

MY HOME LIFE: PROMOTING QUALITY OF LIFE IN CARE HOMES

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This report summarises the lessons learnt from the **My Home Life** Programme examining 'what works' in the promotion of 'voice, choice and control' for older people who live in care homes.

Older people have identified the importance of having control over how they lead their lives and the care that they receive. This is also echoed in government policy across all four nations of the UK. However, there remains a lack of real understanding of what this looks like in care homes and how to make it happen.

Through working in partnership with care homes across the UK, the report:

- offers examples of good practice in supporting 'voice, choice and control' for older people;
- highlights the vital role of leadership in helping to creating a culture that enables older people to experience 'voice, choice and control'; and
- describes some of the obstacles to supporting voice, choice and control and how stronger partnership-working between care homes, the community and the wider health and social care system can make a difference.

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EXECUTIVE SUMMARY

This three-year study is part of the Joseph Rowntree Foundation's *A Better Life* programme. It summarises the lessons learnt from implementing best practice in care homes for older people and, in particular, supporting the promotion of 'voice, choice and control' and 'the development of leadership' within the care home sector.

The project adopted an appreciative action research methodology, working in collaboration with the care home sector, to explore and reflect upon 'what works' and then to identify areas in need of improvement.

Good practice in supporting 'voice, choice and control' was found to be linked to the transformational leadership of care home managers. Positive relationships were also needed between care home managers, owner/providers, local community and the wider health and social care system.

'Voice, choice and control' in care homes

Key messages from over 100 examples of good practice submitted by care homes were explored with the sector.

'Voice, choice and control' means different things to different people. The principles of 'voice, choice and control' align well with the three *My Home Life (MHL)* Personalisation themes, namely: 'Maintaining Identity', 'Sharing Decision-Making' and 'Creating Community'.

Achieving 'voice, choice and control' is more complex in a setting of collective living, such as a care home, where the needs and aspirations of an individual must be negotiated with those of the wider community.

Maintaining Identity – See who I am!

Care homes are uniquely placed to help older people to maintain their personal identity, because staff have the opportunity for regular interaction and engagement with them. Collective living, therefore, creates the potential for staff to really get to know these older people; to look beyond the

dementia, beneath the frailty, in identifying who they are as human beings, what is important to them and what the care home can do to respond to this.

Sharing Decision-Making – Involve me!

Many different approaches exist to support older people to get more involved in decision-making, both in relation to their own care and the running of the home. Informal approaches (e.g. shared meal times) have particular value in eliciting views and engaging older people.

While there is a need to recognise the importance of shifting real power and governance to older people, their families and front-line staff, it is also important to remember how, for some older people, it is often the little things that count.

Exercising 'voice, choice and control' typically involves older people considering the inherent risks involved in any activity. Where older people are unable to make an informed judgement, staff should work in the best interests of the individual to balance self-determination against the potential impact of the risks involved.

Creating Community – Connect with me!

Plenty of examples exist where older people are supported to engage in external community activities and where others are encouraged to come into the care home to engage in meaningful activities.

The team carried out a small number of telephone interviews with community advocacy projects to identify good practice in supporting 'voice, choice and control' for older people living in care homes. Advocacy projects can help to develop longer-term relationships with older people, their family and staff, and foster better partnership-working in care homes.

Volunteering in care homes is in many ways a 'forgotten' area. Lack of time to recruit and support volunteers, the need for easier and speedier Criminal Records Bureau checking and the potential value of an external co-ordinator were seen as key.

The examples highlight the importance of supporting older people to move into a care home, advocating for older people when negotiating with health professionals about how and where care will be delivered, and opening up conversations with older people and their families about the end of life.

Relationship-centred care

Positive relationships enable staff to listen to the older person; gain insight into their individual needs, aspirations, and wishes; and help facilitate more 'voice, choice and control'. This finding is not new. It reflects the strong body of knowledge surrounding relationship-centred care.

Leadership in care homes

The literature on leadership in care homes highlights the importance of positive relationships, valuing different perspectives and fostering creativity, learning and innovation.

Evidence from face-to-face discussions with care homes identified nine outcomes of good leadership in the care home sector and suggested the importance of a number of key themes to make this happen, including: leadership starts at the top, importance of transformational leadership, getting the right staff, helping staff to engage with their work, supporting

staff and role modelling, making the environment more conducive to engage, working in partnership with external organisations, ongoing support to managers.

It is argued that, in order to enhance ‘voice, choice and control’ within the care home community, leadership that supports, nourishes and enables staff, older people and their relatives to engage with each other and the wider community is essential. A transformational leadership model, which embraces the notion of ‘Dispersed Leadership’ and ‘Servant Leadership’, fits well with this goal.

Obstacles to leadership and ‘voice, choice and control’ in care homes

From our ongoing engagement with 124 care home managers across seven sites, we identified how quality in care homes relies on strong partnership-working across the system. When managers have the positive support, trust and backing of colleagues from across health and social care and from their respective care home providers/owners, they feel more confident, more resilient and more able to create an enabling and supportive culture of practice for their staff, older people and family members.

For many care home managers, this trust and support is often absent. Many spoke of the unacceptable pressures placed upon them and their staff, a sense of isolation, and poor acknowledgement of their views and expertise within the wider health and social care system.

Care home managers need to feel less threatened or blamed by external agencies on the occasions when considered things go wrong, especially when every effort has been made to keep the older person safe from harm.

Some managers described how they felt there were mixed messages from inspectors, council officers, health and safety officials, and family members about what is deemed to be acceptable practice and acceptable risk. These leave the care home manager unclear about what *is* and *is not* permitted.

Towards transformational leadership and better partnership-working

MHL has to date supported over 250 care home managers through its Leadership Support and Community Development (LSCD) activity across England and Wales. Data from an initial group of 124 managers identified how the LSCD Programme was providing a safe place to reflect and learn, which resulted in increased resilience at work, changes in their leadership style, enhanced relationships with staff and being better able to deal with challenging staff. Most managers identified that there was a calmer atmosphere in the home and that staff were engaging more positively with the residents.

Some managers described how difficult it was to transform the culture of the care home when care home owners/providers and the wider system are not supporting them to deliver relationship-centred care.

In six local authority areas, *MHL* has acted to facilitate discussion and reflection on the following themes: improving the experience of older people in their transition from hospital to care homes (and vice versa); supporting older people and staff cope with care home closure; improving partnership-working between care homes and quality monitoring, commissioning,

contract and social work teams; and supporting better community engagement in care homes.

The work enabled the different stakeholders to get to understand, value and respect each other's perspectives and contexts and help sort out local issues that were getting in the way of quality of life in care homes.

MHL has also been working at a national level with government and key agencies to communicate how they can better support care homes to deliver 'quality', 'leadership' and 'voice, choice and control'.

Three overarching messages have emerged out of the broader work of *My Home Life*:

- 1 Care homes aren't and shouldn't be seen as, the 'last resort'. They can be a positive experience for older people, offering a better quality of life and new and meaningful relationships.
- 2 They look after some of our frailest citizens and need our support, trust and respect, as well as realistic funding in order to do it well.
- 3 Care homes don't want to be seen as 'islands of the old' – they welcome their local communities in becoming more actively involved.

Recommendations

Our main recommendations fall into four areas:

- **Supporting transformational leadership:** Ongoing professional support is needed for care homes managers to support them in their pivotal role in promoting positive relationships between older people, staff and relatives.
- **'Voice, choice and control':** Investment is needed in advocacy projects, volunteering and new approaches to engage older people in how care homes are run.
- **Better partnership-working:** Statutory bodies should work with care homes to agree a vision for quality and identify supportive ways of working based upon mutual trust and collaboration.
- **Challenging the negative stereotypes of care homes:** Partner organisations within the MHL Programme should consider how collectively they can find ways for encouraging press organisations to report care homes in a fairer and more balanced way.

1 INTRODUCTION

This report provides an account of a three-year appreciative action research study (2009–12) to explore the lessons learnt from implementing best practice in care homes for older people and, in particular, to support the promotion of ‘voice, choice and control’ and ‘the development of leadership’ within the sector.

The work was carried out by the *My Home Life* Programme (www.myhomelife.org.uk), a UK-wide collaborative initiative led by Age UK in partnership with City University, the Joseph Rowntree Foundation (JRF) and, more recently, Dementia UK. *My Home Life* (MHL) began in 2005 as a small project to synthesise the literature on best practice in care homes. Seven years later it is viewed as a social movement to promote quality of life for those who are living, dying, visiting and working in care homes for older people through relationship-centred, evidence-based practice. It is possibly the only movement that has the support of every national provider organisation representing care homes in the UK,¹ as well as the Relatives and Residents Association (see Appendix for more information on MHL).

This appreciative action research study is part of a broader programme of work funded by JRF called *A Better Life* (www.jrf.org.uk/work/workarea/better-life), which seeks to explore how we can ensure quality of life for the growing number of older people with high support needs in the UK. The *Better Life* programme has four main strands of work:

- 1 Defining what makes ‘a better life’** by hearing what diverse older people with high support needs say about what they want and value.
- 2 Improving residential and nursing care** by building our understanding of how to maximise older people’s choice and quality of life in care settings so that we can influence policy and practice development.
- 3 Researching housing with care schemes** by informing those involved in policy and practice about how housing with care schemes can support older people who have, or who develop high support needs.
- 4 Identifying alternative approaches** by exploring other accessible and affordable approaches to support, housing and community for older people who have, or who develop high support needs.

The MHL work represents the commitment in Strand 2 of the programme to improving residential and nursing care.

This report refers to the term ‘care home’ to describe ‘any registered residential care settings where older people live and have access to on-site personal care services’. Occasional references are made within the report to ‘Care homes with, or without, nursing’ – this relates to whether a care home is or is not registered to provide a qualified nurse on duty 24 hours a day to carry out nursing tasks.

In this chapter, we provide the background to the study, outlining the social, political and economic context; the values and principles of *My Home Life*; and the nature of the study.

The social, political and economic context

Policy across the four nations of the UK has, over the past decade, focused on supporting greater choice, involvement and control for service users. All regulatory standards across the four nations make some reference to user involvement or choice for service users.

In England, a raft of literature, policy and guidance has been generated in recent years, locating the individual at the centre of decision-making on issues of health and social care (DH, 2007; DH, 2010; NICE, 2008). Outcome 1 of the Quality and Safety Standards for care homes refers to service-users being enabled to make decisions relating to their care and treatment (CQC, 2010b). The term ‘Personalisation’ has been adopted within English policy to describe the need for greater provision of personal budgets and direct payments for service-users to enable them to have direct control over their own care planning. Following a decision by the Law Commission, this may shortly result in service-users being able to use direct payments to purchase care home services (Law Commission, 2012). However, Personalisation also refers to a broader need for services to be ‘more tailored to individual choices and preferences’ (DH, 2008a, p. 5). Most recently, the Government’s Social Care White Paper *Caring for our Future: Reforming Care and Support* (July 2012) stresses its commitment to hear the voices of people who use care services, as well as those of carers, in order to improve quality in the care and support system, and to prevent abuse.

In Wales, the current National Minimum Standards for care homes (Welsh Assembly Government, 2004) make reference to the importance of supporting autonomy and choice in Standard 8. A new draft Social Services bill has also, at the time of writing, just completed its consultation stage (Welsh Government, 2012). Within the document, it recognises the need for a stronger voice and real control for service users.

In Scotland, Standard 8 of the National Care Standards makes reference to older people having choices in all aspects of life, but does not refer specifically to older people being involved in shaping the care service itself (Scottish Government, 2007). *Reshaping Care for Older People*, an overarching policy framework aimed at improving care services, acknowledges that ‘older people need to be much more involved in planning their own care’ (Scottish Government, 2011, p. 12).

In Northern Ireland, Standard 1 of the Residential Care Minimum Standards refers to the need for older people’s involvement in shaping the quality of services and facilities provided by the care home, including the introduction and review of routines, practices, policies and procedures (DHSSPS, 2011).

Overall, the general policy stance across the UK appears to infer that real choice and control is best delivered by supporting people to remain independently in their own homes for as long as possible rather than by moving into a care home. In this regard, this new emphasis has added further fuel to a broader policy drive to keep older people in their own homes, which began in 1993 with the introduction of the NHS Community Care Act 1990. Arguably, this policy has resulted in care homes being viewed as ‘the last resort’, rather than as a positive option for older people who may not wish or may no longer be able to be cared for in their own home. This stance, coupled with the regular and often unhelpful, biased news coverage of poor practice in care homes, appears to have impacted significantly on the status and confidence of the care home sector.

Care homes are subject to continual changes within the policy environment. Since the new millennium, there have been at least ten new UK public general acts relating to health and social care, and countless sets of new government regulations. In England, the care home sector has seen four changes to the regulatory system over the past twelve years alone. We have also witnessed over the period of the study, in England alone, a new registration process for regulation, the implementation of Deprivation of Liberty legislation, changes to pensions, annual leave entitlements and the minimum national wage, constant changes to framework agreements, commissioning and quality assurance processes within councils and Primary Care Trusts, introduction of new training standards, and a review of workforce induction standards.

Care homes also have to cope with the broader changes in the health and social care system brought on by the significant cutbacks and new structures introduced over the past few years. A report by the British Geriatrics Society (2011) noted the real lack of central policy guidance in relation to how the NHS supports older people living in care homes. It also noted wide variation in healthcare support from the NHS to care homes, and that this was rarely commissioned or indeed planned. In view of the increasing levels of frailty within the care home population, the report called for the UK health departments to ‘clarify NHS obligations for NHS care to care home residents’ (p. 4).

The changing economic climate has led to significant reductions in fee levels to care homes offered by local authorities (Laing and Buisson, 2010), resulting in real challenges for some care homes, which are attempting to provide a service on very minimal amounts of state funding.

The UK care home sector

There are currently over 18,000 care homes across the UK, supporting approximately 400,000 older people. While the great majority of care homes are privately owned (75 per cent) and a growing proportion are being provided by larger corporate organisations, there remains considerable heterogeneity across the sector: approximately 45 per cent of care homes are still run by smaller providers, many of which are family businesses; a significant minority are charitable or not-for-profit in status. Care homes vary substantially in size (averaging 18.5 places in care homes, and 46.6 places in ‘care homes with nursing’ (CQC, 2010a)).

Care homes vary in their organisational and funding structures: some homes cater mainly for privately funded residents, while others depend greatly on local authority funding; some have significant organisational infrastructures, including departments responsible for compliance, HR,

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specialist advice, etc., while others rely almost wholly on the care home manager to take on this range of responsibilities. Care homes also vary in terms of specialism, with some catering for older people with high levels of palliative and nursing care needs or dementia and others offering lower-level care and social support. Within this report we do not typically make a distinction between the different types of care home operators, rather we refer to them as 'care home owners and providers'.

There have been dramatic changes in the size of the care home market over the past 30 years. From the mid-1980s, partly as a result of a policy that entitled older people below a certain income to receive supplementary benefit to meet the costs of care irrespective of need, the care home sector grew by 242 per cent (Netten, *et al.*, 2001). This rapid expansion continued up until 1993 when the introduction of the Community Care Act (DH, 1990) required local authorities to take on the role of gate-keeping resources and ensuring that greater capacity was provided for older people to receive care in their own homes. From 1993, the expansion started to reverse, with the peak in the decline in care homes occurring in 2000. More recently, we are seeing demand increase again (Laing and Buisson, 2010). Any assertion that care homes are a thing of the past is challenged by projections that indicate an 82 per cent increase in beds by 2030 (Jagger, *et al.*, 2011).

The population of older people living in care homes

Approximately 400,000 older people in total live in care homes in the UK. The vast majority (approximately 78 per cent) are women; 48 per cent of older people living in care homes are aged 85 or over (Laing and Buisson, 2012).

There is a generally accepted view that care homes are supporting older people who are increasingly frail. There has been a rapid average increase in the age and levels of dependency of older people living in care homes (RCN, 2010). It would appear that what were previously termed residential homes (now known as care homes) are now more likely to be supporting individuals who, five to ten years ago, would have been living in a nursing home ('care homes with nursing'). Similarly, homes previously known as nursing homes (now 'care homes with nursing') are now supporting individuals who would have previously been cared for in acute care settings.

While there is a real absence of accurate data on the health and social care needs of older people in care homes, we know that this population is increasingly experiencing multiple coexisting health and care conditions. Two thirds of older people living in care homes experience some level of cognitive impairment (Alzheimer's Society, 2008) and 75 per cent of them are classified as being severely disabled (Office of Fair Trading, 2005). In addition to these chronic conditions, many experience a range of further challenges such as hearing loss, continence problems, sight loss, respiratory problems, arthritis, depression, anxiety, and a lack of regular contact with the outside community, which collectively serves to impact seriously upon their quality of life.

The workforce

Half a million people work in care homes and they are mainly women (Centre for Workforce Intelligence, 2011). A significant minority – 19 per cent – were born overseas (Skills for Care, 2010) and a typical wage is £6.46 per hour, which is less than an average refuse collector (ONS, 2010). The work is physically and emotionally challenging, staff turnover is high in this sector (Skills for Care, 2010) and, overall, there remains a real lack of value of their work, a survey by Skills for Care finding that 29 per cent feel undervalued by

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society (Skills for Care 2007). Yet it is on this workforce that we rely to take up the challenge of promoting the quality of life of older people living in care homes.

