My Home Life England
Professional Support and Development Programme

Insights and Outcomes 2023

Authored by Dr Bethany Morgan Brett, Research Fellow, City University of London

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The reference for this report is: My Home Life England Professional Support and Development Programme: Insights and Outcomes (2023). City University of London. Acknowledgements go to all the care leaders who participated in this work.

Foreword

I am constantly impressed by the calibre of people who work in social care. They bring their everything to work, and this is most true of all for those who take on a leadership role within care settings.

However, at a system level, this report shows that many of those leaders can feel isolated and lonely in their role, often feeling close to breaking point as yet more responsibilities and complexities are layered onto an already burgeoning agenda. The impact of the My Home Life England programme, in this context, is inspiring. The core ingredients that the course offers – time, space, development approaches and peer support – have a major impact on key areas around confidence, enthusiasm and retention.

I have had the privilege of meeting a range of participants from different cohorts of the programme. It is clear that, at the end of the course, they not only have great admiration for the work of each other, but that they have reflected on how much they have grown. They have found a voice to support them in engaging with regulators, commissioners and families. They have found a network of peers who they can learn from, harvest ideas and innovation, and gain recognition for their own expertise and experience. Most importantly, they have learned things that directly impact on the quality of care that they provide to people receiving care and support, reinforcing the widespread understanding that there is a direct correlation between the quality of leadership and the quality of care.

This evaluation gives us the evidence base to be clear in our articulation that investing in front line leadership should be a fundamental, both for the leaders of today and, importantly, our leaders of the future.

Vic Rayner OBE

Executive Summary

My Home Life England (MHLE) has a 17-year history of working alongside care providers to support improvement in quality, with a focus on practice development, leadership support and adapting to change. This report summarises the collective research findings from MHLE programmes completed between May 1st 2022 to April 30th 2023. It provides a thematic analysis of 19 end-of programme/short course reports, and a quantitative analysis of the evaluative outcomes from the Endings Surveys completed by programme participants.

It concludes that care leaders work in a mentally, physically, and emotionally demanding role, which often leaves them feeling overburdened with a multitude of different responsibilities. By participating in My Home Life England's Professional Support and Development Programme, care leaders were able to share their challenges, feel supported and, ultimately, learn a variety of tools, skills and strategies. The impact of the programme was not only felt by the care leaders, but reportedly had a wider impact on care teams, the people they cared for, their families, and the overall culture of the care setting itself.

Introduction

This report summarises the research and evaluation data resulting from the delivery of 16 cohorts of My Home Life England's Professional Support and Development Programme (PSDP) between May 1st 2022 to April 30th 2023. 158 care leaders completed their PSDP; a completion rate of 75%. It also includes findings from an additional three programmes. These followed a different model to the PSDP, but were completed within the same time frame. They included a Continuous Professional Development (CPD) programme, a short series of workshops to support care leaders within a single care provider, and the delivery of 6 integrated care workshops to support improved enhanced health in care homes. In combination, these extra programmes were attended by an additional 58 participants. In total 216 participants from the care sector completed a MHLE programme or course between May 1st 2022 to April 30th 2023.

This report describes the challenges faced by care leaders across England and the reported outcomes of the My Home Life England programmes.

Background

My Home Life England is part of an international initiative that aims to improve the quality of life of people living in care settings, to provide support for their families, visitors and loved ones, to empower and enable a positive working environment for care workers, and to foster meaningful relationships between people living in care, families, and those working in care settings. To achieve this, My Home Life England works with a variety of care settings, care at home services, housing support, NHS, statutory bodies, community organisations and others to co-create new ways of working to better meet the needs of people living in care, their relatives and loved ones, and care teams.

One critical element of this initiative is the My Home Life England Professional Support and Development Programme, formerly known as The Leadership and Support Programme. The programme began in England, hosted by City, University of London and since then My Home Life initiatives have developed in Scotland, Northern Ireland, Wales, Germany, and Australia, supported now by My Home Life Charity. To date, the Professional Support and Development Programme has been delivered to over 2,400 care home leaders across the UK.

About the programmes

The Professional Support and Development Programme (PSDP) typically follows the model of three initial workshop days (consisting of group exercises, discussion, and reflection), seven action learning sets and then a completion day. In the initial three workshop days, there is an introduction to the PSDP and the My Home Life evidence base, as well as the opportunity for group learning activities. Each programme ends with a completion day. Participants validate the programme report (authored by the MHLE facilitator), reflect upon their learning and outcomes and occasionally they also engage with invited local system leaders. The broad outline of the programme is consistent across localities, however the actual delivery of the content is tailored and guided by the participants' discussions and questions. The approach centres on helping leaders to arrive at their own conclusions and ideas, by experiencing the power of high-quality listening and engagement. The workshops focus around three key themes:

1. Relationship with Self
2. Relationship with Others
3. Managing Change

This intensive introduction is followed by seven monthly action learning sets. During these, the role of the MHLE facilitator is to encourage participants to listen deeply and ask open questions in relation to an issue brought by a group member, encouraging and modelling curious open questions, reframing language and encouraging exploration.

