

COMMISSIONING RELATIONSHIP-CENTRED CARE IN ESSEX: AN EVALUATION

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How can local authority commissioners work with the care home sector to ensure older people consistently receive high-quality, relationship-centred care?

The evaluation described in this report reviewed the improvements Essex County Council made to the commissioning of its care home services for older people in the county. In particular, the evaluation considered the implementation and outcomes of the My Home Life Essex programme, a framework that was introduced to improve the relationship between commissioners and care home providers, and to enable care home managers to focus on providing relationship-centred care in the face of increasing financial pressure and changing demands.

The study found that:

- the support networks put in place for care home managers through My Home Life Essex resulted in better quality commissioning and an increase in managers' ability to motivate staff to provide relationship-centred care to residents;
- positive changes in the relationship between Essex County Council and the county's care home sector were driven by the council's corporate ownership of the new approach, investment in the care sector, a focus on quality improvement rather than monitoring compliance, effective leadership and a support network for managers.

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1 INTRODUCTION

The [care home] sector is at a crossroads, when it can no longer continue with business as usual.

Demos Commission on Residential Care (2014)

Care homes are under scrutiny as never before. A series of shocking failures such as the revelations of abuse at Winterbourne View, near Bristol, Orchid View, in West Sussex have tarnished the reputation of the sector as a whole. The financial pressures affecting local authorities are also having an impact on the process of commissioning care services, as well as on relationships between commissioners and providers. The delivery of consistently high-quality and personalised care is becoming increasingly difficult with the resources available, suggesting that these resources will need to be used in a different way to achieve the desired outcomes.

There is a growing consensus that the existing provision of care services and menu of support options cannot continue. A number of high-level reviews are underway to explore how care and support services need to change in order to meet future demand and aspirations (Demos, 2014).

At the same time, national policy in each of the UK nations continues to emphasise the importance of personalised services, choice and control. However, such developments have as yet made a limited difference to individuals' lives and this is particularly true of older people. Studies have shown that following a move into care, older people encounter a power imbalance that results in them having less control over decisions about their lives including support, personal affairs and finances. Older people who need support, especially those living in residential care, are often unwilling to speak out or 'make a fuss' about issues that concern them (Bowers *et al.*, 2009).

In spite of the difficulties of the current environment, there are some positive signs of change.

Essex County Council (referred to in this report as 'Essex') is working to radically improve its services for older people, for example by changing its relationships with care providers in the county. It is focusing on the way it interacts with the care sector and has invested in the development of care staff. It has created a two-way relationship between the council and care homes, which has led to signs of improved quality and benefits for older residents, families, staff and managers. There are also indications that these changes can inform the development of new models of care for older people in the future.

This report sets out the findings of a research project carried out by the National Development Team for Inclusion (NDTi), funded by the

Joseph Rowntree Foundation (JRF). The project forms part of a wider JRF programme of work on risk and relationships in the care sector (Joseph Rowntree Foundation, 2014). The project's research aims and evaluation questions are included in Appendix 1.

This report addresses the following questions:

- Why was change needed?
- What did Essex do?
- How did we carry out the evaluation?
- What has changed in Essex?
- What factors allowed change to happen?
- What barriers were there?
- What is the wider learning that can be taken from the experience in Essex?
- What are the policy and practice recommendations?

This report has been written for people working in care homes in a variety of roles and at all levels, as well as for commissioners who are interested in developing services and relationships with care providers. It will also be of interest to others involved in researching and developing diverse care and support services for older people.

2 WHY WAS CHANGE NEEDED?

Who will care for us, the people of Essex, when we need support?
Our population is getting older, larger in number, and an ageing population has greater and more complex care needs.

Market Position Statement, Essex County Council, 2012

In common with most other councils, Essex faces considerable pressure on its services. The council recently supported an independent commission which explored how the people of Essex could care for themselves and their communities in the future. The commission recommended a much greater emphasis on prevention, helping people to take greater responsibility for their own health and well-being and drawing on the community resources that already exist in the county.

The strategic direction in Essex, signalled clearly in the council's 2012 *Market Position Statement*, aims to support greater numbers of older people to live independently (Essex County Council, 2012). Generally speaking, the *Market Position Statement* sets out the council's position for the commissioning of care and support. Helping people to regain their confidence and ability to live independently through reablement services and support is an increasingly important priority for the council, with the aim of retaining and developing meaningful relationships and life experiences that underpin individuals' sense of identity and value. However, between 2010 and 2011 more than half of the council's total spend on care of older people went to residential and nursing care (£92 million). It is estimated that older people and their families who fund their own care paid a further £120 million during this period. The council has not provided any 'in-house' care homes themselves for many years.

So although over time Essex intends to achieve a shift towards more people living independently in their own homes, residential care continues to play an important role in the Essex care landscape and seems set to do so for some considerable time. Essex wants to proactively manage its local care market, in this case by driving up quality in care homes.

This goal is clearly expressed in the *Market Position Statement*. Against the backdrop of concerns about the quality of some residential care highlighted above, the council's goal is:

Reducing the contracted use of residential care for physically frail older people whilst ensuring that good quality registered care is available for those people who need it.

Market Position Statement, Essex County Council, 2012

At the same time, balancing quality and cost is an important goal for the council, as is offering a way of promoting innovation:

As commissioners we need to ensure that we make best use of the public money we have available to us, and we will work hard to achieve an appropriate balance between price and quality in our contractual arrangements with the market. We see this as being central to our vision of having a sustainable competitive social care market that encourages new and innovative ways of delivering support.

Essex

According to the council's lead member on adult social care, a successful future for care services in Essex will depend on the availability of:

- good quality advice and information on the range of options that are open to older people, including independent living and housing-based models;
- a smaller, commercially viable and high-quality care home sector in which 'homes are integrated with communities, and communities are integrated with homes'.

This final point echoes NDTi and JRF's earlier work on older people's aspirations for long-term care, which underlined the importance of older people being able to retain their connections with family members, friends and their community of choice (Bowers *et al.*, 2009). Maintaining and building community connections has become a key theme of the approach adopted in Essex.

Essex's *Market Position Statement* identifies three principles that underpin the development of a thriving, strong and diverse social care market:

- encouraging competition;
- encouraging innovation;
- promoting quality (Essex County Council, 2012).

The vehicle that Essex adopted to help it achieve a high-quality residential care market in line with these principles was My Home Life (MHL), the social movement that aims to improve quality of life in care homes (MHL, 2014).

My Home Life – an overview

Sponsored by Age UK, City University, JRF, participating local authorities and the City Bridge Trust, MHL was established to improve quality of life for everyone connected with care homes for older people. It is seen by many as a voice for the sector, promoting best practice through appreciative support and transformative action.

A core part of the MHL programme is a bespoke Leadership Support and Community Development Programme for care home managers. This is designed to enable local managers to take forward change in their care homes focusing on relationship-centred care among and between older people, staff at all levels and families or relatives.

Typical responses from managers participating in the MHL programme across different authorities include:

- increased resilience, less risk from 'burn-out';
- improved skills and strategies for driving forward transformation;
- a calmer, more relational environment to live and work in;
- reduced staff turnover and sickness;
- opportunities to drive forward quality agendas;
- improved relationships with external agencies.

At a time when important quality improvement discussions were being held in Essex, a senior manager from the council attended a conference that presented evidence from the wider MHL programme (Owen and Meyer, 2012). It was agreed by directors, senior managers and lead members that MHL had the potential to enable Essex to drive up quality proactively in the sector locally and create the market that they wanted to see.

My Home Life Essex focused on the eight central themes from MHL, which are rooted in evidence of best practice in the care home sector. These themes are:

- managing **transitions**: supporting people both to manage the loss and upheaval associated with going into a home and to move forward;
- maintaining **identity**: working creatively with residents to maintain their sense of personal identity and engage in meaningful activity;
- creating **community**: optimising relationships between and across staff, residents, family, friends and the wider community;
- sharing **decision-making**: facilitating informed risk taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life;
- improving **health and healthcare**: ensuring adequate access to healthcare and promoting health;
- supporting a good **end of life**: valuing the 'living' and the 'dying' in care homes;
- keeping a **workforce fit for purpose**: identifying and meeting ever-changing training needs within the care home workforce;
- promoting a **positive culture**: developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option. (Source: Essex County Council, 2014)

In the evaluation, care home managers described how MHL Essex was promoted to local care homes and managers as an opportunity to develop:

Relationship-centred care and collaborative working with local stakeholders including hospitals, commissioners and others.