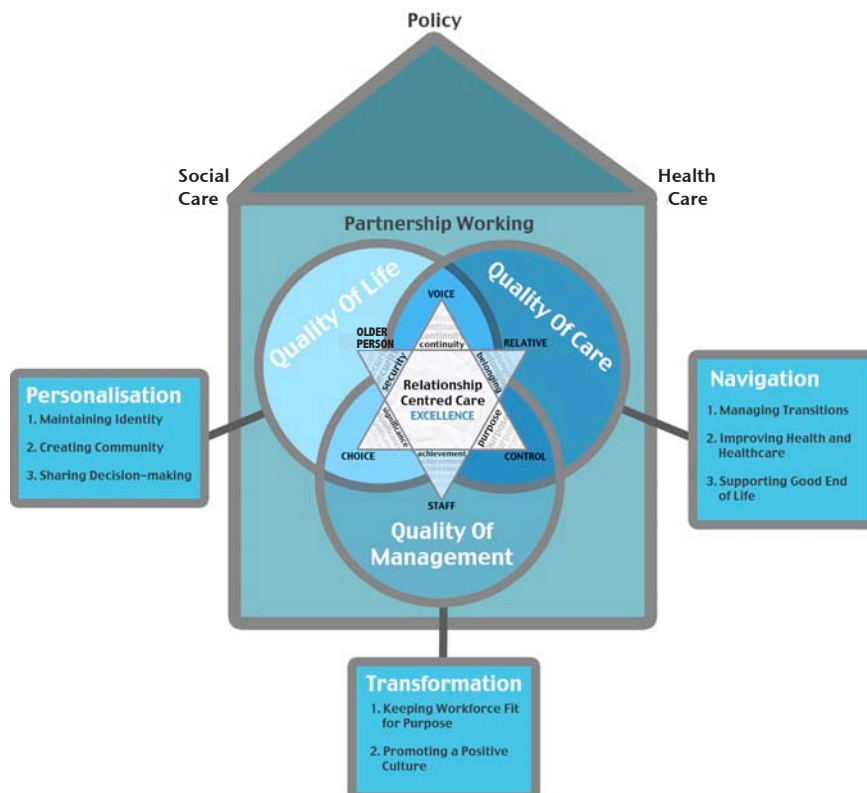
Values and principles of My Home Life

The My Home Life evidence base

The MHL literature review (NCHR&D Forum, 2007) was undertaken by over 60 academic researchers from universities across the UK and focused specifically on identifying: 'What do residents want?' and 'What works well in care homes?'. The evidence identified eight best practice themes, which were translated into a conceptual framework for use by the care home sector to support its practice (see Figure 1).

The eight themes can be grouped into three different types: Personalisation, Navigation and Transformation. The first two groups (Personalisation and Navigation) are aimed at all care home staff; whereas the last group (Transformation) is aimed at care home managers/operators alone. Three of the themes for staff relate to a major policy agenda in social care (Personalisation) and are concerned with quality of life and making care more personal and individualised. The other three themes for staff (Navigation) are more related to the quality of care and what needs to be done to help people navigate their way through the journey of care. The remaining two themes (Transformation) are concerned with the leadership and management required for quality improvement in care homes.

Figure 1: Conceptual framework of best practice themes



Relationship-centred care

Relationship-centred care (RCC) is at the heart of best practice and central to quality of life, quality of care and quality of management. RCC is different from person-centred care (PCC). PCC in policy tends to focus on individual service users, promoting their independence and consumer choice. It is argued that, in long-term care settings, positive relationships between the older people, relatives and staff, and interdependence, matter more. For relationships to be good in care homes, we need to consider not just the needs of the individual older people who live and die there, but also the needs of relatives who visit and the needs of staff who work in care homes. Based on empirical research in care homes in which older people receive care, their relatives and staff were asked what matters most to them in care homes, Nolan, *et al.* (2006) highlighted the importance of six senses (*Senses Framework*). Research has shown that each group (older people, relatives and staff) needs to feel a sense of:

- **security** – to feel safe
- **belonging** – to feel part of things
- **continuity** – to experience links and connections
- **purpose** – to have a goal(s) to aspire to
- **achievement** – to make progress towards these goals
- **significance** – to feel that you matter as a person.

It is argued that quality of life, care and management is enhanced in care homes when the wider health and social care system is working well and in partnership with them. This often depends on the integration of health and social care policy.

Staying appreciative

The *My Home Life* Programme works in an appreciative way with care homes. It places the experience of frail and vulnerable older people at the heart of all that it does and invites those around them to consider what can be done in the wider whole system to help make this experience better. Too often, research focuses on poor practice and blames practitioners for what they do that is wrong. *MHL* focuses on sharing what older people, their relatives and staff in care homes ‘want’, ‘what works’ and ‘how to make it happen’. It is a relational style of working, which values and respects different perspectives and, by focusing on the positive, seeks to inspire improvement without causing unnecessary feelings of threat.

What do older people with high support needs want and value?

There is relatively limited research on the needs and aspirations of older people with high support needs. Indeed, Bowers, *et al.* (2009) commented upon how: ‘... the voices of older people with high support needs are so quiet as to be practically silent or indistinguishable from the other people who speak on their behalf’ (p. 5). In her round-up of evidence of what older people with high support needs value, Imogen Blood (2010) suggests that the following themes emerge about what makes for a ‘better life’:

- continuity, personal identity and self-esteem
- meaningful relationships
- personalised and respectful support
- autonomy, control and involvement in decision-making
- a positive living environment: security, access, privacy and choice

Too often, research focuses on poor practice and blames practitioners for what they do that is wrong. *MHL* focuses on sharing what older people, their relatives and staff in care homes ‘want’, ‘what works’ and ‘how to make it happen’.

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- meaningful daily and community life: making a contribution, enjoying simple pleasures
 - good, accessible information to optimise health and quality of life.

These findings support and reinforce the evidence base that underpins *MHL* and its original synthesis (NCHR&D Forum, 2007). *MHL* offers a conceptual framework for best practice that integrates both health and social care and which appears to have sustained its relevance over time.

The study

Key research questions for this study

Within this broader *MHL* Programme, the team has worked to address the following questions:

- How can care homes support older people to play an active and purposeful role in all decision-making in care homes?
- How can we improve choice for older people and their relatives who are starting to consider the need for a care home?
- What are the ways forward for 'voice, choice and control' in care homes for older people?
- How can we better negotiate positive risk-taking between staff, relatives and the older people?
- What can we learn from practices developing in other models of care or for other 'service-user' groups?
- How does national and local policy, commissioning and regulation impact upon user choice and control?
- How can we better support community and relative involvement in supporting the collective and individual voice of older people living in care homes?
- What is leadership and how can it support 'voice, choice and control'?
- How can leadership and culture change be supported to develop within the care home sector?

Methodology: appreciative action research

The methodological approach underpinning this work is action research, informed by appreciative inquiry. Action research is 'an approach to research, rather than a specific method of data collection. The approach involves doing research *with* and *for* people (users and providers of services), in the context of its application, rather than undertaking research *on* them' (Meyer, 2010). Typically, in health and social care settings, action researchers begin by exploring and reflecting on patient and/or client experience and, through a process of feeding back findings to providers of services (formal and informal), go on to identify areas of care in need of improvement. Through an ongoing process of consultation and negotiation that gives democratic voice to all participants about the best way forward, the action researcher then works to support and systematically monitor the process and outcomes of change. There are many different forms of action research and, in this study, we used a form of action research that was informed by appreciative inquiry (Cooperider, *et al.*, 2003). Appreciative inquiry comprises four important characteristics:

- **Appreciative** – it focuses on the positive, through which participants are more encouraged to engage.

- **Applicable** – it is grounded in stories from the past, which are essentially practical.
- **Provocative** – it invites people to take risks in the way they imagine their future and redesign their organisation.
- **Collaborative** – it listens to the voices of, and values the contribution from, all participants in the whole system.

Data sources

Data has been gathered and analysed from a range of sources in producing the findings relating to promoting ‘voice, choice and control’ and ‘developing leadership’, as noted below. A key source of data was the *MHL Leadership Support and Community Development Programme*. This programme involves the delivery of monthly leadership support over a twelve-month period to groups of care home managers to enable them to deliver evidence-based, relationship-centred practice. Through the group, obstacles to quality that are situated in the wider community or health and social care system are identified. The community development component of the programme then works to support dialogue across the wider system to enable better partnership in responding to these barriers/issues.

Sources generating data to inform both strands (‘voice, choice/control’ and leadership)

- 1 Cross-case study analysis from data gathered as part of the *My Home Life Leadership Support and Community Development* programme:**
 - *Leadership support*: Undertaken across seven local authority areas in the Southwestern, Southeastern, Eastern, East Midlands and North Yorkshire regions between 2009 and 2012. Field notes were gathered from 124 care home practitioners through a twelve-month period. Managers represented a range of care homes (voluntary, independent and statutory sector) with different types of registration (dementia, mental health, with/without nursing). The total number completing the whole twelve months was 93.
 - *Community development*: Activity undertaken to bring care homes together with the wider health and social care community to work on issues of mutual concern; for instance, avoidable hospital admission. Documentary analysis was undertaken from events and meetings taking place across four of the case studies. Three events/meetings involved dialogue with local authority monitoring teams and social work/assessment teams to explore the best way forward to support quality improvement in care homes. A further three events/meetings involved bringing care homes together with practitioners from hospitals, and community health teams to discuss the same issue.
- 2 In-depth interviews with key leaders in delivering quality in care homes (n = 9):** Through a snowballing approach, individuals who were deemed to be demonstrating high-quality leadership attributes and held positions of Director (n = 4), Owner (n = 2) Training Director (n = 2), Manager (n = 1) were interviewed. None of the individuals had a connection to the *MHL Leadership Support and Community Development Programme*. Interviews lasted in the region of 45–60 minutes. Field notes were gathered following each interview.
- 3 Three-year engagement with the care home sector and national and local health and social care system:** Via quarterly meetings with the *MHL England Advisory Group*, *MHL Wales Advisory group* and the *MHL Education and Training Advisory Groups*, representing key representatives from care homes and the broader health and social care

system, we were able to gather critical commentary on the findings that were emerging from the core data. In addition, ad hoc meetings and discussions across the UK with a range of stakeholders within the wider national and local health and social care system have helped the project team to reflect upon its data and take forward new activities to better understand what works in delivering voice, choice and control and leadership.

- 4 Desk research:** A variety of research, policy and practice reports that have relevance to our two main themes were used to inform our thinking. We also re-examined relevant reports created by the *MHL* team; for example: *Maximising Risk, Minimising Restraint* report published for SCIE (Owen and Meyer, 2009); *Quest for Quality* report published for British Geriatrics Society (2011); *Measuring Progress: Indicators in Care Homes for EU Programme for employment and social solidarity 2007–13* (European Centre for Social Welfare Policy and Research, 2010).

Sources generating data specifically around the theme of ‘voice, choice and control’

1 Examples of good practice from care homes

- Written evidence: following an email request to the care home sector to submit examples of good practice, 102 were collated.
- Oral evidence gathered from participants at numerous *My Home Life* events across the UK, and from managers attending the Leadership Support Programme in England as outlined above. Analysis was undertaken from both sources to explore where these examples demonstrated good practice in promoting ‘voice, choice and control’.

2 Workshops for care home managers on ‘voice, choice and control’ in Essex (n = 6)

Data was gathered from small workshops undertaken by the *MHL* team on the challenges and opportunities that existed for managers in enabling ‘voice, choice and control’ for older people in care homes.

3 Telephone conversations and interviews with organisations with a remit for delivering, or an informed oversight on, advocacy

Brief telephone discussions took place with nine organisations, resulting in more in-depth discussions with four of them.

Analysis methods

The *My Home Life* team used an analysis process called Immersion and Crystallization (Borkan, 1999). The process involves researchers *immersing* themselves in the data they have collected, by reading or examining some portion of the data in detail in order to reflect on the analysis experience, and attempting to *crystallise* and articulate patterns or themes noticed during the immersion process. This process continues until all the data has been examined and patterns and claims emerge from the data that are meaningful and can be well articulated and substantiated. Given the focus on action research within this study, the *MHL* team has immersed itself in the data over the past three years and, through ongoing reflection on the data, has identified the themes that are presented here.

Structure of this report

In the next chapter, we define ‘voice, choice and control’ and identify examples of good practice in care homes and the underpinning importance of relationship-centred care in enabling ‘voice, choice and control’ for older

people in care homes. Chapter 3 explores what good leadership looks like in care homes and how it can be developed. Chapter 4 examines the challenges facing care homes in attempting to deliver improvements. Chapter 5 explores how, by supporting leadership in care homes and partnership-working between care homes, the community and statutory services can help support quality. Finally, in Chapter 6, we provide an overview of key messages from the work, offer some broader reflections on what is needed to lead the care home sector to realise 'voice, choice and control' for older people within its care – and make some specific recommendations for specific stakeholders.

Throughout the report, we share examples of the interventions that *MHL* has developed in helping care homes respond to the challenges and opportunities of achieving 'voice, choice and control' and leadership in care homes for older people.

2 ‘VOICE, CHOICE AND CONTROL’ IN CARE HOMES

In this chapter, we explore what good practice looks like in care homes and examine the following research questions:

- What are the ways forward for ‘voice, choice and control’ in care homes for older people?
- How can care homes support older people to play an active and purposeful role in all decision-making in care homes?
- How can we better negotiate positive risk-taking between staff, relatives and older people?
- How can we better support community and relative involvement in enhancing the collective and individual voice of older people in care homes?

What do we mean by ‘voice, choice and control’?

As discussed in the last chapter, recent health and social care policy has emphasised the importance of enabling service-users to have ‘voice, choice and control’. However, exploring ‘voice, choice and control’ in an abstract way is potentially problematic as everyone has their own wants and needs – affected, for example, by age, experience, level of dependency, personal identity and status.

The National Development Team for Inclusion and the Centre for Policy on Ageing has helpfully sought to develop a framework for independent living, which is offered as a guide for strategic planning, commissioning

and support provision for older people (www.independentlivingresource.org.uk/ilrop-principles.html). The framework identifies 'Increase voice' and 'Enable choice and control' as two of six principles. They argue that older people need to be able to have their views and experiences taken into account on an ongoing basis to enable them to have real choice and control in key decisions that are made, which affect them at both an individual and collective basis. The framework notes that older people need to have 'choice and control' over the key 'domains' that they say are important to them. These domains include their personal identity, relationships with others, meaningful daily life, home and personal surroundings, transport and mobility, support and care, income and finances.

'Voice, choice and control' in care homes

The research team propose that the principles of 'voice, choice and control' align well with the three *MHL* Personalisation themes, namely: 'Maintaining Identity', 'Sharing Decision-Making' and 'Creating Community'. Older people need to be seen as individuals and given a 'voice' to express who they are and what they want (Maintaining Identity – *See who I am!*). Equally, there needs to be more than one way of doing things (choice), especially in situations of collective living, and older people need to have 'control' over what is the right option for them (Sharing Decision-Making – *Involve me!*). To enable older people in care homes to experience 'voice, choice and control', interpersonal relationships need to be good between older people, their relatives and staff in the care home, and between the care home and the local community and the wider health and social care system (Creating Community – *Connect with me!*). We will use these three themes to help us explore examples of what works well in promoting 'voice, choice and control' in care homes.

The Framework for Independent Living specifically argues for a move away from traditional forms of support such as care homes to new models that offer older people greater 'choice and control'. Bowers, *et al.* (2009) argue that, following a move into care, older people will encounter the sort of systemic power imbalance which determines that they are seldom in control of their decisions, personal arrangements or finances (p. 53). Testimony from Advocacy Plus, an independent advocacy organisation for older people operating in Westminster, Kensington and Chelsea, suggests that older people (particularly those living in care homes) are often unwilling to speak out or 'make a fuss' about issues that may concern them. This notion of acquiescence is supported by evidence (Hollingbery, 1999; Oldman and Quilgars, 1999, Ross and Mirowsky, 1984; Whitler, 1996) that lack of voice, and the associated impact on choice and control on the part of older people, is neither a new nor uncommon phenomenon. A tendency not to speak out may be attributed to a number of factors: an unwillingness to complain, fear of repercussions, the idea that service providers are 'experts,' and a belief that no one will listen or that the situation cannot be changed (Hollingbery, 1999, p. 2).

Clearly, achieving 'voice, choice and control' is more complex in a setting of collective living, such as a care home, where the needs and aspirations of an individual may need to be negotiated in the context of the needs and aspirations of the wider community within the care home, particularly given that staff levels typically cannot offer one-to-one support to older people. However, the evidence presented later in this report questions the assertion made within the Independent Living Framework that care homes, as a model,

cannot offer the sort of opportunities that older people need to have a voice, and real choice and control, in relation to the things that are important to them.

Examples of 'voice, choice and control' within the care home sector

Over the period of the study, the project team has gathered hundreds of positive examples of practice from care home practitioners across the UK. Some of these are presented on the *My Home Life* website (www.myhomelife.org.uk), which provides a medium for care homes to share what they are doing that is working for them (see Box 1).

Box 1: Bulletins created by *My Home Life* relevant to 'voice, choice and control'



Bulletin 6: Sharing decision-making

Bulletin 8: Personalisation in care homes

Bulletin 13: Giving people with dementia a voice

These positive examples of practice illustrate how care home practitioners believe they have been able to implement the eight *My Home Life* evidence-based themes. The reader is invited to judge the relevance of these examples to their own care home context and make use of them as they see fit. *My Home Life* is purposefully not prescriptive; it seeks to inspire new ways of working by sharing what has been positively achieved by practitioners in 'real' contexts, linked to the *MHL* evidence-based and relationship-centred vision. Researchers rarely share this level of practical detail in their work and frequently sit in judgement over what is 'good' or 'poor'.

