Alignment between workload and resources	• Ensuring all voices are heard • Creating psychological safety and encouraging teams to be compassionate to one another • Valuing diversity including patient groups, positive attitude to differences • Fair resolution of conflict	• Working compassionately with other teams (inter-team compassion) • Being supportive and collaborative • Having a 'How can we help?' attitude	• Creation of a positive climate – high levels of engagement, positivity and creativity • Freedom to be autonomous, but with support • Treating staff with compassion

Conclusions

There are compassionate and inclusive leaders throughout the NHS, as some of the case studies presented in the Appendix illustrate, but there is a need to ensure that compassionate and inclusive values and behaviours are endemic across the system and at every level, from national bodies through to local providers. Most leadership development occurs through experience in the role and through observing good examples of leadership in our organisations. Therefore, we must go beyond only developing compassionate leadership on standardised training courses and ensure that leaders at every level role-model the values and behaviours. We must also offer timely feedback to all staff to ensure that compassionate behaviours are being modelled consistently to nurture a culture of innovation that delivers high-quality, continually improving and compassionate care.

Compassionate and collective leadership encourages individuals to respond autonomously to challenges by innovating rather than relying dependently on leaders to find solutions. In contrast to command-and-control leadership of teams, shared leadership in teams results in significantly higher levels of innovation and better health care team performance generally. Collective and interdependent leadership ensures that all are focused on working together across boundaries to ensure high-quality patient care overall. But such leadership has to be consistent, with all leaders modelling authenticity, openness and transparency, curiosity about how to improve leadership, appreciativeness and, above all, compassion.

The issues we have explored in this paper are not always well understood by leaders and managers in the NHS, so there is still much to do to implement these prescriptions in practice. In particular, NHS organisations do not generally have quality improvement and radical innovation as twin elements in their strategies. This may be changing as a result of the publication of the national improvement and leadership development framework in 2016 – a framework for action on skill-building, leadership development and talent management for all those in NHS-funded roles (National Improvement and Leadership Development Board 2016), which advocates compassionate and inclusive leadership across the sector.

For all NHS organisations to truly aspire to meet the challenges they face, they must draw on the deep knowledge base in relation to innovation and improvement and begin the process of transforming strategies, visions and objectives, their culture and leadership, their diversity and participation, and their systems, processes, structures and resources, to support innovation. Fundamentally, as we have shown, this requires compassionate leadership – at every level of the health sector.

Appendix: Case studies

Transforming junior doctors' working lives

Birmingham Women's and Children's NHS Foundation Trust

Birmingham Women's and Children's NHS Foundation Trust (formerly Birmingham Children's Hospital NHS Trust) has worked consistently over several years to create a culture of high-quality and compassionate care for patients and a culture of compassion for staff.

This began with a programme to develop effective teamworking across the trust – Building Team BCH (Birmingham Children's Hospital). Team Maker and Team Leader programmes have ensured that compassionate and supportive approaches to patients and relatives have been modelled and reinforced across the organisation.

A Caring for Team BCH programme has focused on how leaders can support staff and how staff can better care for and support each other in a time of limited resources. Self-compassion and compassion for each other are strong themes – down to making a cup of tea for a colleague who is clearly stretched and tired.

Listening to staff in the trust highlighted a major problem that is endemic in the NHS – the pressure on junior doctors was intolerable. Gaps in rotas meant that junior doctors were working in unacceptable conditions and that their learning was suffering. A perfect storm of pressure was building that was threatening patient safety and staff resilience. Team BCH responded by bringing together junior doctors, consultants, other clinicians, general managers, the finance department and the HR (human resources) department to listen deeply to people's views in order to understand the issues.

These events led to a wider understanding of the grim experience of many of the junior doctors in BCH and to genuine empathy. The challenge was how to make a difference. All involved committed to making BCH the best place for junior doctors to work in the country. Weekly Thursday morning meetings became the medium for innovation. Thirty-four rotas were redesigned and new roles were created to support junior doctors' work – advanced clinical practitioners and physician associates. Clinicians led the innovation and developed the new roles. Some of the toughest areas, such as surgery, became the lead ambassadors for the changes.