Care home manager

As outlined above, relationship-centred care lies at the heart of the MHL approach. It differs from person-centred care, which focuses on individual service users, promoting independence and consumer choice. The MHL evidence suggests that in long-term settings positive relationships between older people, relatives and staff are interdependent and create a culture in which staff are able to connect with and engage older people as individuals and understand and respond to their interests, opinions, aspirations and needs (Owen and Meyer, 2012). Evidence on relationship-centred care (Nolan *et al.*, 2006) supports the view that where there is a web of relationships that supports older people, relatives and staff, a greater connection is developed through which choice and control can be realised. Other research (Bowers *et al.*, 2009; NDTi and CPA, 2011) has argued that relationship-centred care on its own is not enough to create major, lasting cultural and structural change and that this is more likely to occur when change programmes focus on person-centred approaches at all levels of the care and support system.

3 THE ESSEX APPROACH – WHAT DID THEY DO?

The My Home Life Essex programme, sponsored and supported by Essex, is designed to help improve the quality of life for older care home residents. The programme provides opportunities for constructive dialogue between providers and commissioners, and sharing of good practice.

Market Position Statement, Essex County Council, 2012

The intention of Essex was to improve quality in the care home sector so that the council could fulfil its commitment to providing good quality care to those who needed it. Following the MHL conference attended by the senior manager from the council, an event was held with care home managers across Essex which brought key partners and stakeholders together to explore the potential for the MHL approach to create the kinds of changes people wanted to see in Essex. These managers expressed support for MHL both because its themes resonated with their own values and beliefs and because of the strong evidence base underpinning the approach. They requested that the council adopt MHL as a way of improving care quality in Essex.

Over time, Essex developed its own distinctive local programme, based on MHL and built on the following factors:

- A unifying principle: Relationship-centred care
- An underpinning philosophy: Appreciative enquiry (Watkins and Mohr, 2011)
- A vision for care homes: Based on the eight MHL themes (described above).

A core feature of MHL Essex was the simultaneous focus on commissioning and provision: the council did not just expect care homes to change and improve, but required sustainable, systemic improvements throughout the health and social care community. As part of this process, Essex examined the way that it related to the care home sector and, as a result, changed its commissioning approach. The steps it took to refocus the relationship towards a more equal and developmental partnership are set out below. These are described in more detail later in the report.

What did Essex do?

It changed the commissioning approach.

- It set up the **Quality Improvement team**, replacing the previous monitoring team, with a strong focus on quality improvement, safeguarding and supporting managers to change.
- It **embedded the MHL themes into contracting and procurement processes**, such that funding and contractual decisions were based on these outcomes (rather than more traditional measures such as number of people/beds).
- It produced a **self-assessment process** for care homes based on MHL themes to promote insight and reflection based around the same outcomes.
- It **incentivised quality improvement** by making all funding to homes available on the basis of achieving improvements against agreed MHL themes.

It supported care home managers to change services.

- It introduced a **leadership development programme** for home managers – this was identified as a priority by managers themselves.
- It set up **facilitated networks** for managers who had attended the programme to provide ongoing mutual support and a safe space for sharing progress, experience and problems.
- It promoted **relationship-centred care** as the key route to improvement and better outcomes at all levels of strategy, planning and service delivery.

Further information about MHL Essex can be found on their dedicated website: <http://myhomelifeessex.org.uk/>.

4 ABOUT THIS EVALUATION – WHAT DID WE DO?

The main purpose of this evaluation was to evaluate the impact of Essex's new approach to commissioning care homes. It became clear from the beginning of this study that it should not focus on evaluating MHL. Essex happened to use MHL as the vehicle to bring about change, but could have chosen other quality frameworks. The aim, therefore, was to examine and explore the journey and outcomes achieved by Essex as it adopted a different approach to commissioning care homes and supported quality improvements in those homes in order to achieve better outcomes for the older people living in them.

The evaluation findings shared in this report therefore focus on the nature of this changed relationship and the progress made in working towards a positive partnership between the council and the care home sector.

While signs of change experienced by and evident for older people are highlighted throughout the report, it does not focus on individuals' experiences or the outcomes achieved so far with and for those living in participating homes. However, it is recommended that this should be the focus of future studies designed to inform the ongoing implementation of MHL Essex.

A 'theory of change' framework (Weiss, 1995) was used as the evaluation design. This is the method of choice for evaluating complex, multi-faceted change programmes. The approach focuses on the outcomes and impacts of interventions and pays particular attention to why changes happen and to whom. It also takes into account the effects of local and national contexts on the changes that happen. Establishing a theory of change for the intervention in question was a crucial first step, involving key stakeholders in exploring the aims, rationale, desired and actual outcomes and importantly how these have taken or are taking place and with whom. In this study this meant that the emphasis was less on the vehicle for change, i.e. not on evaluating the themes or mechanisms of MHL itself, and more on the outcomes achieved and how and why these were achieved in Essex in particular.

The National Social Care Research Ethics Committee granted ethical approval for the evaluation under the Mental Capacity Act (2005). This was to ensure that we assessed people who may have lacked the capacity to consent before including them in the research.

Four main data collection methods were used:

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- 1 Theory of change workshops were held with mixed stakeholders from Essex County Council, in order to establish a theory of change for MHL Essex which was then to be used to organise and deliver subsequent stages of the evaluation.
 - 2 An in-depth case study approach was used in nine care homes. There are 279 care homes for older people across the county. A sampling matrix was developed (Appendix 2) to give us a range of care home settings. Sampling characteristics included location, rural or urban setting, size of care home, number of managers completing the MHL Leadership course, dementia homes and residential and nursing homes. At each care home, two members of the evaluation team spent a day observing activities, interviewing the care home managers and other staff and holding focus groups and interviews with residents, volunteers, family and friends. These included observations with 91 older people, interviews and focus groups with nine care home managers, 38 care home staff, 50 older residents, 18 family members and friends and one volunteer.
 - 3 Thirteen senior stakeholder interviews were carried out with local and national stakeholders, including organisations such as the English Community Care Association (ECCA), Essex County Council Adult Social Care, Clinical Commissioning Group Essex, the Care Quality Commission (CQC), Age UK Essex, My Home Life National and MHLE Community Association.
 - 4 Two focus groups were held: one with six members of the council's Quality Improvement team and the other at a MHL Leadership Development network meeting with ten care home managers.

Anonymised quotes from interviews and focus groups are used to illustrate key points throughout the rest of this report.

We carried out analyses of findings using each of the above methods. Emerging, cross-cutting themes were identified. The draft findings were shared with Essex senior commissioning and commercial managers to clarify and refine the emerging themes. The draft findings were also shared with the JRF Project Advisory Group for further clarification of the key messages and recommendations for policy and practice.

5 WHAT HAS CHANGED AS A RESULT? SIX OUTCOME THEMES

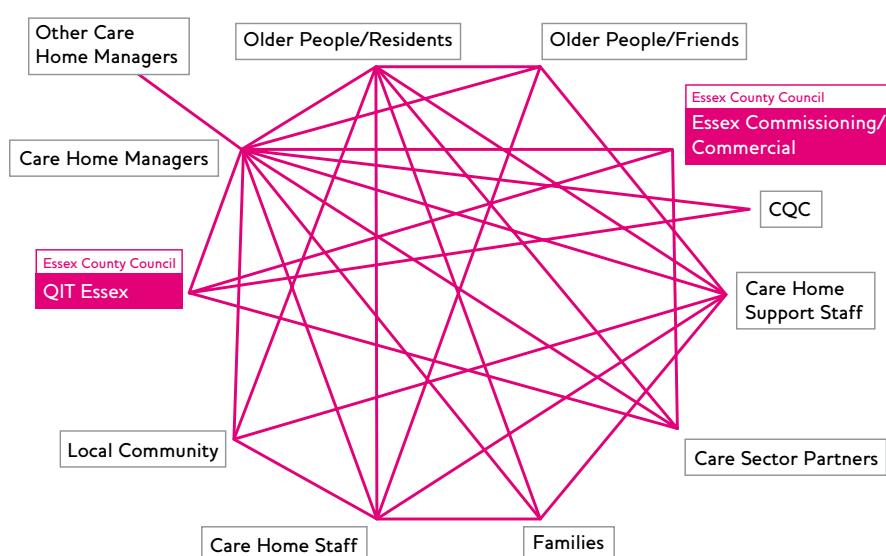
There were clear signs in the evaluation that Essex has embarked on a journey of quality improvement in the care home sector and that this has begun to create positive change throughout the system. The council has shifted its approach from a top-down monitoring, inspection and regulation model to one that focuses on building relationships, offering support and investing in the development of care home staff.