Having established the evidence base for best practice, the *MHL* team respects and values the expertise of those in practice to share with us how they believe they have been able to apply the evidence base in practice. What is good for one may not be good for another, and there needs to be a menu of options about how we enable 'voice, choice and control' for older people in care homes. While it is recognised that these examples have been provided by practitioners rather than by older people themselves, our criteria for their inclusion within this report relate to whether the examples are demonstrating that they are responding to what 'older people in care homes want' as articulated within the evidence base underpinning the *MHL* vision.

It should be noted that the *MHL* team does not make any comment on how prevalent or not good practice is in care homes. This is the role of the

inspector and beyond the brief of this work. It also should be noted that these examples of practice have been gathered within a context of very limited funding for care homes, which ultimately impacts on the levels of staffing available and therefore the ability to identify and respond to the needs and aspirations of the older people. There is no doubt that if greater levels of staffing were provided, we would have identified even more examples of good practice. The examples we have received therefore reflect the current realities, challenges and limitations that are placed upon care home practitioners.

Nonetheless, the good practice examples we have gathered do challenge the negative stereotyping of care homes by the media. By highlighting positive aspects of care, the *MHL* team hopes to stimulate improvement through more helpful and inspiring methods, rather than merely apportioning blame. Care homes are complex settings, and society needs to work in better partnership with them to improve the quality of life of some of our most vulnerable older citizens. The examples presented within this report use pseudonyms rather than the real names of older people to protect their identity.

Maintaining Identity – *See who I am!*

The Independent Living Framework identifies that older people need choice and control to maintain their personal identity. The examples gathered illustrate how care homes are uniquely placed to help older people to maintain their personal identity, because staff have the opportunity for regular interaction and engagement with the older people they are supporting. The examples that we received often related to those individuals who struggled to articulate their views, needs and aspirations due to their mental and physical frailty or low self-esteem. It is suggested that collective living therefore creates the potential for staff to really get to know these older people; to look beyond the dementia, beneath the frailty, to identify who they are as human beings, what is important to them and what the care home can do to respond to this.

Example 1:

Mr Thomas had dementia. He would become very distressed first thing in the morning. Through their ongoing engagement with him, the care home staff discovered that he had previously been a dairy farmer and was used to starting his day at 4am to get out to the fields to round up his cattle. Staff worked with him to ensure that his working trousers were waiting for him when he awoke, and a glass of milk and talk of the cows reassured him that all was OK. He would settle in the armchair and await his cooked breakfast around 6am after milking!

Example 2:

Mr Jennings was reacting aggressively towards staff in the local continuing care and mental health wards; he had been known to throw fire extinguishers at nurses. When he arrived at the care home, he was unable to articulate his needs verbally, but staff worked to explore what was important to him. They noted his history as a handyman and his interest in 'tinkering' about the home, and so supported him to take on a role in decorating the care home (with help from the care home's own handyman). As a result, the gentleman gained a sense of security and purpose in his life.

Collective living ... creates the potential for staff to really get to know these older people; to look beyond the dementia, beneath the frailty, to identify who they are as human beings.

Many of the examples that we have gathered explore how older people have been supported to regain a sense of identity that may have been lost when they were living in isolation, with profound frailty, at home. The example below is typical of many examples that care homes have given, where the older people have felt that over time the care home has allowed them to regain trust in others and begin to actively take an interest in life.

Example 3:

Mr Garrick was extremely withdrawn when he came into the home. Over time, the staff identified that he used to love gardening, so they gave him his own stretch of the garden. The home purchased a small greenhouse for him and, with the handyman's help, the older person plans the year and grows his own produce. Watching him tending to his plants has given great encouragement to some of the other older people. He is proud of his produce and the chef appreciates the supply for the kitchen.

Contrary to the general assumption that care homes restrict the choices of older people, many of the stories that we have gathered suggest how care home staff are bending over backwards to ensure that they understand what is important to older people and explore how they can accommodate their choices.

Example 4:

Geoff recognised that he needed to come into a care home, but was grieving for the loss of his 'book collection'. The manager decided they should endeavour to accommodate this, so 25 feet of bookcases were installed in one of the lounges. Geoff has catalogued the collection and now acts as the librarian, supporting others in the home to enjoy it.

Sharing Decision-Making – *Involve me!*

Hearing older people's voices and ensuring that they are central to decisions made within the care home can be a challenge. Managers have noted how the long list of day-to-day jobs that staff have to complete can result in a focus on tasks and not on the individual older people themselves. That said, the findings presented in Chapter 5 suggest that managers can be effective in supporting staff to ensure that the routine tasks revolve around the choices of the older people, rather than the other way round.

Making everyday decisions and choices about their own care

The three examples presented below demonstrate different approaches that care homes can have in supporting older people to make decisions and have choice and control over their care. The first example describes how the care home has made a decision to shift power to the older people in helping them to document their own comments about the care that they have received. The second shows how routines and regimes can be altered to improve choices for the older people. The final example illustrates how, through the use of sensory cues, some older people with sensory impairments can be supported to feel more in control of where they are and what they do.

Example 5:

A care home is encouraging its older people to participate in writing their own daily life notes, rather than this being carried out by staff. They have noticed how those older people who never complained

about anything are now using this opportunity to communicate some of the things that are important to them and issues that have affected them during the day. These points are then responded to by the staff in a positive manner.

Example 6:

A number of care homes have recognised the value of organising 24-hour buffet provision for the older people who, because of their dementia, may be less able to fit into traditional meal times. One care home reported how they help older people with dementia to choose their food by enabling them to see and smell it instead of offering them the choice verbally.

Example 7:

Care homes are supporting decision-making by helping older people with visual impairment to navigate the home and get to where they want to go. In addition to developing better signage across the home, staff created different aromas in different parts of the home and some staff wore the same perfume each day as this enabled the older people to identify each member of staff individually.

Involvement in the wider activity of the home

MHL received a significant number of examples where older people were playing a broader role in the care home. In several cases, care homes have encouraged older people to have a say in the decor of the home, the choice of armchairs, and the menus that were provided. In some cases, care homes appear to be more proactive in encouraging older people to take control: one care home supported the older people to get out to the supermarket to help them consider the meals that they would like the care home to provide. Another home actively supported an older person to design the garden and manage the budget for it. We also have examples of older people setting up a community shop, a post office and developing fund-raising activities.

In supporting older people to have greater control over the running of the care home, it is argued that power to make strategic and operational decisions should be located as close as possible to older people, their families and those who work with them. Many owners/providers inform their decision-making through the use of consumer surveys. However, it is questionable to what extent these surveys offer older people control over the running of the home, particularly given that they may be problematic for older people (especially those with cognitive impairment) to complete. One example where older people's voices appear to be informing decisions about the running of the home involved a small number of older people who were nominated to represent the voices of older people at a national twice-yearly meeting of senior managers within the provider group. Prior to attending the group, older people would gather information from minutes of residents' meetings, and from other sources, to present to the meeting. Further details of the project cannot be obtained because the provider organisation was recently taken over.

In another care home, a '180-degree' standard appraisal is adopted where both staff and older people in the home are able to comment on what the care home does well, what it doesn't do well, and what managers do well. Another useful example relates to how, in one home, older people and their families are supported through an induction process similar to that used with staff, so that there is very clear understanding of what the older person can expect from the home and how they can get involved.

Power to make strategic and operational decisions should be located as close as possible to older people, their families and those who work with them.

Recently, the MHL team has been involved in piloting The Big Care Home Conversation across the UK (www.myhomelife.org.uk). This potentially offers care homes a more creative way of engaging older people, relatives, staff and the public in a dialogue about what they want from care homes. By using the concept of 'wishing trees', people write their views on paper leaves and hang these up on trees for others to read and discuss. Potentially, this method could not only assist local dialogue and improvement, but also harvest a wealth of new ideas to inspire policy at the national level (see Box 2).

Box 2: The Big Care Home Conversation

Across the UK, care homes have been putting up 'conversation trees' and inviting their community of older people, families and staff to engage in a conversation about 'what makes life good in care homes now, what could make them better – and how might we get there?'

A range of resources has been created on the *My Home Life* website to encourage care homes to engage in the exercise, including posters, films and a 'how to do it' booklet.



Older people's involvement in recruiting staff

Involving older people in the recruitment of staff helps the care home to communicate that the service is driven by the residents themselves, rather than delivered for the convenience of the service provider. MHL received good practice examples of care homes that had made a concerted effort to involve older residents in the recruitment of new staff within the home. One older person described her experience of sitting on a panel:

I asked questions like, 'How would you help residents being fed or dressed? What is important about looking after older people?' I then discussed the people and decided together who to offer the job to. I enjoyed it; it is important I have a right to have a say.

In another care home, staff were asked to bring in an object of importance to them and to talk about it to the older people, as a way of demonstrating their ability to engage in two-way relationships with the older people and being open and sharing with them.

Care homes noted the importance of rethinking the recruitment process to enable those with different levels of physical and cognitive ability to have a voice. Some care homes allow time for the older people to escort candidates around the home to gain some insight into how some of their frailer older people (those living with dementia, for instance) respond to the

candidate. One manager spoke about the adjustments necessary to work with an older person who had suffered a stroke and experienced significant verbal communication difficulties:

I asked if she [the older person] wanted to interview a new member of staff. I said: 'I want you to be my eyes and ears.' Over time, and with support, she finally agreed to sit in on the interviews. She gave thumbs up or thumbs down – that's how we got her feelings on recruiting for the post.

Informal mechanisms for hearing the voices of older people

It is important to recognise that formal mechanisms for supporting older people to have control over the activities of the home may not always reflect how some older people may wish to make their views heard. Use of residents' meetings is fairly common within care homes, but there is no convincing proof that these are always the most appropriate ways to engage those older people who may not be able to articulate their views or, indeed, engage in group conversations. Many will lack the confidence or capacity to contribute their voices in such arenas.

A range of other strategies have been identified, which offer more informal processes for hearing the voices of older people and helping them influence the running of the home. In one care home, very small groups of two or three older people are invited to join the manager for afternoon tea, where they can get to know one another and speak openly in an informal manner without any agenda. In a number of other homes, mealtimes have become an opportunity for older people, staff and families to come together and have a space for quiet conversation and an airing of views. This is a very different approach to the often noisy and rushed mealtimes that can occur in care homes.

While there is a need to recognise the importance of shifting real power and governance to older people, their families and front-line staff, it is also important to remember how, for some older people, it is the small things that are most important. One example showed the importance to one older person of having control over the area close to her chair in her bedroom. For her, having her belongings positioned in specific parts of her table so that she could access them easily was critical. This may seem an obvious example of good practice that we should expect of all care homes; however, sometimes the little things that really matter can go overlooked.

Positive risk-taking

Exercising choice and control typically involves older people considering the inherent risks involved in any activity that they may wish to do. Where older people are unable to make an informed judgement, staff are expected to consider how to help older people gain insight into the risks that they are carrying out and ultimately work in the best interests of the individual in assessing the balance of self-determination against the potential impact of the risks involved. These types of decision are complex: they require ongoing assessment based upon a consideration of the capacity of an individual at any given time, the availability of staff to support the activity and the potential consequences of the activity upon other individuals within the home.

We have many examples of how staff have strived to work in the best interests of the older person in supporting their choice and control where family members or external professionals may not agree with the decision made. These demonstrate that staff need to feel confident in standing up for the wishes of the older person and, where necessary, challenge the

perspective of outside professionals and work to develop a dialogue with family members so that there is a common understanding of what is trying to be achieved. The good practice also demonstrates that, where care homes adopt a philosophy that ‘anything is possible’, they are more likely to identify practical strategies for supporting older people to make choices about what they can do while minimising unnecessary risks.

For instance, rather than stopping an older person living with dementia from walking out of the home on their own, staff in one home described how they would become familiar with where older people chose to walk and, without being intrusive, keep an occasional eye on where the individual had got to. If an older person was seeking to get to a particular destination, staff would ring to check they had arrived (with the agreement of the older person). In another home, a staff member would walk a few paces behind, so as not to intrude on the older person. Finally, one home negotiated with an older individual to take with them written information about themselves and the care home address. The care home would also note down a detailed description of the person, including the clothes he/she was wearing, in case the older person got lost.

In another home, a woman with dementia lacked an awareness of her inability to walk. She was at high risk of falling every time she stood up, yet was irate when staff encouraged her to remain safely in her seat. With considerable negotiation between staff and family members, it was agreed that the older person should not be restrained, but should wear a helmet – this would minimise the negative outcomes of a fall while supporting her psychological well-being.

The challenges that care homes face in supporting positive risk-taking are examined in detail in Chapter 4. Box 3 shows additional resources available from *My Home Life*.

Box 3: Resources on supporting positive risk-taking



My Home Life Cymru booklet on Sharing Decisions

Bulletin 7: Sharing decisions and managing risk

SCIE Report 25: Minimising the use of restraint in care homes

The *My Home Life* DVD on the *My Home Life* website features a film relating to ‘sharing decision-making’; additional films can be found on the *My Home Life* Essex website (www.myhomelifeessex.org.uk).

Creating Community – Connect with me!

The MHL evidence base demonstrates the importance of relationships both within the care home and between the care home, the local community and the wider health and social care system in enabling older people to gain choice and control about the things that matter to them.

There are plenty of examples of care homes that both support older people to get out and engage in external community activities, and invite others to come into the care homes to engage in meaningful activities (see Box 4 for list of relevant resources from MHL).

Box 4: Creating community resources



Bulletin Issue 3: Creating communities

Bulletin on Volunteering in care homes

My Home Life Cymru booklet on Creating Community

The *My Home Life* DVD on the *My Home Life* website also features a film on 'creating community'.

Additional films can be found on the *My Home Life* Essex website, including information about their 'Community Visitors programme'.

We have examples of care homes that have demonstrated how they have supported family members to continue to play a role in supporting their loved one; some have used the internet to enable older people to maintain relationships with families. One home has encouraged greater engagement of the public by arranging training events to help them understand the issues that care homes are engaging with (e.g. dying, dementia, frailty).

Advocacy and befriending services

Community advocacy and befriending projects can play a positive role in supporting older people's 'voice, choice and control'. Described as 'the provision of support and encouragement, or representation of individuals' views, needs or rights,' (Margiotta, *et al.*, 2003, p. 9) advocacy has the potential to support older people's voice, choice and control. The recent Dignity in Care report (Recommendation 21) identified the vital need for independent advocacy in care homes (Commission on Dignity in Care, 2012).

Over the course of the study, we spoke with nine organisations delivering advocacy to gather an overview of good practice, comparing and contrasting provisions for older people and people with intellectual disabilities. We then

followed up with additional interviews with four advocacy organisations, which were recommended to us because of their valuable work in delivering advocacy in care homes to older people. Organisations included Elfrida Society (working with people with learning disabilities), Advocacy Plus, Sefton Pensions' Advocacy Centre and Bedfordshire Advocacy for older people. From our telephone interviews with them, the emergent picture is that advocacy is often delivered in response to a referral and is provided on a short-term case-by-case, issue-specific basis. Recognising that older people in care homes rarely self-refer, perhaps due to lack of awareness about their rights to access advocacy, or because they do not want to make a fuss or be singled out, interviewees noted that their need for advocacy typically goes unrecognised. Self-funders, in particular, were considered particularly prone to 'slip through the net,' as they do not have an involvement with professionals independent of the care home who might refer the older person.

All interviewees identified that where organisations were able to visit care homes on a regular basis to establish long-term relationships, they were offering important supportive services for older people. Indeed, positive relationships between the advocate and the older people, staff, families and social workers was considered key to successful advocacy for older people in care homes:

Building up trust and credibility with residents and staff is vital. If they see you've been successful with other people they are more likely to trust the advocate for themselves. It's small steps – people are often too frightened. You need to gain their trust and hear more and more.

– Telephone interview with advocacy organisation

Interviewees spoke about working innovatively within the unique environments of care homes. Some noted the need to use informal channels to support improvements: for instance, by offering anonymous and/or group feedback to staff to raise awareness of general issues within a home without singling out one older person in particular; emphasising the systemic rather than personal problems that are often at the root of issues that affect older people and through this, preventing re-occurrences of particular issues. Organisations acknowledged the importance of creating the space and safety to have informal chats, allowing people to air grievances and/or request advocacy support in a non-intimidating manner; one organisation had worked with a care home to make rooms available so people could talk about their concerns without disturbing other older people or being overheard.

This good practice identified here mirrors the approach adopted in a larger scale programme in Massachusetts as part of the US Long-term Care Ombudsman programme. This programme nurtures, trains and supports volunteer community advocates to act as a regular community presence in the home and acknowledges the importance of advocates becoming recognised and trusted by the older people, relatives and staff alike in helping to resolve issues and bring problems that older people have to the attention of staff or management (Owen, 2006).

Volunteering

Volunteering in care homes is in many ways a 'forgotten' area, especially when compared to the strong tradition of volunteering within the hospice sector. A report from the Relatives and Residents Association (Heatley, 2007) polled volunteer recruitment agencies with regard to the lack of representation

Positive relationships between the advocate and the older people, staff, families and social workers was considered key to successful advocacy for older people in care homes.

of volunteering within residential care settings. The report found that such agencies tended to concentrate on volunteering within the community, due to a basic perception that homes should provide enough activities themselves, while recognising that in practice this was very often not the case. Care home managers have also described their lack of time to recruit and support volunteers, pointing out the need for easier and speedier Criminal Records Bureau checking, and the value of an external co-ordinator to help with this.