Junior doctors are now carefully inducted into the organisation and made to feel an important part of it, rather than 'transients'. They are steeped in the identity of the trust and told that they are fundamental to the effectiveness of the organisation. They are encouraged to attend trust-wide events and leadership meetings and to contribute their ideas. A previously untapped resource is now a prolific source of learning and innovation for the whole organisation. The General Medical Council survey of junior doctors (**2016**) has shown a shift from one where most junior doctors would not recommend training at BCH to one where 100 per cent would recommend it. One commented: 'I've worked in lots of organisations where the values are on the wall but this is the only one where the values are truly lived.'

Theresa Nelson, Chief Officer for Workforce Development at BCH who was interviewed for this report, believes that compassionate leadership and teamworking are vital because people have to feel psychologically safe in order to innovate. She says that the leadership of BCH are committed to listening carefully to their teams about their experiences, conducting exit interviews, learning from focus groups and monitoring sickness trends to ensure that supportive leadership and teamworking are developing everywhere in the organisation. Crucial is the need to keep nurturing a culture for innovation – 'there's never an end point'.

The Thursday morning meetings continue to generate ideas for new and improved ways of doing things. BCH is now a best-practice example for the West Midlands Deanery in relation to the learning experiences and organisational integration of junior doctors. BCH is the first children's hospital to be rated 'outstanding' by the Care Quality Commission.

Compassionate leadership for innovation in high-quality home care

Buurtzorg, the Netherlands

Jos De Blok founded Buurtzorg, a new organisation and care delivery model, in 2007, with one team of four nurses. They aimed to deliver high-quality and compassionate community care, working together with general practitioners. Today it is a highly effective organisation employing 9,500 nurses in 800 independent teams, supported by 45 administrative staff and 15 coaches.

Jos De Blok's idea was that good health care should connect to the intrinsic motivation of the nurses. It had to be inspiring so that the nurses themselves would be the carriers of the vision of high-quality, continually improving and compassionate care. He felt that the way home care was then organised made it

difficult for nurses to do their work. Moreover, he saw poor leadership, which was leading to bureaucracy, unhappy staff and poor care for patients who were clearly suffering. This meant that staff were not learning and not innovating. He quit his job as a home care managing director, and started the Buurtzorg initiative.

Staff now have the autonomy to make their own decisions and to innovate. They work in an unusually 'flat' organisation (such an organisation being one that has few or no layers of management between staff and executives), which offers a supportive and compassionate culture. The emphasis is on working in self-directed teams, encouraging inter-team sharing of innovative practice, strong values of compassion and visions of high-quality care. Teamworking is based on a consensus model. Staff are encouraged to seek support, and coaches are available to listen, share understanding, empathise and offer guidance and support, based on learning from across the organisation. This has led to a completely different dynamic compared with working in a hierarchical organisation.

Family members of service users are included in the care process. Nurses are supported by volunteers or informal carers, enabling them to build unique relationships with a good mix between formal and informal care. They see themselves much more as part of the community. They invite members of the community to work with them and, in turn, are invited for conversations into people's homes and to community meetings. Many of the nurses now have connections with their counterparts in other countries, sharing good practice and learning about local innovations.

The organisation has won 'best employer of the year' in the Netherlands, has the highest service user satisfaction ratings for any community care organisation in the country and has overhead costs that are a fraction of those of other service providers. Staff sickness rates are less than half of those of other community care organisations in the Netherlands.

Buurtzorg is a network, not a hierarchy, and there are coaches to enable, rather than managers to manage. Trust, flexibility and autonomy are the backbone of its success, set in the context of humanistic, person-centred (rather than organisation-centred) care, partly as a reaction to targets and bureaucracy, which often work against human relationships. It is also about organising care for the person within the context of their community and support networks. In a nutshell, it is all about compassion and relationships.

Further information can be found at:

www.buurtzorg.com/

www.kingsfund.org.uk/sites/files/kf/media/jos-de-blok-buurtzorg-home-healthcare-nov13.pdf

www.enliveningedge.org/features/how-the-buurtzorg-model-of-healthcare-influences-uk-health-social-care/

Empathy in design

IDEO

IDEO, an international design firm, is one of the most innovative companies in the world. It works across sectors, including health care, and uses a 'human-centred' or 'empathic design' approach to help clients innovate and grow. Empathy is used during the design process when designers aim to connect emotionally and mentally with the needs of clients to understand deeply the nature of the problem, so that they can design possible solutions together.