Evidence from the wider MHL programme (Owen and Meyer, 2012) suggests that three of the MHL themes in particular (maintaining identity, sharing decision-making and creating community) can enable older people in care homes to have greater voice and control over their lives through the development of a relationship-centred approach. In this evaluation we found some evidence that these themes were being put into practice in Essex. The impacts of these developments were clearer for staff and managers than they were for older residents at the time of the evaluation. The evidence below highlights where the implementation of these themes was already occurring.

The strongest evidence of positive relationships was between the council and care home managers and between the managers of different care homes. We saw examples of themes from MHL being put into practice when promoting end-of-life care, managing transition into the home, improving access to healthcare through positive relationships with the health sector, keeping the workforce fit for purpose through training opportunities and networks and promoting a positive culture in the home by investing in the development of care home managers.

Our work focused particularly on the impacts of the MHL Essex approach on two sets of key relationships: internal relationships within care homes and external relationships with partners, stakeholders and the wider community. Figure 1 summarises these relationships. Although the map is not intended to be comprehensive, it illustrates the complexity of the context, as well as the scope of the project. The map also highlights the pivotal role of the care home manager, who acts as the hub of a web of connections and relationships.

Figure 1: Map of relationships



The analysis of findings identified six outcome themes that were evident as a result of the changed relationship between the council and the care home sector. They are:

- embedding quality in commissioning;
- enabling managers to improve and innovate;
- modelling relationship-centred care;
- making risk more transparent;
- building stronger relationships with partners in other sectors, particularly in health; and
- challenging traditional models of care.

Embedding quality in commissioning

Essex set up a Quality Improvement team (QI team), previously the Quality Monitoring team, in 2011 in response to a drive for new approaches to working with the sector to improve quality. The Quality Monitoring team had been much larger and was reduced in size as a result of council restructuring. The QI team currently sits in the commercial arm of the council responsible for commissioning, procurement and contract management.

Evidence from this evaluation showed the significance of the way in which the QI team interacted with the sector to bring about change. A highly-skilled team has changed the relationship from a 'hands off', punitive approach to monitoring to one that care homes felt worked alongside them to achieve quality outcomes for older residents. Care home managers felt respected for their contribution and strengths and that the council understood the issues and concerns they faced.

We feel very much part of the journey.

Care home manager

Care homes are supported to improve in a positive way through the use of appreciative inquiry (Watkins and Mohr, 2001), which begins with the positives and builds on them to drive improvement.

MHL is a vehicle for change.

Essex

MHL Essex was a council initiative designed to change Essex's relationship with the sector by serving as a mechanism to drive up quality and improve safeguarding through commissioning. A smaller, cohesive team has adopted a coaching and mentoring style to drive improvement, which has led to improved relationships underpinned by shared values and an expectation among the key partners (commissioners and providers) that quality will improve.

It's a new approach to driving up quality – support rather than criticism.

Care home manager

It is about devising and executing the quality component of contracts.

Essex

The evidence showed that this was seen by care homes as a change from previous experiences of the council's monitoring processes.

[The QI team's] whole remit changed from when they went in with a stick to saying 'we're here to support you'.

Care home manager

Providers felt they were being beaten up.

Essex

Care home managers said that relationships with the council had improved significantly over the last two or three years. The impact on the care home managers was that many of them felt better supported in their roles to promote a more positive culture in the home and therefore to improve quality and manage risk. There was evidence of a shared approach to decision-making between staff and the council, which had the potential to improve safety.

[A QI team member] called proactively: 'What do you need? How can I help?' She saved my sanity, really.

Care home manager

We can work with homes in parallel – we are on the same side.

Essex

If we had issues with safeguarding, I'd go to a QI team member.

Care home manager

There was a focus on managing the many different relationships connected to the care homes. For example, there was evidence of the council mediating between care home proprietors and managers when tensions arose and changes were required.

I've had more support from Essex than I have had from my company.

Care home manager

In another example there was conflict concerning who should choose the new decoration and fittings in the home and whether that was the decision of the owner or the residents. The QI team was able to support negotiations.

There was evidence that a relationship-centred approach based on the MHL ethos and working together with homes to improve quality through support was becoming embedded in the council's commissioning and procurement processes. For example, the council has introduced a self-assessment process that measures three stages – personalisation, navigation and transformation – based on the eight MHL themes. This self-assessment focuses on the relational aspects of living in care homes and from the MHL evidence it appears that meeting these aspects is likely to contribute to the overall positive experience of residents. Progress is measured against these aspects and if no progress is made or sustained by the home, there are processes in place to bring in a breach of contract and remedial action for staff.

The commercial strategy considers quality and price in equal parts, but it was the view of one senior manager that to be successful in the future, Essex's focus should be more on quality to drive improvement in the care home market. Linking cost and quality was a key objective of this exercise.

There is a consistent vision around quality that people can work with around MHL that is being built into the contracting process.

Essex

The QI team also works closely with the health and social care regulator the CQC. In particular when a home has had a poor report they develop bespoke objectives for the homes, with a progress report every 6–12 months with evidence of performance. One manager told us how she had valued the supportive style of the QI team and how it had helped her improve.

Enabling managers to improve and innovate

The care home managers in this study spoke of their previous isolation and loneliness and the lack of opportunities they had to share experiences with others.

As a manager you can get really isolated and lose all confidence.

Care home manager

Managers feel very vulnerable.

Care home manager

They praised Essex for giving them so much support for providing the quality of care they wanted for their residents.

It's an exciting time as we can make changes and someone is listening.

Care home manager

I can invest more of me – there's a huge body [Essex] behind me saying this is right.

Care home manager

The MHL Leadership programme and the facilitated network meetings put in place by Essex have given those who attend a forum to meet other care home managers, reduce their isolation and gain support from peers.

The MHL Leadership programme gave me a different perspective, made me realise I'm not a machine. There was support and connections there.

Care home manager

I wanted to be part of a group of people that are positive and wanted to make a difference.

Care home manager

Although there was initial scepticism from some managers about the MHL Leadership programme, they changed their minds as the programme progressed.

I didn't know what to expect, it made me look at my own values ... care had been ruled with a wooden stick and [the course] made me focus on the positive.

Care home manager

The result was an increase in personal self-esteem and confidence among managers, which they felt has improved their management and relationship skills. This helped them implement MHL Essex through promoting a more positive culture in the home using the development of their leadership skills. Managers told us they did not feel penalised for actions, but instead felt supported to try out new ways of delivering care. One manager explained:

It made me feel safe to experiment and stop everything coming from me. Now everything comes from the residents and our role is to implement it.

Care home manager

Recruitment of the right staff is recognised in the MHL research (Owen and Meyer, 2012) as crucial to improving the experience of residents. Some care home managers talked about the impact that a relationship-centred approach had on recruitment of staff. Some changed their recruitment processes to assess whether staff could relate to residents. One manager explained:

In recruitment and supervision [of staff] it's about telling them to go with their instincts and to lead by example.

Care home manager

One manager told us a story about employing new staff. One applicant arrived whom the manager immediately stereotyped as being unsuitable because of the applicant's clothes and appearance, which the manager classed as 'extreme'. The manager went away and left the applicant in the residents lounge. When she returned the applicant was sitting on the floor engaged in lively conversation with a group of residents. The manager decided to recruit the applicant there and then (subject to processes).

There was a view expressed that staff who did not understand the MHL Essex approach or had negative or uncaring attitudes towards residents were likely to leave. The limited extent to which staff members' values and associated personal qualities and commitment can be developed was fundamental.