That said, the Sunshine Project, developed as part of the *MHL* Programme in 2005, demonstrated that where there is a broker that can support care homes to engage with volunteers, this can result in providing positive benefit to older people. However, the extent to which volunteers in the Sunshine Project were able to really support older people to have ‘voice, choice and control’ was not explored.

Areas where ‘voice, choice and control’ can be enhanced

Managing transitions

It is acknowledged that, for some older people, the move to a care home may feel like a loss of control over one’s life and a restriction in the choices available. Yet the evidence would seem to suggest that, for some older people, life in the care home actually opens up more choices, perhaps because living in one’s own home has become more and more restrictive due to increasing physical or mental deterioration. We have received many examples where older people appear to have regained purpose and significance by moving into a care home and have overcome the social isolation that they had experienced at home.

Good practice appears to focus on providing real support to older people to help them process what has happened to them, to be supported to return home or move to another care home if they are not happy, to have time to gather their belongings, say goodbye to their own home and to be supported to begin a new phase of life.

Improving health and healthcare

The good practice examples that we have received have demonstrated how some care homes are actively advocating for older people when negotiating with health professionals about how and where care will be delivered. There is evidence that care home staff do challenge nurses, GPs and social workers where a decision may not be in the best interests of the older person. There are two specific examples of this: in the first, health practitioners were challenged when they tried to insist on admitting an older person to hospital when it was clearly not in the interests, or indeed the choice, of the older person; in the second, a manager questioned a GP’s suggestion that that medicine be put into an older person’s tea.

In addition, there is evidence of how care homes can work with health practitioners to reduce the use of sedatives and, in so doing, enable older people to be more capable of expressing their views and their choices.

Supporting good end-of-life

Ensuring that older people are in control of the last days, weeks and months of their lives is vital. That said, opening up conversations with older people and their families about the end of life can be very challenging. A number of managers have identified the importance of identifying those points in time,

when the older person appears to feel they wish to talk about dying, rather than simply approaching people with a checklist.

Box 5 offers examples of resources developed in relation to the themes of 'Managing Transitions', 'Promoting Health' and 'Supporting End of Life'.

Box 5: Helpful resources on end of life, health and managing transitions



Step by step guide: The route to success in end of life care

Issue 1: Managing transitions

Issue 5: Improving health and healthcare

Issue 6: Supporting good end of life

Films and booklets relating to these areas of practice can also be found on the *My Home Life* UK and Essex website.

What underpins 'voice, choice and control' for older people in care homes?

The examples that we have received offer a glimpse into the sorts of practice that take us closer to enabling older people to have voice, choice and control. What the examples do not tell us is how the homes have managed to achieve these outcomes and what the conditions were that allowed such good practice to occur.

The project team suggests that underpinning many of these good practice examples was a strong sense of relational connection between the staff, the older people and relatives, enabling staff to listen to the older person, to gain insight into their individual needs, aspirations and wishes, and to help them have more choice and control over their lives.

One manager eloquently described the ‘beautiful moments of connection between staff, highly frail residents and relatives’ that are typically unseen, unheard and unvalued. It is these connections that appear to create the foundation from which older people can develop confidence and feel safe to communicate openly and honestly. Through this relationship, staff and older people together can contribute to decisions made which affect the well-being of the community of the care home and its individual members. These moments are very difficult to capture in research or identify through general observation as they often appear to occur through exchanges that take place in bathrooms, toilets, bedrooms or the corner of lounges; they are typically ‘whispered’ rather than shouted and are deeply personal to those who are party to them. Where older people have very little capacity to articulate their needs verbally, there appears to be some support in the notion that these close and personal relationships allow the member of staff to ‘tune in’ to the older person’s needs and feelings, becoming generally mindful of the older person and their emotional well-being.

In short, it is positive relationships that are the underpinning vehicle for enabling older people’s voices to be heard and in enabling them to have choice and control. Where these positive relationships and connections are absent, older people are at risk of being unseen, unheard and treated as ‘objects of care’, rather than active participants in decisions that affect them. Where there is a community that supports the older people, relatives and staff, a greater connection is developed, through which choice and control can be realised. This finding is not new. It reflects the strong body of knowledge surrounding relationship-centred care that was articulated in Chapter 1, recognising, as it does, that relationships are at the heart of good practice. Box 6 offers an example of ‘relationships in action’.

It is positive relationships that are the underpinning vehicle for enabling older people’s voices to be heard and in enabling them to have choice and control.

Box 6: Relationships in action

A member of staff went to visit a resident who was feeling poorly and didn’t fancy the meal that had been brought to her room. The staff member offered to go and make her a bowl of soup and some bread. The resident was enjoying dipping her bread into the tasty soup when the staff member broke down in tears! The incident had reminded her of her own mother (now deceased) who always brought her children a bowl of soup and bread when they were unwell. The resident was able to bring comfort to the staff member as the two women shared some happy memories and, as a result, felt much better herself for having been able to help someone else. We all need to be needed!

Summary

This chapter has attempted to explore what works well in supporting older people in care homes to have a voice, to be heard and to be involved in decisions that affect their lives. Overall, these examples would seem to indicate that, where they work well, care homes have the potential to play a positive role in promoting ‘voice, choice and control’ to our frailest citizens. It is recognised that, in most cases, the examples we have gathered have not come from older people themselves, and that the absence of older people’s voices in the data is one of the limitations of the study. However, a strength of the study is the sharing of local practice expertise in applying the *MHL* vision in practice.

It is acknowledged that the examples that we are gathered are not necessarily representative of practice across all care homes and that many older people living in care homes may not experience the level of choice and control that they should be experiencing. However, the evidence demonstrates that good practice does exist and, as a model, care homes do have the real potential for supporting older people to have a voice and choice and control over the things that matter to them.

3 THE VALUE OF LEADERSHIP IN CARE HOMES

The purpose of this chapter is to examine:

- What is leadership and how can it support ‘voice, choice and control’?
 - How can leadership and culture change be supported to develop within the care home sector?
-

The policy context for leadership

Over recent years, there has been increasing emphasis within policy on better leadership in social care in order to deliver services that are more personalised. In England, Skills for Care (2008) reported that, while there is recognition that leadership is required, there remains a lack of knowledge over the detail of what this might look like. Similarly, in the development of a social care workforce strategy, the Department of Health and partner organisations from social care published an interim joint statement (DH, 2008b) acknowledging that real ‘voice, choice and control’ for users of social care services requires leadership among employers and managers.

This joint statement led to a government social care workforce strategy (DH, 2009) which concluded that leadership was ‘... crucial to delivering the transformation of adult social care’ and that leaders need to ‘be developed at all levels in the organisation’. The paper made reference to the responsibility given to the National Skills Academy for Social Care for developing a leadership strategy for social care (p. 22). The development of the National Skills Academy for Social Care was therefore seen as a central plank in efforts to strengthen social care leadership.

In Scotland, since April 2010, Scottish Social Services Council (SSSC) has been taking forward developments in leadership in social care in partnership

with NHS Education Scotland (NES). An analysis of existing leadership activity has been commissioned and is leading to the development of a vision for leadership at all levels of the social care workforce. There is currently no dedicated programme for Leadership in Care Homes.

The Welsh Assembly Government also spells out its desire to develop leadership across all sectors within social care in its Framework for Action (2011). In Northern Ireland, the Minimum Standards for care homes document makes reference to the need for managers to be a role model for staff and 'provide leadership, direction and support for their staff team' (p. 47), though reference to 'leadership' is not made within Standard 20, which refers to the specific requirements of the manager (DHSSPS, 2011).

There is now a range of courses and programmes aimed at supporting leadership or improving standards in health and social care. The National Skills Academy has developed a role of endorsing various individuals and training organisations that are providing courses, including those on leadership. They, along with other organisations, such as the Institute for Leadership and Management and the *My Home Life* Programme, are also delivering programmes on leadership for care-home practitioners.

In reality, the proportion of care homes that actively engage in programmes and courses that support leadership appears to be fairly limited. That said, findings from a survey by National Care Forum, a representative body for the 'not for profit' care home sector, (National Care Forum 2009) identified that, of 36 provider organisations (mainly from its own membership), about half were investing in leadership and management programmes, delivered either internally or externally. There was recognition that cost was a significant barrier to its further development, particularly for smaller organisations, which have very limited access to external sources of funding for leadership support.

What do we mean by 'leadership'?

Despite the rhetoric surrounding the need for better leadership, there has been a lack of clarity as to what exactly leadership means in social care.

There are many ways of looking at leadership and many interpretations of its meaning. In developing its leadership strategy, the National Skills Academy for Social Care commissioned The Work Foundation to build on a two-year original study of outstanding leadership in the private sector to explore what leadership looks like in social care (National Skills Academy for Social Care, 2011). The original study identified three key principles to leadership:

- 1 Thinking and acting systemically:** The need to be deeply mindful of what they do and how they behave and how 'empowering people frees them to make a difference and that this drives engagement' in their work.
- 2 People are the route to performance:** Outcomes such as productivity, quality, innovation and great customer care are all achieved by engaging with others, enthusing them, growing them, building confidence, creating conditions of trust and passing power.
- 3 Achieve through their impact on others:** Outstanding leaders act consciously; they operate with full self-awareness and reflection to empower and pass influence to others.

This study was followed up with interviews with 14 social care 'leaders' along with members of their respective teams. The study demonstrated that, while very similar traits were observed in social care, there was greater

emphasis within the original study (and less among the social care leaders) on a nurturing approach to leadership in helping to create self-sufficient and confident staff. It concluded (p. 11) by suggesting that:

The key to building outstanding leadership in social care is to enhance its existing strengths around inspiring a passion for purpose, developing people, relationships and networks, and working in collaboration to deliver the highest quality of care.

– The Work Foundation, 2011

The study recognised the importance of locating power in the hands of those closest to the delivery of care.

It is useful to reflect on whether leadership is about ‘getting others to follow’ or ‘getting others to do things willingly’. Alimo-Metcalfe and Alban-Metcalfe (2005) identify the need for **transformational** rather than transactional leadership, which involves:

- valuing individuals (genuine concern for others’ well-being and development)
- networking and achieving (inspirational communicator)
- enabling (empowers, delegates, develops potential)
- acting with integrity (consistent, honest and open)
- being accessible (approachable, available, in-touch)
- being decisive (willing to take risks).

There is also general recognition that leadership does not reside in one individual, but is distributed throughout an organisation (**Dispersed Leadership**). Buchanan, *et al.* (2007) argue the need to develop policies to support and reward dispersed leadership, highlighting such initiatives as shared governance, action learning and action research, change leadership forums, mentoring and other forms of development.

A model of leadership which was developed by Ken Blanchard takes this thinking further. He describes how:

The traditional way of managing people is to direct, control and supervise their activities and to play the role of judge, critic and evaluator of their efforts. In a traditional organization, managers are thought of as responsible and their people are taught to be responsible to their boss.

– Blanchard, 1991, p. 1

He goes on to argue that this management role is not particularly effective. Rather, he proposes that **‘Servant Leadership’** is where, once a vision and direction has been agreed, the role of the manager is to understand what staff need in order to be successful and then actively to do everything possible to help them move forward. In this regard, the manager becomes ‘the servant’ to the staff: listening, praising, coaching and supporting them in their responsibilities rather than telling them what to do and expecting them to report back once the task is completed.

Servant Leadership is a potentially very powerful model given the nature of social care. It enables managers to role model the sorts of behaviours that are expected of staff towards older people and families and it is not dissimilar to the transformational and dispersed leadership models described earlier.

What does leadership look like in care homes?

In its own evidence review on quality of life in care homes (NCHR&D Forum, 2007) *MHL* identified two themes for care home managers (Transformation themes: Promoting Positive Cultures and Keeping Workforce Fit for Purpose) to help staff ensure the ethos remains 'relationship-centred, evidence-based and continually effective within a changing health and social care context'.

The review identified the need for a model that highlights the importance of personal growth among staff and older people living in the home and a shared commitment to ideas, values, goals and management practices owned by the whole community of the home (older people, staff and relatives). The emphasis for leadership is therefore on developing relationships across the home, valuing different perspectives and fostering creativity, learning and innovation. The review refers to Davies's work on 'Complete Communities' (Davies, 2003) where leadership is about developing an effective team with mutual appreciation and some blurring of roles; relatives as integral members of the team; interdependence being seen as an important value; and close links with the local community. In this regard, these messages echo the attributes of 'transformational' and 'dispersed' leadership as noted earlier.

The review also highlights the vital importance of leaders ensuring that the right skill mix is in place within the home to meet the ever-changing health and social care needs of older people coming into care homes.

This importance of transformational leadership was further echoed in work by Nolan and Davies (2008), who recognise that staff education and training alone is insufficient to deliver real success. They argue that the practice 'milieu', i.e. the care home community, needs to be receptive to change and this requires leadership from the broader organisation to develop a planned approach where: staff are motivated through engagement on what they feel is relevant and of interest to them; they are afforded real support and time to reflect and perfect their skills; the organisation should be creative and demonstrate openness to risk in enabling positive change to occur. Finally, Nolan emphasises the core values of relationship-centred care which place an emphasis on helping older people, their relatives and the staff to achieve a sense of security, belonging, continuity, purpose, achievement and significance in order to enable improvements to occur (as outlined in Chapter 1).

Resources relating to leadership that have been created by *MHL* are listed in Box 7.

Fieldwork: Outcomes of good leadership in care homes

Evidence from discussions with care homes that were considered by our advisory groups/networks as being at the forefront of good practice allowed us to identify nine outcomes of good leadership in the care home sector:

- 1 A confident, resilient manager** who holds a vision for the home, can inspire and drive forward change and can reflect on, and question, their own role and the culture of the home.
- 2 A confident, committed and stable workforce** with low turnover and sickness rates, high commitment and motivation, committed to each other and the community of the home.

Box 7: Resources relating to leadership, promoting a positive culture and keeping workforce fit for purpose



Bulletin Issue 10: Driving forward change in your care home

Bulletin Issue 11: Supporting your staff to deliver a shared vision

- 3 **Greater engagement with, and confidence from, external bodies and communities**, where the care home team feels and acts like equal partners in the wider health and social care system and as experts in their own right, challenging the views and judgements of external professionals, working within the law and policy frameworks, but challenging their application when it is not in the interests of the older people living in the home.
- 4 **A workforce that is more reflective, more questioning, more confident in taking the initiative and ownership**, able to stand up for the decisions that they have made, and challenge stereotypes about what older people can and should do, and equipped with the skills and knowledge to deliver a competent service.
- 5 **A care home that positively welcomes complaints**, recognising them as opportunities to learn, understand and improve rather than as a threat.
- 6 **A more vibrant community of older people**, who can contribute and feel valued, where an 'us and them' culture is replaced by one based upon mutual support and where everyone knows a little bit about each other.
- 7 **Greater spontaneity and responsiveness**, ruled less by routine and more by the feelings, needs and aspirations of the care home community at any given time.
- 8 **Greater emphasis on positive risk-taking** and challenging the boundaries of practice, allowing positive informed risks to be taken within a structure of safety and accountability.
- 9 **Supporting greater community inclusion** (family, friends, the public, school children).

Fieldwork: Attributes of good leadership in care homes

Participants were asked to identify the crucial factors that lead to positive outcomes in their care home. The following themes emerged.

Leadership starts at the top

The key message that came out loud and clear was that good leadership begins at the top of the organisation.

There was a generally held belief that many care home owners/providers organise themselves in a top-down hierarchy, where power and control is held at the top of the organisation and commands flow down to the workforce, often in the form of tasks and operational procedures. Challenging this, participants spoke about the importance of an enabling organisational culture, which is based upon building trusting relationships across the workforce and a sense of 'everyone in it together' (e.g. Transformational and Dispersed Leadership). One participant noted that giving real power to older people required directors and CEOs to feel confident in giving up some of their power and ownership to their staff teams. There was a belief that, if senior managers feel empowered, safe and supported from the top, they were then more likely to mirror this and communicate their confidence at a lower level with staff – who are then likely to mirror this with the older people living in the home and their relatives.

There is a sense of the importance of owner/provider organisations leading from a starting point of confidence, rather than one of fear – and when things go wrong, of learning from mistakes rather than ascribing blame. As one participant noted: 'We know that we don't always get it right but we believe in ourselves, our practice and what we are trying to achieve.'

While endorsement of this enabling style of organisational leadership was echoed across most discussions with participants, there was recognition that being able to move quickly into a more directive style of organisational leadership, where and when it is needed, was essential in dealing with the very real issues that often arise.

Importance of 'transformational' managers

The emphasis should be on nurturing and creating trust with staff, listening, being authentic and approachable, encourage delegation and ultimately model the behaviours that they expect from the staff in their engagement with older people and relatives that result in the realisation of relationship-centred care. Two participants noted the importance of both being prepared to 'get stuck in' to the day-to-day work and also offering direction and support while ultimately enabling staff to arrive at the final decision. Most participants agreed that good leaders were not, as one put it, those that simply 'barked commands and instruction to staff'.

A participant summarised what they felt was positive about their leadership style:

I trust that they [the staff] know their residents. I love the fact that they dare to be different ... push these boundaries on behalf of their residents. They know that I will support them, but also when needed I will put my management hat back on and very quickly jump on things that are simply unacceptable.

The 'relational' style of management is not dissimilar to the Servant Leadership model described earlier in the chapter.