IDEO sees innovation as sitting at the intersection between the needs of people, technological possibility and commercial viability (Paul 2015). Whether it is redesigning a paediatric CT (computerised tomography) scanner with GE Healthcare, so that children feel less afraid to have their scan (and so remain more still during the procedure) (ThisIsDesignThinking.net 2014), creating an effective public health campaign in Bangladesh to promote infant feeding practices (Grubman 2014) or creating 'care-boards' with Kaiser Permanente in the United States (Cox 2015) so that the nursing handovers achieve what they need to for patients and staff alike, being empathic is at the heart of the process.

IDEO's approach to helping clients stems from its values and culture. When employees first join the company, they are given *The little book of IDEO,* which explains the company's seven values (IDEO 2013). These include being optimistic and collaborative, taking ownership, embracing ambiguity, 'talking less and doing more', learning from failure, and genuinely wanting to make others successful by going out of their way to help them. IDEO's working culture is tightly aligned to the four elements of compassionate leadership that are needed for innovation.

IDEO says that the most powerful word in its arsenal is 'we' and it actively nurtures a culture where people ask for and give help, at all levels. People are taught to

assume that they will need help, and while there are few formal roles/titles at IDEO, there are support roles: there are 'discipline leads', who have deep industry expertise and can be called on to provide ad-hoc support to projects as needed, and 'design helpers', who are attached to every project to support design-related processes.

A network mapping exercise (Amabile *et al* 2014) looking at helping interactions within IDEO showed that the popular helpers were spread across all levels of the organisation and that, unlike at many organisations, where employees have clique or 'hub-and-spoke' networks, at IDEO most employees had a large and diverse array of helping interactions. It also showed that the characteristics of good helpers were accessibility and trust, rather than merely competence.

To embed this within its culture, IDEO plans the use of resources to allow slack in its system so that employees have the time to notice, listen, understand, empathise and help colleagues – not least because these are the behaviours that it uses when working with clients during the human-centred design process.

The advantage of 'flat' and fluid structures is the level of interaction and degree of network-building that employees have across their organisation. This facilitates teamworking, helping and the cross-fertilisation of ideas, which are essential for creativity and innovation.

IDEO has no corporate hierarchy and a very flat management structure (Dawson 2012). Offices, or studios, as they call them, work independently but share members and information, as projects require. Teams are project-focused and their make-up depends on the problem at hand. They are always diverse in terms of skills, for example they could consist of a psychologist, an industrial engineer, a marketer, a linguist and an MBA graduate, where the project leader is elected by the team members because of their skills/expertise related to that particular project, rather than on tenure or seniority. These positions are project-specific and therefore temporary.

IDEO has no strict rules, no dress code and no titles. Employees are encouraged to design their own offices and are given the autonomy to choose (to some extent) which projects they feel most excited to work on, and how these projects work. They are encouraged to take ownership (one of the seven values) because individual independence and ownership is what their collective interdependence is built upon.

IDEO's design methodology involves a process of 'inspiration, ideation and implementation', which involves various iteration and feedback loops with clients. Learning from failure (another IDEO value), and sharing this learning, are key to

being innovative. It is also here that optimism (another of the values) comes in. For IDEO, being optimistic is important because its clients need to be optimistic about their future – believing in the possibility of creating something better. Ultimately, being inspired to help its clients (and in the process each other) is what drives IDEO. The parallels and lessons for the NHS are obvious.

Compassion driving innovation in poorer regions of the world

Many sections of Indian society now have access to low-cost and often free health care, thanks to innovative organisations such as Aravind Eye Care Systems, Sankara Eye and Narayana Health. A compassionate sense of duty was at the heart of the initial efforts of their founders, which has since driven their growth through innovation, and which sustains them today. All three organisations have developed high-volume/low-cost and hybrid revenue models at costs that are a fraction of those in the developed world.