Some staff are made for the work, with others it is primarily a job. You can tell from the start – some of them do adapt but most won't and don't stay.

Care home manager

Modelling relationship-centred care

MHL research suggests that if care home managers feel safe and supported they are likely to communicate their confidence to staff, who are then more likely to mirror this behaviour with older people living in care homes and their relatives. Other research (Bowers *et al.*, 2009) highlights the power imbalance between care home managers, staff and residents and how this means that older residents have less control of their decisions, personal arrangements and finances. Care home managers are in a pivotal position to shift power dynamics. Through managers modelling relationship-centred care there were signs that empowerment of staff was beginning to occur.

In the evaluation there were examples of how the increased confidence and support to managers from the MHL Leadership Development group and the QI team changed the relationships between staff and managers. In some cases, the ethos of a relationship-centred approach meant that staff could be supported to recognise the good job they were doing. There were examples of staff being praised for the way they worked.

There were two examples of deputy managers who had been so influenced by their manager's commitment to a different approach that they also wanted to go through the MHL Leadership programme. In their roles they worked closely with care staff and hoped to show the ethos and values of relationship-centred care in practice.

We go on the floor and coach. It's about showing them.

Care staff

One manager modelled relationship-centred care by spending a lot of time speaking to relatives and residents alongside care staff. In another home, good practice was spread among staff through discussion:

We talk a lot about what good care looks like with people of all grades across the site.

Care home manager

The QI team conducted research in a home that had a Greek resident who was unable to speak English and could not read. As a consequence the resident was becoming socially isolated. The team was able to provide the home with contact details for a bookshop in London that stocked Greek language audio books, a Greek Orthodox church in Southend, a Greek monastery in Tiptree and an Orthodox priest in Colchester who had some Greek contacts in Essex. The team member spoke with the manager of the home a few weeks after sending him the research and found that he had followed up some of the leads and was confident about getting the resident to a Greek religious service at Southend.

Source: Summarised from Essex's QI Update Report 2012/13, 2013

There was evidence in the care homes visited by the evaluation team of warm and close interactions between staff and residents, both in one-to-

one situations and groups. Some staff we met identified the importance of getting to know people really well in order to identify their personal preferences. This included in particular residents who had dementia or had communication difficulties. We observed staff in some homes who were very aware of the significance of identifying the wishes, needs and concerns of residents through such means as hand pressure or other alternative communication methods.

One resident explained how the shared vision in the home between staff and residents had liberated people to share their life experiences and skills.

Senior management listen to residents. I had a situation where another resident was rude to me ... I talked to the director who sorted it.

Resident

A member of staff also commented:

We don't see them as residents with needs. We try and understand who they are.

Care staff

One manager explained that while care is sometimes still too focused on physical tasks, there is now insight and awareness of this and a concerted effort to move away from this toward positive relationships and individualised experiences and outcomes:

There's still some task-orientated care, but we are trying to move away from that. The [MHL] training has changed this.

Care home manager

A carer told us that her previous job had been very task-based, but in this home it was more about relationships:

Here it's like a family. You just learn.

Care staff

An older woman living in a care home explained to the QI team member that she could not remember anything after she got married, or why she was at the home. The team member discussed this with the manager and asked for her care plan, which included her life story, to be available in her room so that she could read it or ask staff to read it to her. This gave the resident a sense of belonging and reason for being in the home. It also allowed staff to engage and connect with the resident, giving them a better understanding of the care required.

Summarised from Essex's QI Update Report 2012/13, 2013

In one of the homes in particular there was clear evidence of warm friendships between residents, shown by people in close conversation in the lounge and in the way older people spoke about each other. In the same home five residents were going to the wedding of a woman who worked in the day unit. The residents had each been taken shopping by the care staff for new wedding outfits and were clearly looking forward to the event enormously.

Staff and residents shared their experiences of developing and maintaining relationships in a care home environment, both between staff and residents and among residents. Overall we saw more evidence of relationships between staff and residents and little evidence of friendships between residents, although there was a sense in some homes that this was changing. Staff told us how they tried to encourage friendships between residents by introducing people who shared similar interests and backgrounds with each other. One resident shared their frustration about the difficulties in building relationships in a care home:

My memory means that I cannot remember staff names, so it's hard to build relationships.

Resident

In another home, an older woman who lived in retirement flats located on the same site as the care home visited the care home every day. She felt more comfortable visiting the home than being in her own community and had made friends with several of the residents. One woman with dementia living at the care home had also visited her flat, which both had enjoyed.

Another woman spoke in a joking manner about the support she had received from her peers in the home:

I'm doing well now with help and encouragement, not from the carers but from the inmates!

Resident

There were examples of staff other than carers taking an active part in the lives of the residents. An administrator told us he had not previously had a lot of contact with residents, but that this had changed and they would come and find him for a chat.

They (managers) are working with staff in a different way, empowering staff to take responsibility and finding people doing something good.

Care home staff

Another example was a care home chef who always managed to persuade one resident to eat whereas his wife and his carer had not succeeded in doing so. This illustrated the benefit of modelling and building relationships throughout the home.

Staff with specific responsibilities for providing activities for residents showed they were influenced by their manager's approach to relationship-centred care. In one home, the activity co-ordinator, on the suggestion of the manager, had changed the regular pattern of her hours to include weekends and evenings. Staff had recognised that the hours of the traditional working week did not suit many residents because they slept in the afternoon or got up late, meaning evening activities were often popular.

[It is] creating activities to make a more stimulating life for residents because it must be ghastly to live in a home.

Care home staff

Another activity co-ordinator explained that she used periods of time when some residents were still in bed to engage other individuals one to one, which enabled the latter to share more personal feelings or information with her.

Most of the care home managers spoke about the importance of building relationships with families that were founded on trust and transparency. There was evidence of an open-door approach in many of the homes, with relatives and families calling in to see the manager. Some of the managers stressed the importance of building relationships and working in partnership with families:

If you don't work with families, you can't give the best care.

Care home manager

Care only works in a three-way partnership – home, resident and family. If this breaks down you get deterioration in quality.

Care home manager

Making risk more transparent

The drive to improve quality in care homes in Essex was based on trust, honest relationships and dialogue between the council and the sector, as well as between participating homes and families. At a time when increasing pressure on local authorities in delivering their services can lead to risk aversion, the council took a risk by changing the way contracts were monitored, passing safeguarding responsibilities to a small, skilled team of Quality Improvement managers.

The council changed their approach to decision-making in relation to risk, both for or with individual residents and generally within care homes. An increased focus on shared decision-making between the council and care home managers and within care homes meant that a culture of positive and informed risk-taking has been developing, rather than a dominant culture of risk avoidance. This has been helped by the facilitated network meetings where managers can share problems and experiences in a safe and mutually supportive way and where the focus is on finding solutions together.

Openness and honesty are encouraged between staff and between staff and managers.

Care home manager

This new approach relies on a 'no-blame' culture, where managers and staff are encouraged to learn from what does and does not work and to build on the positives, while being clear about what needs to change. Adopting an appreciative inquiry approach has supported staff to build on successes and to see everything as a learning opportunity, rather than dwell on the negatives. The QI team offers support to improve rather than punishment and control:

We're the managers' critical buddy.

Essex

[The] QI team is a working partnership within the home, open-minded, no preconceptions, evidence-based, using everyone's accounts of any problems or incidents.

Care home staff

Safeguarding remains a key priority in the QI team which has adopted a safeguard recovery approach, working with care homes to go back to the basics:

Rather than putting a sticking plaster on it, we look at ways to improve, focusing on the whole service and the staff group.

Essex

The team adopted bespoke solutions to issues, recognising that one size does not fit all. A dialogue tool was developed for use with different providers, which can be tailored to suit the physical and cultural conditions of the care home. QI team members are good communicators with well-developed interpersonal skills who receive training in assertiveness and negotiation.

When areas of improvement and support are identified, the care home manager submits an improvement plan to the QI team. The team then offers support and guidance to implement the changes. If there is no progress after a year, or progress is not sustained, the issues are escalated to a breach of contract.

One care home staff member explained how risk was managed in their home through adopting a 'no-blame' approach and promoting a positive culture:

The culture is not one of blame but focuses on honesty and the ability to put things right – it is being upfront with mistakes and being able to trust staff behind closed doors with vulnerable adults.