Getting the right staff

Recruiting the right staff is absolutely crucial, though not easy given the complexity of the role and the very minimum wages being offered. A range of strategies was presented by participants. One spoke of the need to recruit

There is a sense of the importance of owner/provider organisations leading from a starting point of confidence, rather than one of fear – and when things go wrong, of learning from mistakes rather than ascribing blame.

staff who originated from, or at least understood, the culture(s) of those living in the home. Three participants described how the interview process involved a whole day of engagement or a 'trial day' so that candidates could get a feel for the work. The manager could also get a sense of how well the candidates connected personally with those people living in the home, were able to disclose something of themselves to them, and held a philosophy of care that complemented that of the organisation.

One participant described how they had moved away from traditional roles for domestic and care assistants to a more blended role, that better communicated the responsibility to support the older person's wider well-being. This was deemed helpful in removing the potential divisions between staff and in creating better team working.

Two providers had reviewed the way they advertised their posts. One advert read: 'If you can't take orders from the residents, don't apply.' Another began with the banner: 'Do you want to have fun and enjoy your job?'

Helping staff to engage with their work

The majority of participants agreed that, if we want strong emotional relationships between staff and older people living in the home, we have to support them to stay engaged, to reflect on their work and process their feelings and fears. Creating regular opportunities to support high quality individual or team reflection was the goal. The extent and type of support that was offered varied, with some participants providing monthly team reflection and others making use of 'staff handover meetings' as an opportunity for reflection rather than, as is often the case, a place where staff are given their instructions. The general view was that regular informal and formal opportunities to allow staff to have time and support to reflect was crucial. Through these opportunities, managers were able to help staff feel engaged, valued, listened to and able to take the initiative, rather than being told what to do. As one participant noted, it's about the manager communicating: 'Here is the general strategy, now 'over to you' to make it live.'

Training was deemed very valuable in helping staff to reflect. One participant emphasised the importance of using training as an opportunity to help staff reconnect with the older people they cared for, through two-way discussions where the manager modelled listening and engagement. Others valued the involvement of outside consultants, who could inject energy and enthusiasm into the staff team; for instance, in exploring new approaches to dementia care.

Supporting staff and role modelling

The role of the manager in modelling the type of behaviour that they expect from staff in their interactions with the broader community of the home was continually mentioned in the discussions. This was seen as particularly important in communicating an ethos of positive risk-taking to enable older people to carry out the activities that were important to their quality of life. One participant described the desire to make staff feel that 'anything was possible!' and, as a manager, she constantly celebrated the examples of how they had overcome their anxieties relating to risk and made a difference to older people.

There is no doubt that supporting staff to remain 'in relationship' with those they are caring for is not simple. Staff may internalise the projected losses that older people experience on coming into the care home, their emotional and psychological pain and/or their cognitive problems. The challenge for managers is to help staff to process their feelings, supporting

them to engage with older people and to maintain their resilience so they can continue the work. As one participant put it: 'You can't understand your residents without firstly understanding your own feelings.'

One participant noted that if staff are supported to really listen and take the initiative in responding to what older people in their care are saying and asking for, older people become aware that it really is possible for their wishes and aspirations to be met, and are therefore more likely to ask again. Similarly, if older people in the home feel that their emotions are being acknowledged, they are more comfortable in expressing their true feelings. One participant noted how important it was that older people's comments or complaints were dealt with sensitively and swiftly and without the older person fearing any repercussions. Without this, they may not be so forthcoming in communicating their views.

Making the environment more conducive to relationship-centred care

Some discussions focused on how creative thinking about physical space in the care home could develop opportunities to support relationships across the community of the home.

One participant described how, in an attempt to nurture stronger relationships, particularly between older people in the home, armchairs were rearranged into small circles. The team replaced the institutional tea trolley with individual tea trays and teapots for each group. The intention was that this simple ceremony of 'taking tea' would stimulate conversation across residents and staff. Where the hot teapot was considered a risk to an older person, staff would help with pouring.

Another participant noted that simple things, such as the position of the desk in the office, can make all the difference in terms of how approachable management is perceived to be by those living, working and visiting the care home. Another noted that small, unitised living spaces appeared more conducive to strong relationships between staff and older people in their care. Two participants spoke about how uniforms can, on the one hand, help older people and relatives identify staff members; but on the other, can represent power and authority (something that may be an obstacle to positive two-way relationships). One participant had reached a compromise by agreeing the use of more informal styles of uniform.

Working in partnership with external organisations

Quality of life and care for older people in care homes require the support of external community, health and social care agencies. Two participants described how, having developed an inner confidence within the care home team, they had become more proactive in developing relationships and improving mutual trust between themselves and external organisations. One participant had, through this dialogue, offered social work placements, and a one-day induction to all new social workers. Another had agreed quarterly meetings with a range of health and social care professionals to maintain positive relationships.

Ongoing support to managers

One participant described how their home had created an internal structure of regular group clinical supervision for managers. Another talked about how senior managers had been trained in coaching skills, which they use in their meetings to support managers to reflect upon their work and process some of the issues that they are working with. Two participants emphasised the importance of new managers being teamed up with another more

The challenge for managers is to help staff to process their feelings, supporting them to engage with older people and to maintain their resilience so they can continue the work.

experienced manager who acts as an informal mentor. Some participants, managers themselves, described how their confidence had developed over time, through building relationships with external professionals. Another noted the vital source of support provided by their own personal friends and family.

The findings of the fieldwork reflect well the need for a transformational model of leadership that seeks to support the delivery of relationship-centred care.

Summary

This chapter has identified nine outcomes of good leadership in the care home sector and suggested the importance of a number of key themes to make this happen, including: leadership starts at the top; importance of 'transformational' managers; getting the right staff; helping staff to engage with their work; supporting staff and role modelling; making the environment more conducive to engage; working in partnership with external organisations; ongoing support to managers.

We have argued that, in order to enhance 'voice, choice and control' within the care home community, leadership that supports, nourishes and enables staff, older people and their relatives to engage with each other and the wider community and that ultimately creates the conditions in which relationship-centred care can be role modelled and rolled out, is essential. A transformational leadership model, which embraces the notion of 'Dispersed Leadership' and 'Servant Leadership', fits well with this goal.

The next chapter explores the contextual obstacles – both within and outside the home – that can prevent care home managers from demonstrating transformational leadership and achieving 'voice, choice and control' for older people.

4 THE OBSTACLES TO LEADERSHIP AND ‘VOICE, CHOICE AND CONTROL’ IN CARE HOMES

This chapter seeks to examine the context in which care homes, and in particular care home managers, try to develop their leadership, management and communication skills in order to create the conditions for older people’s ‘voices’ to be heard and to enable them to have ‘choice and control’. The chapter also explores some of the pressures and stresses on care home managers, which, in many ways, take them away from their primary role of delivering quality of life for older people with high support needs. In addition, the following research question is covered here: how does national and local policy, commissioning and regulation impact upon user choice and control?

Many issues were raised by the care home managers through the action learning sets for the Leadership Support and Community Development Programme. The care home managers wanted the findings to be shared as ‘obstacles’ so that the reader could understand better the context of their work and more fully appreciate how hard it is to deliver best practice in such a complex environment.

The Community Development strand of the *MHL* Programme attempted to resolve some of these issues through Appreciative Inquiry methods and to leave the care homes and the wider health and social care system in a state of better partnership-working. Findings from this strand are shared in the next chapter.

It should also be noted that, despite the challenges they face, care home managers come across as a highly motivated group, who enjoy their work and feel very committed to caring for older people. While there is much that makes their day-to-day work harder than it probably needs to be, most find it a very rewarding role. Their desire to give 'voice' to the obstacles they encounter appears motivated by a frustration that they are not able to do as much as they would like for the people for whom they care, and also to a desire for the work that they do to be better understood by the rest of society.

The challenging relationship between care homes and the wider health and social care and regulatory system

Quality in care homes relies on strong partnership-working across the system. When managers have the positive support, trust and backing of practitioners and professionals from across health and social care, they feel more confident, more resilient and more able to create an enabling and supportive culture of practice for their staff, the older people in their care and their family members.

The current reality for many care home managers is that this trust and support are often absent. One manager told a story of an 'inspector'² visiting her home and saying to her: 'I've come to find out what you are hiding because I know you are and my job is to catch you out!' Another described the real isolation of the work: 'I've got no one else to talk to, at this level it's a very lonely position.'

Managers described how dealing with mistrusting or blaming attitudes towards themselves, their staff and occasionally even the older people living in the care home was draining, and reduced their passion to strive for quality, as their energy often appeared to be going into continually defending their position. One group noted how the wider system was quick to formally report a perceived problem rather than engage in a wider discussion with the care home about the issue in order to understand and resolve it. 'What has happened to communication and talking?' one asked. Care home managers want to be treated as equal professionals, but often feel unfairly treated and inappropriately blamed.

Interestingly, discussions with officers from monitoring, assessment, reviewing, contract and commissioning teams within two local authorities resulted in some acknowledgement that, sometimes, professionals from the wider health and social care system view care homes as 'a bit of a problem'. Some suggested that, because of the emphasis within national policy on trying to support older people to remain in their own homes for as long as possible, care homes were seen as 'the last resort' and were therefore afforded less value.

In one authority, there were interesting discussions about whether their own expectations of care homes were realistic. Some officers noted that they sometimes felt disappointed by the fact that there is often very little activity going on in care homes. Yet, on reflection, they acknowledged that, given the context of funding, staffing and the high levels of frailty within the population living in care homes, perhaps this was unsurprising.

Care home managers want to be treated as equal professionals, but often feel unfairly treated and inappropriately blamed.

There was some acceptance that this feeling of disappointment might be communicated to the staff and manager, and might simply exacerbate an atmosphere in the home among the older people, relatives, staff and managers of feeling isolated, unvalued and unappreciated.

Table 1 presents data from one workshop with local government officers where they were invited to talk openly about both the emotions that were stirred up within them when they visited care homes and also how they felt they came across to staff, the older people and relatives. Their views reinforce some of the messages from managers about the level of mistrust and suspicion that they experience from some outside professionals.

Many care home managers spoke of the unacceptable pressures put on staff in homes to cope with what they saw as failings within the wider system, e.g. accepting discharges quickly and without the appropriate support being in place; dealing with out-of-date assessments; sorting out medication problems; a lack of attention to whether the care home is best suited for a specific individual. Some managers have noted how hard it is to access certain professionals and practitioners when they need help, yet were expected to respond quickly when it was these practitioners that were demanding something of them (see Box 8).

Overall, there was a sense of isolation from the wider health and social system. Managers felt their views and expertise were not acknowledged, and some described how they were being made to feel like 'second-class citizens'.

Difficulties supporting positive risk-taking

As noted earlier, supporting older people to take positive informed risks is complex. In a research study undertaken for SCIE on 'Managing Risk and Minimising Restraint', we note how decisions made in the best interests of the older person require negotiation skills, creativity and resilience (Owen and Meyer, 2009). There are many occasions when staff try to support an older person's decision to undertake activity, even though there is a risk attached to it. However, care home managers argue strongly that they need to feel less threatened or blamed by external agencies on the occasions when considered risk is taken and things go wrong, especially when every effort has been made to keep the older person safe from harm.

Table 1: Workshop for local government officers engaged with care homes

What emotions are stirred up when going into a care home?	How are we regarded in care homes?
<ul style="list-style-type: none"> • Positive – this is going to be great 	<ul style="list-style-type: none"> • Policing, safeguarding, dealing with breach
<ul style="list-style-type: none"> • Alert – suspicious, until proven wrong 	<ul style="list-style-type: none"> • Official and powerful
<ul style="list-style-type: none"> • Problem-focused 	<ul style="list-style-type: none"> • Poking about
<ul style="list-style-type: none"> • Anticipating the worst 	<ul style="list-style-type: none"> • Interfering
<ul style="list-style-type: none"> • Low expectations 	<ul style="list-style-type: none"> • Suspicious – checking up
<ul style="list-style-type: none"> • Neutral – no expectations 	<ul style="list-style-type: none"> • Threat to their credibility as a manager
<ul style="list-style-type: none"> • Anxious about what you are going to find 	<ul style="list-style-type: none"> • Undermining the manager
<ul style="list-style-type: none"> • Vigilant 	<ul style="list-style-type: none"> • Bias towards negative

Box 8: Accessing health support in care homes

My Home Life was actively involved in the production of 'Quest for Quality', a report produced in 2011 by the British Geriatrics Society, which identified the significant lack of support offered by the health service to care homes in meeting the healthcare needs of residents. The report can be found at: www.bgs.org.uk/index.php?option=com_content&view=article&id=1487&Itemid=719



The need for better access to healthcare is also outlined in the report by the independent Commission on Dignity in Care (2012).

The following example from the research by Owen and Meyer (2009, p. 34) demonstrates how, without real support and trust, care home managers become less inclined to support older people in their care to take risks. A manager attempted to positively support an older person's wish to walk down the stairs unaided, having discussed with the individual, and documented, the risks involved. Although this was an informed and positive decision, sadly the older person consequently died as a result of falling down the stairs. The manager described how he already felt a profound sense of guilt and loss as a result of what had happened. However, rather than being supported by the wider system to deal with this emotion, he felt the world was caving in on him, as various professionals intervened with their own statutory requirements to investigate from a position of mistrust, and, in the manager's eyes, blame towards him. The absence of relationship-centred care between the manager and the wider system was striking. His immediate reaction was to 'tighten the reins' in the care home: his staff were told to minimise any risks associated with the activity of older people within the home.

Many managers have echoed this sense of anxiety about the vulnerability of the care home to the blame and suspicion of outside agencies. One manager described how, if anything goes wrong, she witnesses a 'tsunami of agencies' that come to her door to investigate.

Some managers described how they felt there were mixed messages from regulatory inspectors, council officers and health and safety officials about what is deemed to be acceptable practice and acceptable risk. These leave the care home manager unclear about what is and is not permitted. For example, one manager reported that, while some officials have asked

them to remove coded locks from doors to ensure that older people are not deprived of their liberty, others have instructed them that they should be kept locked. Another was criticised by a regulatory inspector for having beds still unmade in the afternoon – however, the manager had been trying to support her staff to see the older people in her care home as the priority, rather than the task of making the beds.

Problems working with safeguarding teams

Across all groups, managers highlighted how the local safeguarding processes could be improved to reduce the sense of anxiety associated with supporting risk-taking. There was a shared view that sometimes referrals to safeguarding were inappropriate or unnecessary and that the whole process felt threatening to them and their care home. In three local authority areas, managers described how, on most occasions, the process of investigation took a considerable number of weeks to resolve. Some managers reflected upon how the process of investigation is happening behind their backs and they are often not aware of who is involved or what is happening. The investigation often results in a hearing, which many managers described as being organised in such a way as to put them in the position of the ‘accused’ having to defend their corner. The experience created huge anxiety for many, reduced their ability to remain resilient and made them think twice about supporting older people to take positive risks.

Local safeguarding processes could be improved to reduce the sense of anxiety associated with supporting risk-taking.

Support from the care home owner/provider organisation

Many managers reported on difficult or unsupportive relationships with their line manager, whether this was an owner, director or other senior manager within their organisation. It was an issue that, for some managers, acted as a substantial obstacle to taking forward improvement in their care homes. Some described how they felt they were being controlled or ‘done to’, where they felt unable to make requests of the line-manager or to even express feelings about their work. One manager described how their organisation would be ‘jumping up and down on her head’ if an incident in the home had occurred. Many reported that they felt criticised rather than supported when things went wrong, with too much focus on the ‘business’ of care – filling beds, hitting targets and so on – at the expense of any deeper understanding and support for the real nature of the ‘caring’ work that they are engaged with. Some owners would communicate their own ethos, override managers’ views or orders, and act ‘un-rationally’ with the manager and the staff. Ultimately, this was deemed to impact upon their anxiety and therefore their ability to deliver a positive culture where staff felt able to build up relationships with older people to promote their ‘voice, choice and control’.

The burden of paperwork

Across all groups, managers have argued strongly for the reduction in the sheer volume of paperwork that they need to read or complete on a daily basis. This would give them more resilience and time to work directly with their staff to support the development of practice.

Some managers have spoken about 'drowning in paperwork'. One manager said that in her home 'too much paperwork means less time for activities'. Another manager playfully suggested that they spend their time 'feeding the system rather than feeding their residents!' Ultimately, the level of paperwork was taking them away from the primary aim of delivering quality.

The various bodies and agencies surrounding care homes would appear to require an enormous amount of paperwork. Care homes are expected to respond to the needs of NHS and LA commissioning, regulation, social work assessment and reviews, health and safety assessment, coroners' investigations, fire service requirements and agencies' safeguarding protocols, training requirements, continuing care assessments, and so much more. Managers argued that, if there could be less duplication of information needed across these agencies, this would reduce the paperwork and allow them greater ability to deliver quality. Our advisory groups suggested that it is not just the paperwork that is sent to care homes that needs attention, but also the internal requirements to complete risk assessment forms that take up considerable time. Some managers argue that the fear of getting things wrong leads to extensive risk assessments for all manner of activities that older people within their care may engage with. One manager described how she had almost given up building a greenhouse in the care home garden for older people to use because she believed that she was expected to assess the risks associated with it in relation to all the older people in her care. This related both to the danger of the glass and also of fertilisers and composts that had chemicals within them.

If there could be less duplication of information needed across these agencies, this would reduce the paperwork and allow them greater ability to deliver quality.

A lack of trust from the public

I live in constant fear of somebody doing something wrong and the home shutting.