Aravind Eye Care Systems

Dr Venkataswamy, the founder of Aravind, set it up after his retirement in the late 1970s, as a small clinic from his house, aiming to provide high-quality eye care for all. With a vision of 'seeing all as one and giving sight to all' (Mehta and Shenoy 2011), and inspired by McDonald's fast-food restaurants and Henry Ford's assembly line, he focused on using surgeons' time in the most efficient way (**Frugal Solutions undated**). Aravind organises clinics as factories, with lower-wage crews preparing patients for surgery and rolling them into theatre, while two assembly lines operate in parallel, so that surgeons move immediately from one patient to the next (**Shah and Murty 2004**). In keeping with its ethos of affordability and inclusion, it maintains a ratio of 1:2 between paying and non-paying patients, to allow the cross-subsidy to cover those who cannot pay (**Shah and Murty 2004**). It has also continued to innovate in terms of products, and in the 1990s invented a low-cost intraocular lens, which costs US$2 and is now exported throughout the world (**Govindarajan and Ramamurti 2013**), making up 8 per cent of the global lens market (**Aravind Eye Care System undated**). In 2011, each day the group saw 7,500 patients, performed between 850 and 1,000 procedures and provided workshops for 400 visitors/professionals to learn how it operated (Worline and Dutton 2017). A sense of deep compassion and commitment, and strong leadership, are the key elements of the Aravind model (**Shah and Murty 2004**).

Sankara Eye

Sankara, much like Aravind, had humble beginnings, starting out as a 10 foot by 10 foot clinic near to the home of its founders, Dr Ramani and Dr Radha. The founders started this free clinic for the local underserved population because they were driven by a passion 'to do good and to do more'. Sankara has always maintained its not-for-profit status, but has now grown into one of the largest community eye care networks in the world. It has performed 1.6 million free eye operations for adults and children in the past decade (80 per cent of Sankara's patients are treated for free) and has also started to expand across to other states in India.

Sankara was one of the first organisations in India to offer screening programmes that focus exclusively on children. In one such programme called 'Rainbow', it trains school teachers to provide preliminary screening for eye problems. Children who they are concerned about then receive a comprehensive assessment from Sankara's visiting eye teams and subsequent treatment, either locally or at the nearest Sankara hospital.

Much like Aravind, Sankara can maintain a high-volume throughput at its hospitals because of its rural community outreach camps. In 2014–15, Sankara ran 1,798 camps and screened almost 350,000 patients. It also introduced the use of tablet personal computers to field workers for the purposes of registration, surveillance and follow-up, and the rich data collected is now being used to develop targeted public health programmes, for example in diabetes, for these far-to-reach communities.

Another Sankara initiative, the 'Vision Care Technician' course, is offered exclusively to girls aged 18 who are leaving school. This two-year Sankara-sponsored residential training course also comes with a stipend, subsidised board/lodging and the opportunity to work at a Sankara Eye hospital upon graduation. Bharath Balasubramaniam, President of Sankara Eye Foundation India, commented that: 'While this was conceived as a part of our capacity-building strategy, it has turned into a women's empowerment programme. In many parts of India, these young women might have stayed at home and never worked after finishing school, but our graduates end up being the breadwinners for their families and they are then inspiring others to also come and find work at Sankara.'

Narayana Health

Narayana Health was founded in 2001 by Dr Devi Shetty, former cardiac surgeon to Mother Theresa. He believed that, as a physician, he had a moral duty to make health care affordable and accessible to everyone, regardless of caste, creed, religion or income (Radjou *et al* 2012). Narayana Health was created to provide low-cost (or free) cardiac surgical care to the millions in India who could not afford care at all.

At the hospital in Bangalore, they perform 4,000 cardiac surgeries per year, more than the top two hospitals in the United States (**Davidson 2015**) with outcomes comparable, if not better, than the West (**Davies 2012**), for a cost of US$2,000 each (versus US$20,000 to US$100,000 in a hospital in the United States) (**Smith 2012**). Its model relies, as Aravind's, on concentrating high volumes of patients in its centres, standardising processes and keeping costs low. For example, the use of its theatres is maximised, its high purchasing power means a strong negotiating hand with suppliers, it often leases rather than buys expensive equipment and it has partnered with Texas Instruments to create low-cost x-ray plates.

Narayana Health has pioneered micro-insurance and flexible payment schemes so that low-income people can access its services, with 40 per cent of its patients paying a discounted rate and 20 per cent nothing at all (**Smith 2012**). It has also worked with Stanford University to create a training programme to give families the skills they need to help provide care for relatives coming out of an Intensive Care Unit (**Govindarajan and Ramamurti 2013**), for example helping alongside nurses and coaching rehabilitation exercises. In a sample size of 100 patients, the Stanford team found a 24 per cent reduction in re-admissions and a 36 per cent reduction in complications after 30 days (**Bibby 2015**).

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