Care staff

In one home, relatives too told us that homes were open and communicated quickly if anything had gone wrong. They appreciated this honest attitude to risk.

However, the impact of this changed approach to risk was not always evident in the day-to-day lives of the residents. We found that risks within the home between residents and staff were often interpreted narrowly and focused on the everyday activities of the residents. These included not being allowed to make tea or go out alone or with relatives and limitations on the use of hot water bottles. One resident told us:

They don't like us going out on our own – well, that's only sensible.

Resident

If I go out in the garden without my frame I get told off.

Resident

There was another example of residents no longer having kettles in their rooms because of concerns for residents' safety. Instead these were provided in communal areas. These examples challenge the fundamental principles of choice and control for older people and demonstrate the issues for care homes in trying to adhere to person-centred approaches where the focus is on the person and what's important to them rather than the relationship between staff and residents.

Some care home staff described a more balanced and creative approach to risk as a result of adopting a more relationship-centred approach and shared decision-making with the residents. One example cited arose at a residents meeting, where residents asked that the home should have a dog. The residents were involved in selecting the dog and shared responsibility for the animal's care. In another example a care home provided a shed in the garden for a resident who wanted to smoke.

Some managers spoke of a risk-averse culture in care homes and how challenging this could be, creating tensions with other professionals and with

family members. One example of this was a resident who wanted to end her life at the home but was, because of concerns raised by GP, moved to hospital, where she died the next day.

Staff recognised that a risk-averse environment restricted opportunities for residents. There was often an acceptance of risk aversion by residents themselves. One resident felt that he was held back because of the cautious approach of the home and pointed out:

I know a fall could set me back weeks, but I've lived my life taking risks.

Resident

Building stronger relationships with partners in other sectors

Care home staff and council managers have developed stronger links with health and social care partners since the introduction of the MHL Leadership programme and with the support of the QI team. The confidence and increased self-esteem gained through the MHL programme has increased managers' credibility with other professionals and shifted the way they work with their teams. The programme has helped managers to clarify their role in the system and to work more closely with colleagues in other organisations.

Managers are now valued and listened to, treated as equals by other professionals.

Essex

One senior stakeholder explained that the most significant change brought about through the MHL programme was around the relationship that developed between carehomes and Clinical Commissioning Groups (CCGs) created as new health care commissioning bodies in the reorganisation of the NHS. Joint visits have been made to care homes across the county to look at potential development areas and joint solutions where problems are identified. In some instances, through seeking out direct relationships and building trust, individual care home managers have been able to change existing, formal patterns of communication or responsibilities, for example to ensure more appropriate admissions or discharges from hospital. This is a good example of how the theme from MHL to improve health and healthcare for residents was brought into the quality change programme.

Care homes now have 'a face' in the CCGs and the CCGs have developed a greater understanding of the context and culture of care homes. Trust between the organisations is growing and when concerns arise it is hoped that joint solutions can be found:

Good relationships give a good foundation to create openness towards new proposals and ways of working.

External stakeholder

A network of meetings between Essex, care homes, CCGs, health providers and acute care services are picking up issues that arise and are starting to work together to drive up quality. An example of where the sectors have worked together has been with the 999 Project, which aims to reduce the number of 999 call outs to care homes and admissions to hospital of care home residents.

Representatives of the QI team attend the quarterly information-sharing meetings with the CQC. These meetings are seen as a way to communicate a shared vision of care and support in Essex and make it a reality:

It's important that we all meet at the same time. Essex is a large county, and these sessions involve seven CCGs and other surrounding councils – these meetings are key because if something is going wrong in [one area], you can bet your bottom dollar it is going wrong in [another area].

External stakeholder

As a result of these meetings, the CQC has requested that the QI team presents information about MHL Essex at one of their internal team meetings. One of the CCGs' concerns is about consistent management in the sector and they are particularly interested in the leadership aspects of MHL.

Challenging traditional models of care

We can make change now to offset the future.

Care home manager

An interesting finding from the evaluation was that as a result of the new approaches in Essex a debate was underway between the commissioners and providers about the development of new models of care, in which there was a requirement to involve older people and local communities. There was an emerging consensus about a future in which older people's voices are at the centre and a range of community-based options would be in place, offering much greater choice and control.

The resident would have the loudest voice ... residents are our customers and should be listened to.

Care home manager

There was evidence that the increased confidence and clarity of shared values was allowing Essex and care home managers in the county to begin to change the way they worked in line with their vision to make care homes a positive choice for older people.

[The MHL approach is] how standards of care should be.

Care home manager

Looking at the future vision we can be creative about what quality looks like.

Essex

I'd like to see people going into homes expecting more.

Essex

One council manager spoke of the need to move from high-density homes to smaller ones where it was believed choice and control for residents could be more easily achieved, as reflected in the 2010 CQC report on the state of adult social care (CQC, 2010).

In this study we heard a consistent view across the council and care home staff of a future that was likely to involve many more variations in independent living, with fewer care homes and far stronger community

connections. This included a recognition that everyone needed to be part of the change:

We do need to engage hearts and minds, engaging with the community, our residents and families, people who work here. It's around looking at the fact that this is something we all need to think about earlier.

Care home manager

Surely we need to think along the lines of continuity, the things that are important to me should not change as I get older.

Care home manager

Interviewees from both the council and from care homes spoke about the need to halt the growth of residential and nursing homes and instead develop more options and create greater choice and homes for life.

There is a lot of discussion and recognition that we need different models of care and support, including care villages ... more choice and a menu of options and style of accommodation beyond residential care.

Essex

6 WHAT HAS HELPED CHANGE TO HAPPEN? FOUR KEY DRIVERS

The evaluation showed that changes in the relationship between the council and the care home sector and the development of relationship-centred care were being driven by a number of factors. From the evidence we identified four key drivers. These were:

- corporate ownership by the council;
- investment in the care sector;
- effective leadership;
- a community of practice.

Corporate ownership by the council

My Home Life is business as usual: it forms part of what we are and what we do. It's part of the ethos, part of the fabric.

Essex

Although the QI team and other elements of Essex's MHL-based approach have been in place for a relatively short time, there was evidence that this way of working had become integrated into the way that the council does business. Staff at all levels, as well as the elected council member we spoke to, recognised the importance of MHL in driving up quality and helping to deliver the council's goal of reshaping care in Essex. Staff saw MHL as embedded in the council's culture, not as a 'project' that operates in isolation from the mainstream. The MHL themes are integrated into contracts with care homes and additional resources have been tied to improvement in the theme areas.

The value of MHL also lies in the programme's ability to influence care homes that provide services for older people who are funding their own care. The MHL Essex Leadership Support team and the QI team have provided a trusted route for communicating messages about the future of care services in Essex to care homes that may otherwise have little contact with the council. At a time when rising numbers of people are funding their own care and the council's traditional contracting levers are becoming weaker, MHL has been able to influence more widely. MHL has therefore offered an important new way for the council to influence and shape the Essex care market.

This has been achieved through considerable work on the part of the QI team, working closely with colleagues across the council to demonstrate MHL Essex's contribution towards meeting corporate priorities. Internal communication within the council has been important to showcase successes and to position MHL Essex as a good news story, at a time when these are scarce in local government.

Investment in the care sector

Essex has invested in staff development in the QI team and has also provided resources to support change in the care sector.

This investment includes offering the MHL Leadership Programme to care home managers: a 12-month action-learning programme followed by six months of support and continuous professional development. A total of 168 managers have now taken up the offer and word is spreading among care home staff that it is very worthwhile. The programme encourages managers to be reflective and explore their own values in relation to their role:

I finally acknowledged the need to step back and analyse my own strengths and vulnerabilities.

Care home manager

This care home manager said that these insights had helped her to improve the quality of her relationships within the home and the way she approached risk.

There has also been an £8 million investment made available to incentivise care homes to adopt the relationship-centred approach. It is still too early to see how this is driving change across the system, but it shows the sector that the council is willing to invest in quality improvement.