The programme is underpinned by a series of four key frameworks. These focus on improving care through promoting positive relationships and meeting the needs of care teams, people who use care services and loved ones, whilst recognising the contribution they can make to the creation of a caring environment.

These frameworks include:

1. *Developing Best Practice Together:* What is it that people value and what works well in care homes and other care settings?
2. *Focusing on Relationships:* This includes an introduction to the Relationship-Centred Care Framework (Tresolini, 1994) and the Senses Framework (Nolan, Brown, Davies, Nolan, & Keady, 2006).
3. *Being Appreciative:* This offers an overview of "Appreciative Inquiry", which is a process for improving practice by focusing on core strengths, then using these strengths to reshape the future. It involves four steps: discover, envision, cocreate, and embed.
4. *Having Caring Conversations:* The Caring Conversations Framework (Dewar and Nolan 2013) provides a method for enhancing communication and compassionate, dignified care by using the 7C's (be Courageous, Celebrate, Connect Emotionally, be Curious, Collaborate, Consider other perspectives, and Compromise).

In addition to this PSDP model, some programmes include an additional 'integration strand' and other one-off workshops: focusing on 'technology' and 'quality improvement'. MHLE have also run Continuous Professional Development (CPD) programmes, offering ongoing support to those that have completed the main programme.

During the programmes, a range of resources and tools are shared that support leadership and quality of service.

When, Where and Who?

The Professional Support and Development Programmes which form the basis of this report took place between May 1st 2022 to April 30th 2023 and were held in the following locations: Knowsley, Shropshire, Telford and Wrekin, Essex, Norfolk, Suffolk, Sefton, and North East and South London. Programme participants came from a range of backgrounds and levels of care experience. There was one programme that was delivered specifically to leaders within a single care provider group.

The "About You" survey taken at the start of the PSDP showed that the profile of participants was 88% female, 75% White British, and there were a wide range of ages. Programme participants held a variety of senior care roles, including: managers, deputy managers, clinical nursing leads, registered managers, activities providers, and other senior roles (including roles in care homes, home care, settings for older people, and for those living with learning disabilities and/or other complex needs). The lengths of service varied, with 24% of participants having been in their role for less than a year and 25% having been there for over 10 years. Collectively these participants are described as "care leaders" throughout this report.

In terms of the care service that they were representing, 69% were from the independent sector, 20% were local authority, and 11% were a charity or third sector provider. 35% of the participants came from care homes with nursing, 38% were from care homes without nursing, and the remaining services included home care/domiciliary care, care homes or supported living for people with a learning disability or other complex needs. Cohorts included leaders from both rural and urban care environments, as well as a range of sizes of providers.

It is important to acknowledge that, through working with these 194 care leaders (who completed the programme), this had an impact - through a ripple effect - to many thousands of care team members, care receivers and their families.

Attrition from the Programme

The Professional Support and Development Programmes recruited 210 participants, of which 158 completed the programme; a 75% completion rate. The alternative model programmes saw an additional 58 participants complete a course. There were a number of others who signed up, showed an interest, and wanted to keep in touch about attending future courses, but did not attend these groups this year.

There were a number of reasons why participants missed individual sessions or were unable to complete the programme, including:

- Critical care team shortages (by far the biggest issue, especially for care leaders working in the domiciliary care sector)
- Resignation or change of job role
- Compassionate leave/ Own illness or increased stress levels requiring time away from work
- Unexpected visits from relatives/professionals or inspectors
- Preparation for inspections and formal inspections
- Serious safeguarding events
- Managing poor performance meetings
- Health appointments
- Sudden accident or illness or death of a resident
- Outbreak of COVID-19 in their setting or having COVID themselves
- Unexpected family and domestic issues
- Annual leave and special family occasions.
- Unable to commit to the demands of the programme
- A feeling it was 'not for them' or they did not give a reason

Evaluation approach

At the completion of each PSDP, the facilitator/s write a final report about the observations, experiences and outcomes, using direct quotations from participants. All the data in the reports have been used with the permission of the participants and have been anonymised to protect participant confidentiality. Participants have been given the opportunity to remove, add to, or amend their contribution to the programme reports. All have verified that the results presented in the reports are accurate and reflective of their experiences, increasing the reliability and validity of the presented data.