There is no doubt that managers felt that the ongoing negative portrayal of care homes within the press had an impact upon their daily work. It reduced their status and made them feel mistrusted. Some managers described how some staff were embarrassed about telling friends that they worked in a care home.

Managers also described how the perceived mistrust from the wider public affected their ability to deliver quality. They spoke about being worried about the potential repercussions of making decisions that could be viewed as not appropriate by the 'world outside' even if it was considered the best decision in responding to the interests and needs of older people within their care. One manager noted that 'it is always in the back of their [the staff] mind, how this is going to be seen by others ...'. One group of managers reflected upon how public anxiety about care homes reduces the trust that families have in them and so they become more anxious and add greater stress to the community of the care home.

Motivating the staff team

Given the limited status and pay of staff working in care homes, and the physically and emotionally exhausting nature of the work, it is perhaps no surprise that managers identified staff problems as a key obstacle and daily challenge to delivering a positive enabling culture in their home. Managers

often expressed deep distress, and a burning desire to understand why staff didn't appear to be able to take the initiative and do things without being told. One manager noted how she spent her whole time checking, checking, and re-checking. 'Why don't they take responsibility?'

Managers reflected upon the energy it took to keep staff engaged in their work. Managers spoke of how some individual members of staff did not listen, or would skew everything that was communicated by the manager in a negative manner, so nothing could change. In some homes, 'older' staff members took it upon themselves to force a culture of rules and ethos, telling new staff members what they could and couldn't do, creating stress and anxiety to toe the line, and attacking those who are being too slow or spending too much time with the older people. At its extreme, staff behaviour manifested itself as bullying.

The lack of independent support

A common finding across all groups was the feeling of isolation. Managers described how there was little support or acknowledgement for the role that they undertook: 'I've got no one else to talk to; at this level it's a very lonely position.'

Some noted the lack of support from inside their own organisation, and how they were often not given permission to attend outside meetings to help them inform their practice. Others spoke of how support meetings within the provider organisation and local authority manager forums, where they exist, were not run in such a way as to enable them to have honest and frank conversations about the difficulties that they were encountering.

Stress and 'burn-out'

Given that managers are typically taking on problems, stresses, anxieties and emotions from a variety of sources, including their own staff, care home owner or provider group, the older people, families and external agencies, it is no surprise that some described how it made them feel 'numb' and at risk of 'burn-out'. Many described themselves as 'being everything to everyone'. The role clearly impacted significantly upon many managers both at a personal level and in their ability to support positive relationships in the home.

Care is stressful and often thankless – we need support as an industry.

We are like little mice on a treadmill, spinning the wheel as fast as we can to keep the wheel turning – this emotion of chasing, an endless circle with no end.

It affects the kids – because I shout at home rather than at work.

Work is taking over my life. There is always something to do and attend to. It's affecting my family – but I need to try and stop it doing so – but I love what I do, so I need to find a balance.

On a day-to-day level, many managers spoke of how the pressures and anxieties and mistrust from outside the care home impacted upon their style of management, leading them to try to control everything that was

going on in the care home. We often heard managers say that they felt like 'mothers' to everyone, that they adopted a 'command and control' style of management (i.e. they told staff what to do rather than facilitating them to reflect and take the initiative, or helping them engage with the older people they are working with). This style of management goes against the evidence on good leadership, and results in staff simply taking orders, being focused upon getting the tasks done and lacking ownership over their work and the relationships they have with each other, the older people and relatives. Overall, managers reported that this can result in staff becoming disconnected from the older people that they are there to support, which ultimately impacts upon the care home's ability to support 'voice, choice and control'.

Ironically, it could be argued that, as a society, our desire to improve the circumstances of older people in care homes has led to an ever-increasing culture of paperwork, pressure and stress being placed upon care home practitioners, which feeds into the culture of the home and impedes the very thing we are trying to promote, i.e. quality of life.

Summary

The work of care home managers is complex. This chapter has focused on some of the obstacles identified by them to developing leadership so that they can achieve genuine 'voice, choice and control' for older people in care homes. These obstacles include: the challenging relationship between care homes and the wider health and social care and regulatory system; difficulties supporting positive risk-taking; problems working with safeguarding teams; a lack of support from the care home owner or provider organisation; the burden of paperwork; a lack of trust from the public; unmotivated staff; the lack of real independent support for care homes; and risk of burn-out. These obstacles are likely to get in the way of any attempts to improve practice and need to be considered most seriously.

Overall, the constant bombardment from external bodies, the lack of trust and support from both within and outside of the care home, and the fear that they might make a mistake resulted in managers leading the home from a position of defensiveness, stress and anxiety. These emotions get carried into the atmosphere and culture of care home practice, resulting in older people, relatives and staff also living with these harmful emotions and ultimately reducing the potential for positive relationships between staff, the older people and relatives to flourish.

5 MOVING FORWARDS: TOWARDS TRANSFORMATIONAL LEADERSHIP AND BETTER PARTNERSHIP- WORKING

In the previous chapter we described some of the obstacles that care home managers felt reduced their ability to effectively lead their teams and support older people's 'voice, choice and control'. In this chapter we describe some of the activities that have been undertaken within the *My Home Life* Programme both to support care home managers deliver relationship-centred care in care homes and to facilitate greater partnership-working between care homes and the wider community and statutory services.

These two distinct strands of work comprise the *MHL* Leadership Support and Community Development Programme. The research questions that are most pertinent to this chapter are:

- How can leadership and culture change be supported to develop within the care home sector?
- How can we better support community and relative involvement in supporting the collective and individual voice of older people living in care homes?
- How can we improve choice and control for older people and their relatives who are starting to consider the need for a care home?

Supporting leadership in the care home sector

The *MHL* Leadership Support Programme was developed to support groups of between 12 and 15 care home managers to engage in a 'journey' of positive culture change, through the delivery of leadership skills training and action learning sets.

Given that creating real sustainable culture change in care homes is a complex process, the programme adopted a developmental approach, working with managers over a period of time (12–14 months) at whatever level they find themselves, and supporting them as individuals and as professionals leading change. Individuals were helped to reflect closely on their day-to-day work and to recognise that real change begins with themselves – starting with the development of their own leadership, management and communication skills and examining the emotional undercurrents at play within themselves and the individuals they work with, which, if ignored, may inhibit positive change.

The model aimed to help them think objectively about the culture of care in their home and to work creatively, with support, to identify realistic solutions for improving the quality of life of the older people, relatives and staff in line with the evidence base developed by *MHL*.

What is action learning?

Action learning is at the heart of the Leadership Support model. It is a continuous process of learning and reflection, supported by colleagues, with the intention of improving practice. It recognises that individuals learn best when they learn with and from each other, by working on real problems and reflecting on their own experiences. Action learning helps develop styles of communication that are more relational and more reflective. This enables members to role model, in the workplace, new ways of working that facilitate enhanced 'voice, choice and control' with older people, relatives and staff. Through action learning, care home managers develop and evaluate plans for quality improvement and discuss with each other what factors help to facilitate or inhibit change.

Outcomes of the Leadership Support Programme

The *MHL* Programme has, to date, supported over 250 care home managers through its Leadership Support activity. However, the outcomes summarised below relate to feedback from our work with the first 124 managers.

A safe place to reflect and learn

Mindful that care home managers are constantly having to respond to the agendas of other agencies, our programme was very much about allowing them to steer how they use the space to support them to cope with the pressures, to resolve issues and develop their skills to take forward improvements in line with the evidence base for quality in care homes and transformational leadership. The need for managers to feel safe and supported to speak openly, honestly and confidentially was crucial. Many managers spoke of the preciousness of having such a space, to share ideas and to feel the support of others in helping them through sometimes very difficult personal and professional issues.

It's allowed us a safe environment to discuss concerns and worries and, collectively, people have put forward good ideas, which we can take back and put into practice in our own homes – so that's been very positive.

It feels like going through a work-out, working really hard, and coming out feeling much better and thinking 'I'm going to do this, or that', or even, 'It's not that bad after all'.

Increased resilience at work

The action learning process worked to support managers to cope with some of the huge stresses and anxieties described earlier. For some, it helped them recognise the professional and personal boundaries of their work, being more realistic about what could be achieved and accepting that they could not take it all upon their own shoulders. Overall, the process allowed people to develop their own inner strength to stay 'in the game' and be less affected by the torrent of pressures upon them.

I am looking after myself better, I take breaks, don't work so late; I could not function. The professional boundaries helped me work more efficiently and create more resilience, I have more 'headspace' to reflect on issues, and now wonder what I was doing, racing around. It has positively affected my personal life.

Managers described how they felt less numb, burnt out and professionally isolated, restored and more resilient. This gave them the energy and focus to work positively with staff, leading directly to positive outcomes for older people.

Changes in leadership style

Some of the managers described how their ability to reflect upon their role and practice had developed enormously. They were learning to challenge their own attitudes and assumptions and question whether the way they did things is always right. Through the programme, they developed a transformational style of leadership. Many claim that MHL has provided them with the courage, skills and security to take on a more authentic role, acting more naturally rather than hiding behind the badge of manager, and sending out the right messages to staff about their need to be authentic in their work with older people.

It's made me look at who I am and how I am as a manager, made me realise how I can change for the better for the home.

I now feel that 'I can' change things, I have clearer clarity over my role, what actually I want changing, what ethos I want to build, it's all clear.

Enhanced relationships with staff

Many managers described how, prior to the Leadership Support Programme, they would adopt a 'command and control' leadership style which could result in staff feeling 'done to' and not able to properly engage in, or take ownership over their work and the relationships they have with one another and with the older people and families. They began to recognise that, by shifting to a transformational approach, modelling those behaviours that they expect of their staff in their engagement with older people and providing higher quality support to staff to reflect upon themselves as a

team and their work, they were able to help staff to reconnect with the older people that they were working with:

MHL does help you a lot in managing your staff. We tend to rush around telling them do this, do that, but to actually give them, the staff, time to unpick it, to see it for themselves, to feel it, to have their goal in mind and they can see how they can get there. If we all have a common goal, they have got to feel it, I can't just tell them to do that, they have to go through the same process.

Managers began to demonstrate a very different style of management, from 'handling people' and 'telling people what to do/checking up on them', to being very relationship-centred; mirroring, validating, opening a real dialogue with staff to help them connect with their work, and the older people in the care home, rather than hiding behind their formal role of 'Manager'.

I came to MHL and I got some great ideas out of it [for running a staff meeting]. I took [the ideas] to a staff meeting and it worked really well and the staff completely opened up, they were fantastic, and they came to all the decisions themselves – I didn't feed them with anything like I normally would, they got to the end conclusions themselves and it was all by technique. It was amazing; I came out of the office saying 'YES'. I even got the flipchart and showed it to my manager and said, 'Look at this!' That's culture change!

The whole point of the culture change is that staff actually start thinking about what they are doing and put it in human rather than task terms. So when they're asked to think about what they are doing, they can actually really think about it, because we are asking the right questions.

Better able to deal with challenging staff

Managers also talked about how the culture of their care home and their ability to support relationship-centred care were often affected by problematic staff dynamics or issues around specific staff behaviour. Again, having the time and support to explore the underlying reasons behind these problems meant that managers were more likely to successfully reduce some of the problems they had with staff.

I had difficulty with a care staff member, who was ... coming over quite angry ..., and it was affecting residents. I engaged in active listening time with her with tremendous effect, and she is now giving so much back with such hard work and so responsive. It has been fantastically positive. Without MHL, I wouldn't have tackled her issues and she would have spiralled down; she would have gone off sick with her problems at the time.

Perceived outcomes for older people living in the care home

Most managers taking part in the Leadership Support Programme agreed that older people were seeing the benefits of the programme, but also that it was not always easy to measure. In discussion, they identified the following outcomes.

Calmer atmosphere

If you have a happier staff group, happiness cascades down, there's a better atmosphere.

Everything has a knock-on effect, people feel more relaxed (staff, residents), they take the initiative, feel safer to try things, residents appear to feel listened to valued – it's hard to put your finger on what has changed.

While changes were relatively subtle, managers noted that because they themselves had become calmer and more able to engage relationally, so had their staff and that this had led to a calmer atmosphere generally. Many noted how they witnessed less 'back-biting' among staff and more of a culture of 'openness'; some managers reported how families would increasingly describe the atmosphere as 'friendly' and how they were more likely to see staff sitting and spending time with older people.

The whole place is calmer. We have noticed that more residents are referring to staff by name rather than shouting 'nurse', which some of them used to do. This is because there is better human engagement between residents and staff, and the modelling of practice by the manager to staff. It is wonderful and, now, residents feel seen and acknowledged by staff.

Overall, many of the managers agreed with the sentiment offered by one manager:

Because I am not so stressed, not so angry with staff for not doing it right, for not understanding the person behind the dementia, I am more approachable, staff are less on the defensive with me, they talk to me as an adult rather than coming with excuses. They are relaxed, feel more supported and do not feel the need to play out their insecurities and anxieties; they are calmer, they don't have to feel seen to be doing a task in order to ensure that they are not going to be criticised. This has a major effect on the resident experience and the quality of relationships between staff and residents.

Staff engaging more positively with older people

We have moved away from the mindset of 'doing someone in the morning' [getting someone out of bed and washed]. Residents are seen more.

Most of the managers who completed the programme described how their new management style had helped to support staff to interact more positively with the older people living in the home and, in so doing, offered greater 'voice, choice and control'.

Residents are no longer simply at the receiving end of a task, they are part of a two-way relational connection.

One manager remarked on how older people in the home were taking greater responsibility for roles in the home (watering plants, flower arranging, feeding fish):

Because [managers] themselves had become calmer and more able to engage relationally, so had their staff and that this had led to a calmer atmosphere generally.

... something that we had encouraged them to do for ages, but suddenly they seem to be doing it, like that our new relational approach has helped them feel more engaged and closer to the home, rather than ordering staff around as if they were servants.

Some managers have also remarked at how they and the staff have developed confidence to challenge some of the practices and decisions within the wider health and social care system that may not be in the older person's best interests. One manager remarking upon on how thrilled and energised care staff had become having witnessed their manager stand up to the health professionals on behalf of an older person.

Perceived outcomes for the organisation

My sense is that sickness among staff is less, and there is greater staff retention.

Given that the Leadership Support Programme was created primarily in order to support managers simply to cope with the complex and highly stressful work that they were doing in delivering quality, we were not expecting to gather data on broader outcomes of the programme in relation to the impact on staff. However, the data has demonstrated that, in some homes, it was perceived that the changes in the culture of the care home had led to a reduction in the levels of staff turnover and staff sickness. This finding is not consistent across all groups of managers that we worked with. For instance, in a small number of homes, there has been an increase in turnover because some staff were not able to adjust to the new culture that was being adopted in the home. This was viewed as a positive finding by care home managers:

My sense is that when you start doing positive culture work, you can expect staff to leave because they are uncomfortable with the new ethos, but once this has happened, then the staff group are more stable.

Sustaining culture change

It is recognised that 25 per cent of the managers did not complete the programme. While the reasons for this have not been fully evaluated, we know that many left for reasons of general poor health or because they had moved out of the area, left the care home or where the care home itself had closed. We are aware of one manager who left the group because of her own discomfort with the action learning process, specifically in terms of the emphasis placed upon supporting personal and professional reflection.

Real transformation in the culture of practice is a long-term ongoing pursuit. It is important to acknowledge that for some managers, the monthly action learning sets simply offered them support to cope with the enormity of pressure that they were experiencing. Some managers described how difficult it was to transform the culture of the care home when the owner or wider provider organisation was not supporting them to deliver a culture of relationship-centred care.

For the many managers who reported real success in making improvements in their care home and helping relationships across staff, the older people and relatives flourish, the question remains as to whether these

changes are sustainable once managers have completed the Leadership Support Programme. In some local authority areas, investment has been made in offering ongoing action learning support to these managers. In other areas, managers have strived to continue to meet, but recognise the value of an independent facilitator to create a formal structure within which they can process the challenges facing them and move forward. Some managers have spoken about how difficult it is for them to gain permission from the care home owner or provider organisation to leave the care home to receive training or support, particularly if the local authority is not directly requiring them to attend.

Manager support in Wales

In Wales, a different approach to supporting managers has been developed as part of the *MHL Cymru* programme. Since March 2009, the Programme Manager has engaged with 38 care homes from across Wales (5 per cent of the care home sector for older people in Wales), meeting with them in a more informal capacity both individually and in groups to share ideas and help managers reflect upon what is working well and what could be improved. The work involves the Programme Manager gathering up the views of the older people, relatives and staff and offering some feedback to managers along with space for them to reflect upon their issues. The final evaluation has yet to be completed.

Better partnership-working between care homes and the community and statutory services

The second strand of activity within the *MHL* Leadership Support and Community Development Programme aims to support better partnership-working between care homes, the wider health and social care system and the wider community to work on issues of mutual concern and, in particular, to help reduce some of the obstacles that face care home managers in striving to deliver quality for older people.

In six local authority areas in England, *MHL* has acted to facilitate discussion and reflection on the following themes: improving the experience of older people in their transition from hospital to care homes (and vice versa); supporting older people and staff cope with care home closure; improving partnership-working between care homes and quality monitoring, commissioning, contract and social work teams; and supporting better community engagement in care homes.

The approach that *MHL* adopted varied according to what was felt to be the best strategy for taking forward a particular issue. In some instances, *MHL* spent time to share particular concerns raised by care home managers informally with officers who held some level of responsibility within the local authority or PCT that was relevant to the issue of concern. In other areas, *MHL* held events with particular groups of stakeholders (commissioners, contract officers, quality monitoring officers) to help them reflect as a team on their work and how they could improve their relationships with care homes.