Essex has developed training consortia to offer training to groups of care homes depending on their needs. While this demonstrates that staff training is valued by the council, it is the responsibility of the sector to make the best use of these opportunities. In some homes, take-up of training and staff development opportunities was seen as an important priority in valuing staff and encouraging them to reach their potential. It fitted with the embedding of MHL themes in keeping the workforce fit for purpose.

Effective leadership

Leadership is an essential factor in all change programmes as it shapes the context, holds the vision and directs the way forward (Bate *et al.*, 2004). Leaders are critical to success because they can inspire commitment, mobilise resources and create and recognise opportunities. Within the MHL ethos leadership should promote a positive culture where relationships can flourish. The way change is described, discussed and presented by leaders to both internal and external audiences is crucial.

Essex recognised the need for effective and strong leadership from the outset of MHL and invested in a member of the QI team to take the role of Quality Innovations Lead. She was supported in this role by effective line management and through attending an inspiring Emerging Leaders Programme, tailor-made for Essex, early in the process. Also, once the individual had been appointed, Essex trusted and backed her in taking the vision forward, capturing 'hearts and minds' in the process. The consistent

message from the Lead to the care home sector was that the MHL evidence base was developed within the care home sector and the way in which the MHL movement continued to develop would be determined by them.

A key role of a strong leader is to spread the vision and there was strong evidence that this was happening. One care home manager told us:

[The Quality Innovations Lead] has taken the ideology and has made sure it does not come into Essex and go out of Essex.

Care home manager

Essex County Council for the first time articulated values that we could buy into and that was [due to the Quality Innovations Lead]. Before that it was absolutely dire; they seem to have had a heart change.

Care home manager

Care home managers felt they were in a partnership with the council because their views were listened to and taken seriously. There was a sharing of values that care staff felt able to sign up to and move forward with.

[The Quality Innovations Lead] is coming to managers and asking how she can support us.

Care home manager

Senior staff in Adult Social Care encouraged and supported the Quality Innovations Lead to work corporately, recognising that MHL was relevant to the council as a whole, rather than limiting information to Adult Social Care. There has been a consistent message from directors, elected members and senior staff that working in a different way can increase quality. Driving up quality will mean that poor quality homes will be supported to improve or will cease to exist due to market forces. Success stories about the MHL ethos have been promoted and spread locally and nationally at a time when councils are under severe pressure from funding cuts, thus raising the profile of the movement and encouraging partners to invest in the success.

A community of practice

There was strong evidence that the opportunity created by Essex to bring care home managers together in a safe and supportive network, or 'community of practice', has contributed to driving the changes that are starting to happen. A community of practice is described as:

A group of people who may not normally work together, but who are acting and learning together in order collectively to achieve a common task while acquiring and negotiating common knowledge.

Bevan et al., 2004

Other evidence on how innovation can be spread throughout a system suggests that communities of practice may be one of the most important mechanisms for an improvement movement (Hildreth and Kimble, 2004; Goodwin et al., 2004).

Managers involved with the MHL Leadership Programme valued the time it gave them to meet with other managers in order to gain support for their values and to explore practical solutions to problems. It provided a reflective space for appreciating their own roles in creating change. It is building a more

confident and stronger workforce that wishes to raise quality and remove bad practice. Consequently, more confident and valued managers have been able to start encouraging their own staff to develop and change.

This is an interesting finding given the business model and competitive marketplace that care homes are operating in, but also shows the need to support staff who feel isolated and sometimes disempowered to make change.

Similar to what is described in the 'Challenging traditional models of care' section of Chapter 5, the opportunity to meet and share ideas together was beginning to open up constructive debate about how the whole care system could be changed in order that care homes are transformed and seen as a positive choice from among a wide range of support options for older people.

7 WHAT HAS GOT IN THE WAY? IMPLEMENTATION ISSUES AND BARRIERS TO CHANGE

The study identified a number of interrelated implementation issues that have affected the extent to which change has been achieved to date in Essex and for that need to be addressed in order to realise the full potential of the MHL programme. Many of these issues are due to wider policy and contextual factors that can only be tackled at a national level, but the experience of Essex can inform debates such as those about how local authorities can overcome seemingly insuperable barriers in order to improve outcomes for older people with high support needs.

Financial climate

There's lots of disillusionment about the funding. It's sad, but it's all we've got.

Essex

All the care homes are the same – primarily interested in money.

Relative of resident

Money, it's always money.

Care home manager

Not surprisingly, all care home managers cited financial pressures as the biggest obstacle to improving services. A number mentioned that Essex had not increased the fees it was prepared to pay for a care home place for some time. For most managers who took part in the MHL Leadership Programme, there was a feeling that the financial climate was, in the main, outside the control of the council and these managers were better equipped to deal with pressures as a result of a stronger, more positive partnership with their local commissioners. Managers were also very positive about the additional contractual payments that the council had built into service contracts, which were linked to demonstrable progress on MHL themes.

Staffing and quality issues

It would be helpful if people that work here felt more valued.

Care home manager

I can go home not having eaten and barely having had anything to drink ... that's a normal day.

Care home manager

The availability of staff with the right skillset to deliver personalised, high-quality support clearly impacts on the finances outlined above (and vice versa), but also on the quality improvement drive that lies at the heart of MHL Essex. At a time when older people entering care homes need increasingly intensive and skilled support to live their lives, and therefore staff skills and capacity are increasingly stretched, the pressure to keep costs low is stronger than ever before. While in some of the homes in our sample carers were spending time one to one with older people, in others older people told us that staff were usually far too busy to stop and talk.

The capacity of managers to concentrate on driving up quality was also limited. As Figure 1 on page 13 illustrates, managers are responsible for managing a complex web of relationships, as well as in some cases leading the development of new services or project-managing building works. Skilled and experienced managers are also often used as troubleshooters, dealing with crises in other homes in the company or organisation.

Many managers highlighted the poor image of care, which has been battered by high-profile failures and press coverage of poor pay and conditions which they believe affects staff morale as well as recruitment and retention.

We also heard concerns that MHL is not a requirement, as care home managers have to opt in to the programme. A number of care home managers and participants in the evaluation from the council spoke about the homes that have not yet been touched by MHL and expressed concern that many managers and staff are not yet benefiting from the approach.

These concerns have been recognised by Essex and the MHL Essex partners, as demonstrated by their ongoing commitment to the programme and investment in a dedicated community association, MHL Essex website and associated resources (see <http://myhomelifeessex.org.uk/> for further information). The aim has been to create a partnership programme with full coverage across the county and ownership from provider organisations, provider companies, individual homes, local communities and third-sector partners.

Organisational challenges

[The company's] governance gets in the way ... there is a different philosophy of care which is very strict and quite regulated.

Care home manager

The [organisation's in-house] audit team is in theory brilliant, but they come in and upset everyone. It's better if you work alongside.

Care home manager

Managers are being let down by their proprietors.

Essex

The study sample contained care homes that were part of various different types of organisations and ownership models, including:

- large national private companies;
- stand-alone homes with a proprietor;
- not-for-profit, or charitably-owned homes;
- faith-based charitable providers.

Each of these types brought different issues. For care homes owned by a proprietor (often a local businessperson with just one home), the relationship between the manager and the proprietor was crucially important. Where a proprietor was supportive of MHL Essex principles, the relationship played a key role in supporting change. In other cases, proprietors saw the home as 'their' home, rather than that of the residents, which could lead to conflict with the manager.

Some homes in the sample were owned by large private companies. For them there were tensions between the MHL Essex approach and the centrally-driven corporate quality systems adopted by the company. This meant that some homes were working with three parallel approaches to quality: MHL, the corporate approach and CQC quality standards.

A number of homes in the sample had changed ownership: in at least one case ownership had changed more than once in a period of two years. Changes of ownership inevitably resulted in some level of instability for the staff team, particularly the manager. One manager, for example, noted that she had not had a formal supervision session for over two years. In another home, residents had noticed the impact of a change of ownership, which had led to staff cuts and a disruption to relationships in the home.

There had also been a great deal of organisational change within Essex County Council during the life of the MHL Essex programme. This meant that maintaining the profile of the MHL message and the quality agenda required substantial effort on the part of the QI team.

Changing profile of needs and wider societal attitudes

A lot of the residents here are deaf and don't seem to be able to operate their hearing aids; it makes it very difficult to communicate with people at meal times – people who are at the same table – so I keep to myself. Can't go into the lounge as the TV is on so loud it'll burst my ear drums.