The programme participants also completed a pre-course survey, which helps MHLE profile the backgrounds of participants, followed by a second survey at the end of the programme, which measures the outcomes of the programme and provides feedback on the experience. My Home Life England was given ethical approval to use this data for research purposes by City University of London Research Ethics Committee Ref: ETH2223-2004.

For the purpose of this annual report, the full sample of 19 reports across all the programme types has been thematically analysed using NVivo. This has been analysed along with the responses from the pre-survey and PSDP Endings Survey (gathered via Qualtrics), which have provided quantitative evidence as well as some free response qualitative answers. At the end of each PSDP, participants completed an Endings Survey containing an adapted Perception of Workplace Change Schedule (POWCS), which includes a series of questions assessing how participants have felt over the past 12-month period. In the same Endings Survey, participants completed a set of questions relating to the 'Assessment of Work Environment Schedule' (AWES) in which they were asked to think about their place of work.

The deductive themes for the thematic analysis focused on the challenges faced in care settings and the outcomes of the MHLE programmes. However, emergent, inductive themes noticed a range of organisational, interpersonal and internal challenges, as well as outcomes which rippled through to care teams, relatives and care receivers. There was a saturation of themes with significant issues being raised repeatedly across the reports. Finally, instances of good practice which might be shared were drawn out from the data, as well as identifying implications for the wider health and social care system.

Findings

Participant Expectations of programmes

In the workshops at the beginning of some of the programmes, facilitators asked participants what their expectations were and what they wanted to gain from the programme. This formed a useful base from which the programme could develop and be developed to meet the participants' needs.

Responses included:

- Improving morale of care teams
- Connecting emotionally
- Getting to know what drives their team
- Changing the ways in which they hold staff meetings
- Encouraging increased self-reflection by their care teams
- Looking at how they hold their one-to-one supervision meetings with their team members
- Using the MHLE frameworks with the team
- Finding out how others view them
- Creating better links with the community
- Improving leadership skills
- Being prepared to respond to opportunities for promotion
- Working to improve the culture of the home. including the mental health and well-being of care teams

Challenges faced by participants in their care settings

Care leaders reported a number of significant challenges in their care settings which have been categorised here as 'organisational challenges', 'interpersonal challenges' and 'internal challenges'. In each section, the challenges are described and how the MHLE programmes made a difference.

1. The Impact of COVID-19

This particular cohort of participants who completed a programme between May 2022 and April 2023 were just emerging from the COVID-19 pandemic and the devastating impact it had on their care settings. Many, if not all, of the participants had experienced immense challenges created by the pandemic, in addition to their usually stressful roles and responsibilities. At the time they attended the first workshops, many of them were still reeling from what they had survived. They were unsure how to appraise what they had achieved and were uncertain what the future would bring in terms of new contracts, government requirements and attracting both new residents and new carers to their homes. Their general experience had been that support from the CQC, internal and external inspectors, County Councils, and regional sources had not been particularly available or appreciative of their circumstances. In some instances, effective partnerships and joint working approaches flourished. In others, it added an additional layer of challenge and complexity. The wider national picture was one of rapidly-changing COVID-19 policy and guidance, which at times was unclear.

> "*We've really struggled. We need more peer support, more understanding and recognition." (PSDP facilitator notes: care leader quotation)*

> *"I don't think people really understood what we went through. What was asked of us and how we were just expected to get on with it."* (PSDP facilitator notes: care leader quotation)

As the pandemic and lockdowns receded, some care leaders reported that expectations from certain external agencies and individuals appeared to return to the pre-pandemic status with little or no

acknowledgement of the challenges of the past two years, and the leadership required to keep care homes functioning. This added to their sense of feeling undervalued, isolated, frustrated and angry.

Care leaders often recalled how isolating the pandemic was for them. Some described how other people were scared of care home workers, turning their backs on them, and gave examples of having taxis refusing to take people to hospital. Even the carers' own families were sometimes too scared to visit them. As care homes opened up, care teams faced a new set of challenges. Some homes welcomed visitors, but for others there was a continuing concern about bringing infection into the home. Care leaders described a nervousness and reluctance amongst some of the residents to join others, particularly at mealtimes. They had become used to eating meals in their room through the pandemic and care leaders had to think carefully about how they could encourage reintegration and socialisation in the homes.

However, some care leaders described how they felt closer to families than before. Others described how families had praised the care teams, volunteered to help, and left gifts and cards for teams, especially once they realised how hard it was for workers. Yet some care leaders also mentioned that they had borne the brunt of relatives' anger with the government's rules, often because families did not understand the pressures the home was facing.