In five local authorities, the work resulted in the development of events which brought together key stakeholders from across the relevant communities of practice to work together in identifying what was working well, what could be improved and what needed to happen to make things

better. This appreciative approach helped the different stakeholders to get to know each other, understand each others' contexts, learn to value and respect each others' perspectives and to help sort out local issues that were getting in the way of supporting older people living in care homes. Presented below are some of the key outcomes arising out of the work to date. We have made special mention of the work of *My Home Life Essex* where, over the past three and a half years, a number of activities have been undertaken to support better partnership-working between care homes, the statutory services and the wider community.

Improving the experience of moving from hospital to care home

Work was undertaken in four sites to create a stronger dialogue between care homes and the wider health and social care system, in order to deliver better outcomes for older people in relation to the transition from hospital to care home. In each area, an Appreciative Inquiry event was organised. Participants typically included care home managers, social workers, hospital staff including individuals from discharge teams, strategic managers in health and social care and Directors of Nursing. Participants were invited to identify what worked well currently in supporting outcomes for older people, and then to 'dream' the perfect scenario where positive outcomes for older people were commonplace. The groups were then invited into a 'design' phase where they would examine what needed to change in order to move towards this 'preferred future'. Finally, delegates were asked to specify how, as individuals and as a group, they were going to take forward change from the event into their working day.

Unfortunately, it was not possible in the time frame and other constraints of the study to follow up and evaluate these proposed changes. However, across all four Appreciative Inquiry events, practitioners identified the following areas where they hoped to take action in making improvements.

Improved support and choice

Participants highlighted the importance of the older person being supported to reflect upon their circumstances, to process what was happening and to have a real say in the decisions that were being made. Participants recognised the importance of staff needing proper time to build relationships with older people and to help them to cope with the changes that they are experiencing. They recognised the value of offering older people counselling to support them through the emotional upheaval involved in going into a care home. They also suggested that a specific role within the hospital and/or community could be developed to help people to make proper informed choices about the care homes that were available, and to support them on visits to these homes.

Information to older person and family

Practitioners agreed that written information should be presented clearly without the use of acronyms or abbreviations. Some participants suggested that older people in hospitals could benefit from DVDs or iPads that presented information and images of care homes to help them make choices. Overall, the need for better-tailored information to individuals rather than giving them anything and everything was seen as vital, together with the use of trial visits.

Better planning and co-ordination between care homes and wards

A seamless process where older people, care home staff and hospital staff had shared information about what was happening was seen as crucial.

Practitioners identified the importance of identifying a named, single staff member in the hospital with whom care homes could liaise about hospital discharge. The need for a common system of information-sharing was also seen as helping to improve co-ordination and reduce unnecessary or duplicated paperwork. Practitioners argued that more could be done to ensure that the older person was provided with the correct medicine at the time of discharge and that a dedicated transport system was in place to ensure that older people returned home at an appropriate time.

An assessment period in the 'right' setting

Practitioners recognised that once the older person has moved into a care home, further input from health practitioners may be valuable given that many older people's needs, choices and health status will change significantly following on from the move. Practitioners also noted the importance of step-down facilities – from hospital to transition placement – so that the individual could continue to receive rehabilitation and have additional time to consider the long-term options available to them.

Continued access to day care

Practitioners spoke about the need to change the local rules, which stipulate that once an older person moves into a care home they can no longer attend their day centre. Practitioners noted the huge importance of continuing the connection with the day centre as a way of minimising the impact of the transition.

Creating a supportive community of practice

Participants from both care homes and hospitals acknowledged that they were not always working collectively for the common good and that more attention should be given to setting up locally based meetings between care homes and hospitals and to creating better awareness among professionals of the work that care homes do. They also recognised how the 'blame' culture within the health and social care system reduced their ability to support older people to take informed risks in relation to the choices that they were making. Having a shared vision – being co-operative not competitive – between care homes and the wider system was seen as vital.

The events that were organised were intended to be the start of a process whereby participants identified their own personal actions and met together following on from the event to report on progress. It is unfortunate that, in three areas, our statutory partners have not been able to formally follow up the events to take forward the work or to evaluate what has been achieved. This is perhaps not surprising given the economic downturn, which, along with the ongoing changes taking place currently within the NHS, has reduced their ability to prioritise this work.

Following on from an event in Essex, a smaller subgroup of hospital practitioners and care home managers have been coming together on a regular basis. As a result of the actions of this group, older people are now returning to care homes from hospital no later than 5pm in the afternoon. Hospital staff now recognise the importance of ensuring that a nurse in the ward who is aware of the circumstances of the older person is present when the care home manager comes to do an assessment. Overall, co-ordination of care across hospital practitioners and care home staff has improved.

Better partnership between care homes and other statutory agencies

Within three areas, work was undertaken to explore better partnership-working between care homes and the teams responsible for contracts and commissioning, quality monitoring and assessment so that the partnership could be improved to support quality improvements. Particular emphasis was placed on describing how the behaviours, practices and attitudes of individuals within these agencies can sometimes result in high levels of stress and anxiety for care home managers.

During the period of the study, Essex County Council was transforming its Adult Social Care strategy to enable a more flexible approach to quality improvements. This has resulted in the Quality Monitoring Team being restructured and redesigned. Essex recognised that 'monitoring' in itself does not necessarily improve quality and took on board the messages from the work of *MHL* that 'checking up' on care homes may simply create anxiety and stress for care home managers and reduce their ability to develop relationship-centred care.

The Quality Monitoring Team was renamed the 'Quality Improvement Team' and, while it works with all providers of care services, the *MHL* philosophy and movement feature strongly in the way in which it engages with care home providers.

The new Quality Improvement Team (QI) described its role in a letter sent out to all care homes:

The Quality Improvement Team is keen to work in partnership with you in a proactive and positive way, helping you to deliver the best possible quality of life for your service users.

– letter from Essex County Council, 28 Jan 2011

A number of managers known to the *MHL* team through the Leadership Support Programme have, unprompted, spoken positively about the new relationship that has developed with Essex County Council through QI. One manager talked about how she had always been very nervous and stressed when she was expecting a visit from the Monitoring Team, which automatically created an atmosphere of stress and anxiety within the home. She spoke powerfully about how the relationship was now more trusting, describing how QI was helpful and supportive, which meant that the manager felt more relaxed.

QI has also noticed how care home staff appear to be more relaxed in their presence. One officer remarked upon how they are getting a truer picture of the home because the manager and staff don't feel they have to 'put on a show'.

There remains significant challenges in balancing QI's supportive approach with its other roles in relation to safeguarding and contract compliance. However, the direction of improvement remains positive.

Improving partnership-working with local communities

In Essex, as part of the *MHL* Community Development work, Essex County Council has developed an Inclusion and Outreach project aimed at supporting better community engagement in care homes through the use of an independent co-ordinator brokering relationships across care homes and the wider community. Examples include:

- pilot project for joint work between schools, care homes and a local radio station where students talk to older people in care homes and play music of the older person's choice

Essex recognised that 'monitoring' in itself does not necessarily improve quality.

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- schools organising music and art workshops, bringing children and local choirs into care homes
 - plans in place for sixth-formers and university students to work with older people on specific projects: photography, for example
 - awards being presented to individual members of the community who have undertaken significant work in supporting older people in care homes. These awards are available to anyone, young or old, who contributes significantly to the promotion of the *MHL* themes and values. This includes the older people as well as staff and students, etc. The staff awards come with a transcript that relates their contribution to NVQs.

In addition, a new initiative is being piloted called 'Essex Community Visitors'. This initiative aims to train and support volunteers to act as an informal advocate on behalf of older people, relatives and staff. The initiative is modelling itself upon the long-term ombudsman programme as referred to earlier. The pilot will be evaluated over the next two years. More information on the *My Home Life Essex* programme can be found at www.myhomelifeessex.org.uk.

National development work

MHL has also aimed to support better partnership-working between care homes and the wider health and social care system at a national level. In Spring 2011, 40 care home managers shared their experiences of trying to deliver culture change to 30 stakeholders representing relevant national organisation and government agencies.

More recently, the House of Commons and Welsh Assembly launches of the Big Care Home Conversation enabled a small number of care home managers to communicate their views on quality with national stakeholders including the Minister for Care Services and the Deputy Minister for Social Services for Wales.

MHL has also engaged in ongoing discussions with the Department of Health, as part of its reference group for the White Paper, and other national agencies, to communicate the opportunities and barriers facing care homes in delivering quality and to encourage those bodies wishing to deliver resources to the sector to do so in real collaboration with the care home sector to ensure that what is produced is helpful and does not duplicate other activities.

In addition, *MHL* has been supporting research activities that are relevant to care homes with the development of the British Geriatrics Society report, *Quest for Quality* (2011), the report of the Dignity Commission and the development of an Excellence Framework for care that was developed by SCIE. Internationally, the programme was also engaged within the Progress Report, a European Union study exploring indicators for quality (European Centre for Social Welfare Policy and Research (Co-ordinator, 2010)).

Finally, and just as importantly, *MHL* has presented the evidence for leadership and 'voice, choice and control' at over 30 care home conferences to an estimated 2,000 care home practitioners across the UK. In addition, *MHL* has presented at conferences for geriatricians, commissioners and academic researchers nationally and internationally.

Summary

Findings from the Leadership Support work have demonstrated the value of ongoing regular monthly independent support to managers in helping them create a positive culture where the voices of older people are better heard.

MHL has also strived to foster better partnership-working across care homes and the community and statutory services with varying degrees of success. Without carrying out a systematic evaluation, it is possible to claim some emergent outcomes, in particular, the substantial ongoing work in Essex both in relation to better partnership-working between care homes and the wider health and social care system, and also between care homes and the local community.

MHL has also been working at a national level with government and key agencies responsible for quality to communicate how they can better support care homes to deliver quality.

6 CONCLUSION

This report presents findings from a three-year research and development project aimed at supporting leadership in the care home sector and enabling improved ‘voice, choice and control’ for those living in, dying in, working in and visiting care homes.

Overview

My Home Life has worked intensively at a national and local authority level with care homes, statutory bodies and community organisations to identify ‘what works well’ in relation to leadership and supporting ‘voice, choice and control’, as well as examining the opportunities for, and barriers to, improvement. *MHL* has taken opportunities to work across communities of practice to broker better partnership-working between care homes, the community and statutory services, to share challenges and explore new ways of working that could promote leadership and ‘voice, choice and control’.

The main message is that the good practice in supporting ‘voice, choice and control’ for older people in care homes recognises the vital importance of ‘transformational’ leadership of care home managers as a key vehicle to making it happen. Without ongoing professional development for managers and broader support to the care home from the owner/provider, the wider community and the health and social care system, it is very difficult to improve the ‘voice, choice and control’ experienced by older people.

Key points

Good practice in supporting older people’s ‘voice, choice and control’

‘Voice, choice and control’ means different things to different people. The research team proposes that the principles of ‘voice, choice and control’ align well with the three *MHL* Personalisation themes, namely: ‘Maintaining Identity – *See who I am!*’, ‘Sharing Decision-Making – *Involve me!*’ and ‘Creating Community – *Connect with me!*’.

Achieving 'voice, choice and control' is more complex in a setting of collective living, such as a care home, where the needs and aspirations of an individual may need to be negotiated in the context of the needs and aspirations of the wider community within the care home. With greater levels of staffing and investment in care homes, care homes will be better placed to work with older people to understand their wishes and aspirations and to help them realise them.

Maintaining Identity – See who I am!

The examples gathered through the study illustrate how care homes are uniquely placed to help older people to maintain their personal identity, because staff have the opportunity for regular interaction and engagement with the older people they are supporting. It is suggested that collective living therefore creates the potential for staff to really get to know these older people; to look beyond the dementia, beneath the frailty, to identifying who they are as human beings, what is important to them and what the care home can do to respond to this.

Sharing Decision-Making – Involve me!

The study has identified some of the different approaches that care homes can have in supporting older people to make decisions and have choice and control over their own care and greater control over the running of the care home. Informal approaches to eliciting views and engaging in dialogue with older people would appear to have particular value.

While there is a need to recognise the importance of shifting real power and governance to older people, their families and front-line staff, it is also important to remember how, for some older people, it is the small things that are most important.

Exercising choice and control typically involves older people considering the inherent risks involved in any activity that they may wish to do. Where older people are unable to make an informed judgement, staff are expected to consider how to help older people gain insight into the risks that they are carrying out and ultimately work in the best interests of the individual in assessing the balance of self-determination against the potential impact of the risks involved.

Creating Community – Connect with me!

There are plenty of examples of care homes that both support older people to get out and engage in external community activities, and invite others to come into the care homes to engage in meaningful activities.

The team carried out a small number of telephone interviews with community advocacy projects to identify good practice in supporting 'voice, choice and control' for older people living in care homes. The work identified the importance of advocacy projects being enabled to develop longer-term relationships with older people, the staff and family in order to foster trust, and work with care homes on identifying solutions to issues.

Volunteering in care homes is in many ways a 'forgotten' area. Care home managers have also described their lack of time to recruit and support volunteers, pointing out the need for easier and speedier Criminal Records Bureau checking and the potential value of an external co-ordinator to help with this.

Other examples of good practice

The examples gathered also highlight the good practice within care homes in supporting older people's move to a care home, in advocating for older

people when negotiating with health professionals about how and where care will be delivered, and in opening up conversations with older people and their families about the end of life.

Relationship-centred care

There is recognition that a strong sense of relational connection between the staff, the older people and relatives enables staff to listen to the older person, to gain insight into their individual needs, aspirations and wishes, and to help them have more choice and control over their lives.

In short, it is positive relationships that are the underpinning vehicle for enabling older people's voices to be heard and in enabling them to have choice and control. This finding is not new. It reflects the strong body of knowledge surrounding relationship-centred care.

The value of leadership support and improved partnership-working

The emphasis for leadership in care homes within the literature is on developing relationships across the home, valuing different perspectives and fostering creativity, learning and innovation. It is argued that, in order to enhance 'voice, choice and control' within the care home community, leadership that supports, nourishes and enables staff, older people and their relatives to engage with each other and the wider community is essential. A transformational leadership model, which embraces the notion of 'Dispersed Leadership' and 'Servant Leadership', fits well with this goal.

MHL has demonstrated the value of providing monthly independently facilitated support to managers to help them build resilience, confidence, gain insight into their home, their management style and equip them with the skills to lead their teams effectively. For many managers, the support can make a significant difference in helping them cope with the personal impact of the work and in creating a more relational and calmer atmosphere in the home where staff have greater capacity to connect with older people and support them to have choice and control.

The report also identifies how real culture change in care homes is a long-term pursuit, requiring ongoing support to help managers, owners and provider organisations more generally take forward transformation.

The study has identified the importance of better partnership-working between care homes, the wider health and social care system and the local community in order to reduce the isolation and anxiety experienced by care homes and to help achieve quality and 'voice, choice and control' for older people. The impact of our work has no doubt been affected by the lack of commitment that statutory agencies have been able to afford the work, given the more immediate and significant priorities that they are facing and the widespread changes currently taking place within health and social care. That said, we have highlighted a number of ways in which the wider health and social care system could improve the transitions from hospital to care home for older people. Through our substantial ongoing work in Essex, we continue to examine how services can support care homes rather than add to the pressures placed upon them.

Good practice from other sectors

This study aimed to explore examples of good practice in leadership and 'voice, choice and control' found within services and settings. Limited attention has been afforded to this area given our need to prioritise work on other key research questions.

Our initial exploration with organisations within the field of intellectual disabilities would suggest that good practice in this area has emerged out

of the long history of people with intellectual disabilities fighting for their rights, which has resulted in 'voice, choice and control' becoming engrained in policy and the broader culture of services. It is argued that the structural ageism that exists in society may need to be tackled in order to fully realise real choice and control for older people in care homes.

Reflections

Care homes are viewed as 'the last resort' but can be a positive option for older people

The findings of this study indicate that care homes are often viewed with suspicion and mistrust from the public and from external agencies. They are often viewed as 'the last resort'; yet we know, when they work well, they can be a positive option for many older people and can support 'voice, choice and control'.

There is no doubt that the portrayal of care homes within research, practice reviews and in the press exacerbates the negativity surrounding care homes. *MHL* has witnessed how in the weeks after a care home scandal is broadcast on the television, there is a heightening of anxiety and mistrust from both family members and professionals alike. Some managers describe an escalation in the number of referrals to safeguarding teams (mostly inappropriate) and how it affects the atmosphere and creates a less 'relational' culture of practice.

Poor public attitudes towards care homes may have an impact upon the care home's ability to recruit leaders and high quality staff. Certainly, anecdotally, we have heard of staff feeling embarrassed about telling their friends that they work in an 'old people's home' in contrast to others who speak with pride about working in a hospice or as a veterinary assistant.

It may be worth exploring how the negativity surrounding care homes might also impact upon an older person's choice about their care options. Might it be that many older people are too afraid of care homes to consider them an option? Perhaps most concerning is how older people in care homes may themselves feel undervalued by the stigma attached to the places that they are living in.

Care homes don't want to be seen as 'islands of the old' – they welcome their local communities in becoming more actively involved

To an extent, the potential for older people to feel that their voices are heard and that they are offered choice and control relies upon their ability to interact with others outside of the care home. Their needs, aspirations and quality of life should be the responsibility of the wider community, not just of the staff working in the home. While there is evidence of many care homes working to forge positive partnership with their local communities, there remains a sense that many care homes feel like 'islands of the old', isolated from families and the community at large. This appears to be in direct contrast to hospices, which are providing a very similar role but benefiting from real support from their communities.