Resident

I do get very depressed at times; so many people are not 'with it' here.

Resident

Both care home staff and older people spoke about the impact of residents' physical and mental health on their ability to form and maintain positive relationships in a care home setting. Staff who had worked as carers for some time spoke about the changes they had seen over the years. While they had previously been able to spend time talking with or playing games with individual residents, this had become increasingly difficult as the older people entering care homes needed more intensive care and support. The growing demands of the caring role meant that it was more difficult for carers to carve out the time needed to really get to know older people if they continued to work in a traditional way. This illustrated the need for staff

with different skillsets when supporting people with high support needs, to recognise that different jobs and different roles are required in order to achieve person-centred approaches in the care home environment.

It is clearly a positive development that many more older people are able to continue living independently in their own home for much longer than was the norm in the past. But this does have an impact on the way that homes operate and the level of skill that carers need, as well as on the experience of older people. As the quotes above show, a number of older people in homes told us that it was sometimes difficult to build and sustain relationships with others.

Negative perceptions of older people with high support needs undoubtedly affect the climate in which care is delivered, as well as the expectations of older people, their families and staff caring for them. Older people do not always expect to influence the care and support they receive, and rarely protest if they do not.

At 87, I can't be too particular can I?

Resident

We also heard many examples where families felt that they knew what was best for the older person, causing conflict with staff in the care home who were committed to trying to deliver what the person wanted, therefore creating barriers to person-centred care.

8 WHAT IS THE LEARNING FOR OTHERS? KEY MESSAGES AND LESSONS

There are clear signs that Essex has begun a journey of quality improvement in the care home sector and that this is beginning to create positive change throughout the system. The council has shifted its approach from a top-down monitoring, inspection and regulation model to a focus on building relationships, offering support and investing in the development of care home staff. The evaluation found a number of key lessons that could be applied by other councils and care providers.

As previously outlined in Chapter 5, the most positive relationships that led to signs of improving quality were between the council and the care home managers, and between care home managers in other homes. We saw a variety of examples of themes from MHL being put into practice, for example through promoting a positive culture in the home through investing in the development of care home managers.

The box below summarises some of the shifts that are taking place in Essex. Some are undoubtedly better established than others, for example, as indicated in earlier sections, evidence of progress is strongest in relation to the impact of changed commissioning practices and relationships between the council and care home providers. The focus on the eight MHL themes has created a shared vision around quality and outcomes for older residents – changing the way that the council does its ‘commissioning business’ and providing a framework for staff training and development within homes. The MHL Leadership Programme has had an important impact on care home managers, boosting their confidence and freeing them up to work in new and more personalised ways.

Table 1: What is changing in Essex – commissioners

From	To
Focusing on what's wrong	Building on what's going well
Wielding the 'big stick'	Working alongside
Commissioning primarily for volume	Commissioning for quality using MHL themes
Having an adversarial relationship with care homes	Creating a partnership
Sending out a strategy document	Building a shared vision for the future

Table 2: What is changing in Essex – care home managers

From	To
Having little confidence in their own views and values	Being able to challenge and share decision-making
Having an unequal partnership with other stakeholders, e.g. the NHS	Able to operate as an equal partner
Feeling isolated and lonely	Part of a supportive network of peers
Behaving as if powerless	Behaving like a leader

Table 3: What is changing in Essex – older people

From	To
Care is about tasks	Care is about building good relationships with people
No risk-taking is allowed	Risk managed well
Isolated from the community	Part of the community
The proprietor's home	The older person's home
Not being able to continue the things that give life meaning	Getting the support needed to continue doing the important things

For older people, the changes brought about in Essex have yet to show clear impacts, although there are some signs of progress that have been shared in this report and summarised in the box above. Work is ongoing to embed the concepts and practices of relationship-centred care within existing care homes signed up to MHL; and to spread the approach to more homes and older people across the county. Further work is needed to ensure that the views, experiences and aspirations of older residents are known and used to drive the MHL programme forward from here.

The following points summarise the key messages and learning identified in the evaluation, reinforced by those taking part in this study:

- Changing the nature of the relationship between the care home sector and commissioning authorities can drive up quality in the market. The approach used to change relationships is crucial to success, for example using appreciative inquiry and common themes such as the MHL themes can create a shared agenda for change.
- The QI team and MHL themes are vehicles for spreading consistent messages and building a consensus across the health and care community

about the need for change and the strategic direction the change must take.

- Systemic change of this nature requires strong leadership. Leaders with the right skills, attributes and credibility are needed to create and push forward the local vision. These leaders need to be trusted and supported by senior and operational managers and have a clear values base to help them stay focused on the outcomes that are to be achieved in the long as well as short and medium terms.
- An organised and facilitated community of practice provides a crucial mechanism to drive change on the ground and creates opportunities for staff to come together to share experiences and solve problems. More opportunities to do this with colleagues across the health and social care system could be developed to support ongoing commitments to MHL Essex.
- Other care homes and staff that are not yet part of MHL Essex should be encouraged to get involved. A peer challenge approach undertaken by the managers from the MHL Leadership programme has been suggested. This can capture 'hearts and minds' and drive forward improvement.
- There is tension evident between the business model of care homes and improving quality through investing in relationships. Not all proprietors and large corporate organisations are yet fully committed to the MHL Essex approach and incentives and regulation may be required to involve them. Additionally, bringing people together at a strategic level to identify common principles and practice would be beneficial.
- So far, the voices of older people in the improvement programme have not been strong: the next phase of MHL Essex should focus on engaging both with older people living in care homes and the wider population of older people. Research indicates that while a relationship-centred culture supports an environment where older people have more choice and control, the power imbalance that currently exists within care homes needs to be addressed if older residents are to speak on issues that concern them and exercise self-determination in the way that is envisaged. A greater focus on co-production involving older people and other stakeholders could help achieve this ambition and ensure the underlying ethos of MHL is fully embraced in Essex.
- Essex and partners have recognised the need to do more to create a sense of community between family, friends and the wider local community and develop stronger community connections. The Community Visitors programme, which offers a structured approach to volunteering in care homes, is already being piloted in three homes. The MHL Essex Community Association, with the support of the Quality Innovations Lead, has plans to establish groups in each locality. The vision is to establish care homes as part of the community in a two-way process. NDTi has an initiative called the Community Mentors programme (NDTI, 2014) which may offer suggestions and support for developing and strengthening community connections.
- The QI team should continue the dialogue with the care home sector about new and alternative models of care, including integration with the health sector. This links to findings from other JRF funded work as part of the Better Life Programme around widening options for care and support for older people – for example through models such as Shared Lives, Co-housing and Homeshare (Bowers *et al.*, 2013).

9 RECOMMENDATIONS FOR POLICY AND PRACTICE

This section sets out a number of recommendations that were identified from the analysis and conclusions and explored with members of the JRF Project Advisory Group. They are designed to inform the ongoing work in Essex but will have relevance for other areas, commissioners and providers of care and support wanting to adopt practices that link individualised care and support within services to outcome-based commissioning practices within authorities. The timing of this work is key, with the anticipated, imminent passage of the Care Bill by the House of Commons (which will reform the law relating to care and support of adults, carers and safeguarding), the provisions of which should come into force from April 2015.

Areas for further work and action in Essex care services are presented in two broad sections here: priorities for local partners concerned with improving services for older people in Essex such as health and social care commissioners) and priorities beyond Essex for improving outcomes with and for older people who need support in their lives.

What should happen in Essex?

The evaluation team's recommendations for what should happen next in Essex can be broken down further into two categories. First, we consider ways to further develop the MHL approach:

- Current and prospective partners should continue to support the MHL Essex community of practice and explore ways of replicating this for other groups of care home staff in non-participating homes so that they can support their peers and be supported themselves. This would achieve a more integrated, whole-system approach to securing better outcomes and experiences for older people in Essex and those working with them in a variety of roles and at different levels.
- In all aspects of improvement initiatives in Essex, especially MHL Essex, there is a need to strengthen the voices of care home residents at all levels: in participating homes, in training and development opportunities and in commissioning decisions and support (e.g. within the QI team). One way of including older people's views more substantially in these areas could be to focus on co-production, for example by co-producing a future

vision for care and support in Essex. A model for taking this forward can be found in other publications (Bowers *et al.*, 2009; 2010).