It is interesting to reflect upon why there is such a dislocation between care homes and the community. Perhaps care homes conjure up a range of difficult emotions that reduce our desire to engage with them? Perhaps care homes represent to us some level of failure or even guilt that we are not looking after our own? Perhaps the disconnection simply reflects the lack of value ascribed to older people in this society? What is clear is, in these times of tight resources, there is even greater need for the community to actively

What is clear is, in these times of tight resources, there is even greater need for the community to actively support and supplement the work of staff in delivering a quality service.

support and supplement the work of staff in delivering a quality service. We know that when care homes feel part of a thriving community, where they are valued and supported by the local community, this can transform the culture of practice, the confidence of staff, the older people and relatives, and enable quality of life to be realised.

Care homes are looking after some of our frailest citizens – they need support, trust and respect, as well as realistic funding in order to do it well

The population of older people living in care homes has changed significantly over the last few decades. As government policy continues to focus on supporting individuals to remain at home in the community (even when, for some, this may not be the best option), older people are typically moving into care homes at a very late stage in life, with high levels of physical, mental or psychological frailty. This creates a real challenge for care homes both in responding effectively to their health and social care needs but also in trying to nurture positive relationships with these individuals in order to promote their sense of ‘voice, choice and control’.

We would argue that care homes themselves and those who live, work and visit them need to act as the catalysts for change in opening up an honest dialogue about what they are striving to achieve and the support they need to make it happen. Overall, greater transparency and openness across the care home sector should help engage the trust and partnership of professionals, community groups and the public at large.

A shared vision for care homes will help ensure that the public and the wider health and social care system have a better understanding of what they can realistically expect and what role they might play in helping to achieve this. *MHL* has developed an evidence-based, relationship-centred vision for the care home sector which is a useful starting point for such dialogue. The vision also recognises the crucial importance of greater integration of health and social care within care homes in order to properly support older people with high support needs.

However, it is recognised that such engagement may not feel easy for care homes given that they may feel a stronger desire to defend against some of the mistrust and negativity that plays out in the press and in wider public attitudes. To shift this dynamic requires real investment in the sector in order to help it develop the confidence to embed evidence-based practice and relationship-centred care within its culture. Care home managers clearly play a pivotal role in helping us move forward. Through ongoing investment in their professional role and status, managers will be better equipped to influence front-line practice and take forward the Transformation and Personalisation agenda so that care homes can take a leading role in delivering ‘voice, choice and control’ to our frailest citizens. With support and nurturing, care homes may also feel better placed to offer a range of new and flexible services to our increasing population of older people living in the community. In doing so, they may potentially play an even greater role in helping to reduce the pressures on the NHS.

Recommendations from the research

Our main recommendations fall into four categories:

- 1 Supporting positive relationships and transformational leadership.
- 2 Supporting ‘voice, choice and control’.

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- 3 Strengthening partnership-working.
 - 4 Challenging the negative stereotypes of care homes.

1 Supporting positive relationships and transformational leadership

- **Care home owners, providers and managers** should:
 - recognise that positive relationships between older people, staff and relatives are at the heart of good practice in delivering quality and promoting ‘voice, choice and control’ and take steps to help its realisation
 - recognise the importance of creating positive transformational leadership which starts from those at the top of the organisation
 - actively role model the types of behaviour that they expect from their teams
 - review how their organisational culture may be inhibiting the realisation of effective leadership across their workforce
 - enable staff to have ‘protected time’ to foster positive relationships with, and greater knowledge about, the older people and family members
 - share (and learn from others about) best practice on transformational leadership.
- **Care home owners and providers** should:
 - enable managers to have regular opportunities to support their practice
 - reflect on how their actions, policies and behaviours can impact on the manager’s well-being and ability to deliver improvements within the home
 - plan changes in the organisational culture to enable relationship-centred care to flourish
 - invest in (and allocate specific budgets for) leadership training/mentoring/practice development for all managers.
- **Care home managers** should:
 - take responsibility for their own ongoing practice support and professional development, recognising the value of regular facilitated action learning in supporting them to cope and take forward improvements.
- **Regulators and commissioners of care home services** should:
 - consider introducing mechanisms (e.g. Quality Assurance Frameworks currently being developed by many local authorities) to encourage or require providers to demonstrate that managers are having regular access to external sources of support and practice development
 - consider the value of partnership programmes such as *My Home Life* in offering an affordable approach to reflective learning and professional development for care homes.
- **Professional bodies within health and social care** should:
 - actively promote the value of continuing professional development, highlighting examples of best practice to their members.

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- **Local and national agencies responsible** for commissioning, training and quality improvement should:
 - continue to invest in the *MHL* Leadership Support and Community Development Programme to enable care homes to deliver quality and ‘voice, choice and control’ to older people
 - ensure that all training developed and promoted is affordable to all care homes, big and small.

The need for improved support to care home managers is also reflected within recommendations 3 and 10 of the Commission on Dignity report (2012).

2 Supporting ‘voice, choice and control’

- **The Government** should:
 - invest in helping care homes to develop new approaches so that older people can influence strategic and operational decisions at a level within the care home organisation
 - commission schemes aimed at delivering long-term community or volunteer advocacy for older people in care homes so that they can feel more confident in sharing their views and concerns without fear of reprisal (in line with recommendation 21 of the Dignity in Care report, 2012).
- **Statutory agencies** should:
 - work in partnership with care homes to develop a shared understanding of what is and isn’t acceptable practice in relation to supporting positive risk-taking for older people. This will help care homes feel more confident in supporting older people to take positive informed risks without fear of repercussions
 - support care homes to develop stronger links with the community by brokering CRB clearance and providing advice on supporting the volunteer.
- **Care homes** should:
 - consider what measures may be necessary to afford real power and control of decision-making, including in the running of the home, to older people, their families and those who work closest to them
 - pilot more creative approaches to engaging the views of older people, including providing informal opportunities for older people to engage in dialogue with staff
 - draw on the many examples of positive practice in this report and in the broader range of *MHL* resources.
- **Local commissioning teams** should:
 - recognise the importance of providing more individual tailored support to older people and their families to cope with the practical and emotional upheaval of moving into a care home
 - consider developing a specific post to help older people within hospital and community settings make decisions about their futures.

3 Strengthening partnership-working

- **Statutory agencies** (including health and well-being boards) should:
 - reflect on their working relationships with care homes and agree a statement which communicates the importance of positive partnership-working with care homes and offers some steps to making this happen
 - seek to work in partnership with care homes from an early stage to agree on a shared evidence-based, relationship-centred vision for quality in care homes and use this to identify collaborative ways of working which will help to deliver quality
 - create regular practice forums to enable communities of practice across health and social care to develop partnerships based upon mutual trust and collaboration
 - actively encourage and support care home managers and operators to participate in any other local structures and processes for dialogue both between themselves and across health and social care professionals (or if these do not exist, set them up)
 - oversee commissioning arrangements to ensure that care homes are actively engaged as equal partners in exploring ways to meet the needs in the community.
- **Agencies responsible for local safeguarding** should:
 - review their processes and practices to minimise the anxieties and stresses experienced by the community of the care home, and improve their capacity for relationship-centred care
 - agree safeguarding processes which are proportionate to the issue being raised, within a no-blame culture
 - make decisions as quickly as possible
 - value care home managers as colleagues who are making complex professional judgements that need support rather than investigation.
- **The Government** should:
 - consider the costs and benefits of reducing the duplication of paper-driven systems from the variety of agencies that work with care homes
 - review how greater pooling of shared information across these agencies could release resources back into the services and reduce the time that care home managers spend on paperwork, thus enabling them to focus on their primary aim of delivering a quality service.
- **Representative bodies for care homes** should:
 - consider the value of working together to identify the types of data that may be helpful for care home managers to systematically collect to support their own quality assurance processes and meet the demands of external bodies.
- **Commissioners and regulators** should:
 - assess the resource implications for care homes of introducing any new requirements in terms of additional paperwork or changes in the service specification that are being required of them.
- **Care home owners and providers** should:
 - review their own systems to ensure that internal paperwork is proportionate, relevant, streamlined, user-friendly and non-intrusive.

4 Challenging the negative stereotypes of care homes

- **The partner organisations of *My Home Life*** should promote care homes as a positive option by:
 - supporting the ongoing work of the programme to identify and share good practice, through the production of bulletins, videos, website and other communication vehicles to counterbalance some of the negative stories within the press which reduce the value, status and, ultimately the capacity, of care homes to deliver ‘voice, choice and control’
 - developing a strategy for encouraging press organisations to report care homes in a more fair and balanced way.

Broader recommendations

Although the following additional recommendations do not directly relate to the evidence on the Joseph Rowntree Foundation-funded programme of work, they have been identified and developed through the broader work of *My Home Life* with the care home sector, and in discussion with the advisory group:

- **Engaging with families:** Greater exploration is needed into how family members can be better supported to continue to play a role in supporting a loved one in the care home and to cope with the emotional stresses involved in the move to a care home. Care homes should review how they engage with family members and who, within and outside of the care home community, may be able to help in delivering such support.
- **Investing in care homes:** Government and local strategic commissioning boards should:
 - invest both support and financial resources in the sector to help it respond to the needs, wishes and aspirations of older people with increasing levels of frailty
 - recognise the business case for providing real investment into the care home sector to enable it to develop services which will reduce the need for acute services within the NHS (e.g step-up and step-down services)
 - help the sector, through its national and local representative bodies, to work strategically and collectively to open up an honest dialogue with the community in order to create a shared vision of what we want from care homes and how collectively we can achieve it. Using an appreciative approach to such dialogue in examining ‘What works well?’ and ‘What will success look like?’ at all levels of engagement may be helpful.
- **Better access to health services:**

In line with Recommendation 17 of the Dignity report (Commission on Dignity in Care, 2012) and the British Geriatric Society report (2011):

 - the UK governments should examine the role of health departments in supporting older people with high support needs in care homes. Given the multiple co-existing conditions that older people in care homes experience, they should be seen as a priority group and given at least the same range of access to health and support services as those available to younger people living in the community
 - all older people living in care homes should have access to rehabilitation services, whether or not they are likely to be able to return home.

A final note

As this report goes to print, the Government has just published its long-awaited Social Care White Paper *Caring for our Future: Reforming Care and Support* (July 2012). We are delighted to see that it reflects many of the values of and recommendations from the *My Home Life* Programme.

Communities

The document recognises that:

Residential care providers have a role to play as neighbours and partners in local communities. Successful care homes will be an integral part of the community, bringing community groups and activities into their spaces in order to connect older people in care homes with their local community networks.

It makes a specific commitment to: 'support the work being led by *My Home Life* and national care provider organisations to work with their members to connect care homes to their local community'.

Quality of care

The document also states that every registered residential provider will have a provider quality profile on the NHS and social care information website at www.nhs.uk, and that this will state whether the care provider meets '... recognised quality charter marks, such as *My Home Life* ...'.

Volunteers

New local Healthwatch organisations will champion the views of people using health and care services and 'help to connect older people in care homes to their communities, by talking with them about their experiences and scrutinising how care homes are working'.

Access to health services

The Government will also 'improve the access that people living in care homes have to a full range of primary and community health services'.

End-of-life care in care homes:

... we will look at how the guidance for local authorities and the NHS on intermediate care can be updated to encourage better transitions out of hospital at the end of life, and to help more people to die at home, or in a care home, should they wish to do so.

My Home Life looks forward to working with the Government, the care home sector, older people and their families over the coming months and years.

NOTES

- 1 National Care Forum, English Community Care Association, Registered Nursing Home Association, National Care Association, Care Forum Wales, Scottish Care, Independent Health and Care Providers in Northern Ireland.
- 2 The data does not make clear whether this person was a regulatory inspector or an official with an 'inspection role' from the local authority or primary care trust.

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APPENDIX: SUMMARY AND ACHIEVEMENTS OF THE *MY HOME LIFE* PROGRAMME

Background to the *My Home Life* Programme

Retrospectively, *MHL* can be described as having had three distinct phases. The first phase (2005–7) was initiated by Help the Aged (now merged with Age Concern to form Age UK) together with the National Care Forum and set out the evidence-based and relationship-centred vision for best practice in care homes for older people (NCFR&D, 2007). The second phase (2007–9) was funded by BUPA Giving to disseminate this vision to 18,000-plus care homes across the UK, through a variety of different resources (research reports and briefing papers, bulletins, posters and DVDs). The work described in this report falls into the third phase (2009 to date), which focuses on supporting the need of care homes to implement the *MHL* vision in everyday practice. To do this work, *MHL* engages in relation to six key areas of activity:

- **Synthesising the evidence:** Supported by the National Care Homes Research and Development Forum, *MHL* provides the evidence base for best practice in care homes.
- **Empowering leadership:** *MHL* works with the care home sector, empowering leaders to take forward quality improvement across the whole system.
- **Creating resources:** *MHL* is working with care homes to create and distribute resources, in line with the evidence base, to stimulate positive practice.
- **Developing networks:** As a social care movement, *MHL* is organically developing networks across the UK to support improvements.
- **Supporting change:** *MHL* is creating opportunities to influence the care home sector, as well as broader statutory and community organisations.
- **Maintaining momentum:** *MHL* gathers data, presents papers and publishing articles to share the vision and learning with other practitioners and academics and, where possible, with the general public through events and press coverage.

My Home Life is driven by a number of core principles, which dictate how we undertake our work:

- *MHL* promotes quality of life for older people in care homes through evidence-based and relationship-centred care (Nolan, *et al.*, 2006; NCHR&D Forum, 2007). This requires consideration not only of the needs of the older people, but also of the needs of relatives and staff.
- *MHL* celebrates and builds upon the good practice that already exists in care homes, focusing on ‘what the older people, relatives and staff want’ and ‘what works well’.
- *MHL* takes a whole systems approach to its work, acknowledging that quality of life in care homes relies on a shared vision and partnership-working between care homes, the community and the wider health and social care system.
- *MHL* is committed to working in true partnership with the care home sector to realise a shared vision for quality of life in care homes.
- *MHL* acts as a ‘broker’, listening to the ‘voices’ of all those in the system and striving to improve practice through dialogue.
- *MHL* reflects on the lessons learnt from attempts to improve practice (social change) and shares its learning with others in the wider context of the body of knowledge (social science).

The overall success of *MHL* can be demonstrated by the way it has crossed national borders. In Wales, the Welsh Assembly Government has funded a five-year roll-out programme of *MHL* (www.ageuk.org.uk/cymru/home-and-care/my-home-life-cymru-home); in Northern Ireland, colleagues have part-raised funds to do the same there; and there are ongoing discussions about the way forward in Scotland, with Scottish Care. In England, *MHL* is working with 19 local authorities to deliver a leadership support and community development programme to help care home managers take forward quality improvement in practice and to enhance the partnership-working between care homes and the wider health and social care system.

Achievements

Impact – synthesising the evidence

- BGS (2011) *Quest for Quality: British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes*
- European Centre for Social Welfare Policy and Research (Coordinator) (2010) *Measuring Progress: Indicators for Care Homes*
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Impact – empowering leaders

- sharing and cross-fertilising ideas across national borders
- working with 250 care home managers in 19 local authorities in England and 38 care homes in Wales.

Impact – developing resources

- informing 18,000 care homes through delivery of research messages/ top tips to every care home across the country (15 bulletins, two DVDs, hundreds of events and website)

Impact – creating networks

- through our Leadership Support and Community Development programme for care home managers, we are improving quality of life for around 6,000–10,000 older people living in care homes in England
- creating additional networks in Wales, Northern Ireland and Scotland.

Impact – sustaining change (local)

Through our local development work in local authorities, we are:

- easing the transition for older people from hospital to care homes
- creating better community connections with older people in care homes
- improving partnership-working to support care staff to deliver quality
- helping staff cope with the trauma of care home closure.

Impact – supporting change (UK)

- shaping new indicators for quality
- written and oral evidence to Welsh Assembly Inquiry into residential care
- influencing White Paper (Quality and Workforce) and Dignity Commission (oral evidence)
- promoting ‘voice, choice and control’ in care homes (sharing inspiring stories)
- highlighting the need for better healthcare support for older people in care homes
- working with End of Life and Dementia Strategies
- ongoing national discussions about formal structures of support to care home managers
- presentations on the evidence for leadership and ‘voice, choice and control’ at over 30 care home conferences to an estimated 2,000 care home practitioners. *MHL* has also presented at conferences for geriatricians, commissioners and academic researchers nationally and internationally.

Impact – maintaining the momentum

- beginning a dialogue with public to better understand what care homes can potentially deliver
- enabling better ‘voice, choice and control’ for older people, relatives and staff
- increasing the direct support to managers to deliver quality
- further strategic work to create a sector better able to respond to the changing needs of older people.

Impact – *MHL* Wales

Supporting 38 care home managers in changing their practice, resources/ events include:

- a quarterly newsletter which is sent to all care homes for older people in Wales
- hosting of national and regional networking events;
- publication of printed resources:
 - eight *Good Practice Guides* (each Guide focuses on a *MHL* theme)

-
- *Getting to Know You*: a guide to reminiscence and life-story work in care homes
 - *Open your heart to see me*: a guide to working with people who have dementia in care homes
 - *My Home Life Cymru*: introductory booklet promoting quality of life in care homes for older people
 - regular training events for home staff (training needs are identified in partnership with care homes).

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