- There is potential for developing a peer review or challenge approach in Essex to build on the community of practice and established relationships between the council and participating care homes. This would help embed this approach within participating homes but also spread the MHL Essex approach to a far greater number of homes across sectors and companies or providers.

Second, we consider how to extend the reach of MHL Essex:

- There has been considerable discussion within Essex and wider MHL partnerships as to the most effective ways of extending the reach of MHL – for example by exploring the implications of making involvement in MHL a mandatory requirement for all care homes in Essex. Exploratory conversations with a range of local providers (many of whom are local or regional branches of national organisations) and provider associations will be an important component of future discussions. The benefits and impacts identified through this study could be shared in these future discussions, as could the findings of future or ongoing work with older people to identify outcomes and impacts of MHL Essex for individuals. It is important to stress that these considerations are not unique to Essex but reflect wider issues shared by authorities and their delivery partners across the UK. The benefits for different stakeholders of participating in MHL Essex need to be identified and shared in order to demonstrate the potential for involvement in the programme. The shared vision referred to in the box below could also be a key unifying factor in taking this programme beyond the current participants.
- As part of the desire to widen participation in MHL Essex, it will be important to secure stronger links and relationships between care homes and local communities, with a greater focus on overcoming barriers and creating more opportunities for community involvement and engagement in the programme. This is a key aim of the recently formed MHLE Community Association (see <http://mhleca.org/useful-links/>). Guidance and practical suggestions for achieving this can be found at <http://www.ndti.org.uk/what-we-do/community-inclusion/community-inclusion-mentors/> and <http://odi.dwp.gov.uk/docs/ils/the-seri-story.pdf>.
- It will be important to consider how knowledge and support can be extended to older people who fund their own care, as mentioned in Chapter 6, to achieve the most appropriate choice of care.

Key messages from MHL Essex – sharing the learning from Essex

The following list summarises the key elements found by the evaluation to be instrumental in developing positive and productive relationships between commissioners and care home providers. In developing these relationships, commissioners and providers can therefore create a care environment that enables positive outcomes for older people to be achieved as a result of relationship-centred care and support. The purpose of sharing these lessons here is to highlight their central role in enabling such positive outcomes to occur. The lessons can also serve as questions for care home managers and commissioners to ask themselves in order to determine whether they are already doing what is suggested in the lessons, and/or to consider whether older people and families are able to do so.

What commissioners can do:

- focus on developing proactive, enabling relationships with providers based around a shared vision and agreed outcomes for older people rather than volume and cost measures and margins;
- find ways of communicating and engaging with providers that are developmental in style (e.g. focusing on progress and problem solving rather than performance management and punitive action);
- find ways of supporting and encouraging the leadership potential of care home managers;
- build quality and broader life outcomes for older people into contracts in order to promote individualised support and relationship-centred care;
- involve care home providers in discussions about the future shape of care and support, including where care homes fit into this, e.g. involving care home providers in the development of local *Market Position Statements*.

What care home managers can do:

- continue focusing on relationships and seeing this as a central part of the role of manager;
- engage older people in decisions about the way that the home operates and the provision of their own support;
- be transparent in dealings with families, regulators and councils;
- build a constructive relationship with the council;
- build connections between the home and the community;
- build stronger, more confident links with health, social care and other partners.

What older people and their families can do:

- make demands – learn from what happens in other homes and ask why it doesn't happen in theirs.
- families should get to know about the MHL Essex programme, what to expect from it, how to influence it and how to get involved;
- families should ensure their older relatives get the individualised care and support they want and need by one-page personalised profiles (Bowers *et al.*, 2009) and contributing to support plans.

Finally, we believe there are a number of national policy developments occurring such as the passing of the Care Bill that will influence local developments and which lie outside the immediate control of councils and care home providers in Essex. There is no doubt that change is needed at all levels: strong national as well as local leadership and social policy and political movements will help to create necessary incentives and levers in the future delivery of care and support for older people. As a result, although the wider national context did not form a core part of this evaluation, we believe the following three areas deserve attention and could be implemented with the help of the influential work of JRF and the Joseph Rowntree Housing Trust (JRHT) to create a clearer national vision and strategy for change in the care home sector.

- In terms of the skills and leadership styles most likely to create positive and enabling care home environments, there is much to learn from the Essex experience of designing and running leadership development programmes for care home managers and commissioners. We think that

organisations such as Skills for Care and the National Skills Academy for Social Care are well placed to share leadership learning in addition to vehicles such as MHL networks and JRF's Better Life programme.

- There is a tension between locally developed and owned quality-management frameworks involving care homes and providers and those adopted by large companies and corporations. The model adopted in Essex has shown the benefits of local solutions for local residents and potentially for local communities. This clearly has implications for companies and corporations that need to be aired and explored in partnership with, for example, the Association of Directors of Adult Social Services, the Local Government Association (LGA) and the English Community Care Association. There may well be other forums that can consider how to manage these tensions. In terms of who should take this agenda forward, we wonder if this is something that JRHT might consider, being both a major care and support provider as well as a thought leader in this field.
- This evaluation has demonstrated the benefits and potential impacts of a shared, local vision of current as well as future delivery of care and support for older people (focusing on residential care). We believe this is something that is underestimated and under-developed. Council leaders (via the LGA), the CQC and JRF are in strong positions to work collaboratively with each other and care providers to identify and unify common principles, practices and features in care provision, in line with the requirements and potential statutes set out in the forthcoming Care Bill.

APPENDIX 1: EVALUATION QUESTIONS

- 1 What is different about how Essex County Council, as a commissioner, operates now compared with before it embarked on the My Home Life Essex journey?
- 2 What were the drivers for change, and how were these harnessed? What resistance was faced and how was this tackled?
- 3 What resources were invested? Have there been any additional costs or any savings?
- 4 How have issues around safeguarding, risk and regulation been addressed? What happened when things went wrong?
- 5 Have people in care homes and their relatives experienced better outcomes as a result of this journey? Has the user experience changed demonstrably?
- 6 How has the experience impacted on the staff and management within the care homes?
- 7 How have providers responded in Essex – and with what effects?
- 8 What have been the key behaviours, attitudes or actions that have brought positive change or that have got in the way?
- 9 How have wider issues of demand, supply and the funding of care impacted on the approaches taken, particularly in relation to risk and relationships in the care homes? How has the My Home Life journey affected care home providers' and commissioners' approaches to risk and the importance of relationships in the provision of care?
- 10 How have relationships between residents, their families and staff changed as a result of My Home Life? How have these relationships been navigated to promote more enabling approaches to risk?
- 11 Where there is evidence of positive shifts in Essex, what have these been and how did they happen? Who were the key actors – including local media, regulators, local providers and consumer groups? What were the incremental practical steps that were taken? What happened when things went wrong?
- 12 How has My Home Life changed approaches to risk and the formation of relationships in Essex care homes with high numbers of people with dementia and/or complex needs?

Additional questions

- What signs are there that there is a whole community approach to change? Who are the key stakeholders and how have they brought about change?
- What evidence is there that MHL has enabled more dementia-friendly environments? What barriers are there to enabling the design of calmer spaces for people with dementia?
- How are the Health and Well being boards in Essex engaged in the process? How is MHL influencing their decisions? What more needs to be done?

APPENDIX 2: CARE HOME SAMPLING MATRIX

Characteristics	Essential	Desirable
Location in Essex County Council		
Rural setting	E	
Seaside setting	E	
Urban setting	E	
Economically disadvantaged	E	
Economically advantaged	E	
One in each of the five council districts		D
Other features		
High concentration of care homes in the community		D
Size range of care homes in terms of numbers of residents	E	
Care Quality Commission ratings		D
Whether care is self-funded or state-funded	E	
Dementia care	E	
Care home with nursing service		D
Care home without nursing service		D
Providers		
Private provider	E	
Local authority provider	E	
Specialist home e.g. occupation, societies and charities, religion, ethnicity, dementia		D
Manager has undergone or is undertaking Leadership Development Programme	E	
Manager has NOT undergone or is NOT undertaking Leadership Development Programme	E	

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