Unanimously, there was a sense of pride amongst care leaders on the programmes. They described how the pandemic had brought their care teams closer together. They "became family" and "really good mates", and had all "mucked in" taking on new roles, although a few now felt that this feeling of togetherness was fading. At the time of the pandemic they felt that they had "no choice but to cope". They felt that they "could get through anything now". One care leader mentioned how he "loved coming into work" and, even on a bad day, there is "always someone there to pick you up."

Generally, care leaders were proud of how they had managed infection control, becoming more confident in their roles with no healthcare professionals visiting the homes. This cleanliness and focus on hygiene, as well as support provided by care teams, was appreciated by those living in the homes. Care teams had supported many people who had COVID-19, and some leaders described how they felt they had saved many lives. One person mentioned having to isolate for a week in the home to look after the people living there.

> *"Everyone stepped up. We made our choice; we were willing to work. We packed a bag ready to move into the home." (PSDP facilitator notes: care leader quotation)*

There were some quite dramatic stories which emerged from the care leaders' experiences. The care team in one home had carried out what they called a "military operation" to get one person to hospital after the Liverpool hospital bomb. Another home mentioned getting food for families who were too terrified to go out. When it came to end of life care, care teams did everything possible to offer a dignified death, including setting up video calls with priests for last rites, reading the Bible to the person, and setting up memorial services that were live streamed for relatives. However, one facilitator reported that "*several (of the care leaders) mentioned how traumatic it was to wrap those who had died into a sheet before putting them into a coffin without any preparation*". Care leaders described how it was "heart-breaking" when there were deaths, and "eerie" not to be able to go into rooms. The compassion and understanding shown by teams was recognised by visitors; one visitor said that they all "needed a pat on the back" and the other praised the fact that "they couldn't do more than they did".

Leaders sought to create a sense of normality in their services. Activities in care homes continued in all the homes, including pamper days, eating ice creams, making cakes, gardening, running a "(HOME) Got Talent at Christmas" competition, dressing trees in PPE to look like people, drawing, keep fit

exercises and joining drama and dance groups on Zoom. Families kept in contact via Zoom or phone and would come to wave at their family members when permitted. Examples of local support included businesses leaving Easter eggs, water and clothes for those working in the home, plus blankets and toiletries for those living in the home. These were very much appreciated. In shops, people would ask them to thank everyone working in their home or give them free food or taxi rides. Schoolchildren sent residents cards and letters and home-made visors for the care teams. A relative of one team member raised £6,000 for a sanitising device for rooms where someone had had COVID-19.

The effects of the pandemic still remain a real concern for the care sector. This was a theme running through the programmes. Many were still experiencing incidents of COVID-19, which impacted on both people living in care and care teams (leading to short notice short staffing). There continued to be a lack of clear information about managing outbreaks. There were also many conversations about the legacy of the pandemic, including its effect on recruitment and the emotional and physical trauma it has caused the workforce.

Through the PSDP, care leaders were invited to consider the highs, lows and learnings of the pandemic in recognition of all they had held, endured and achieved. They were encouraged to think about how they had managed to enhance and maintain the morale of care teams, and how they had coped with multiple challenges, losses, grief, trauma, and moral distress. They began to recognise the learning that came out of this difficult period, and these are some of the things they reported:

- Better communication between services
- Care sector coming together - unity across the sector, networking, sharing knowledge
- Introduction of vaccines
- Robust contingency planning
- Quality time with service users
- Effective internal communication
- Staff commitment, resilience and team work
- Personal resilience, self-belief and confidence
- Positive feedback from relatives and residents
- External and internal support
- Appreciation of infection control
- Caring and positive attitudes
- Feeling upskilled in remote management and crisis management.
- Adaptability, creativity and resourcefulness

"We are here to tell the tale; we are still standing".

Spotlight 1: COVID-19

In spring 2023, My Home Life England produced 'Rebuilding Together' - a detailed account of the strengths that care homes demonstrated during the pandemic.

The report built upon significant work that MHLE undertook to support care homes in two areas of England to rebuild morale and resilience after the pandemic.

The report can be found here.

2. Recruitment and retention

COVID-19 and Brexit also resulted in massive challenges for the care sector. Leaders frequently reported serious problems recruiting and retaining qualified, skilled and experienced staff. This left them dealing with a constant turnover in their care teams and gaps in the rota, as well as trying to support tired, burnt out, or underperforming members.

> *"Recruitment has always been difficult but, since the pandemic, nobody wants to work in a care home."* (PSDP facilitator notes: care leader quotation)

Another issue was that, once new staff were recruited and inducted, care leaders found that some were not comfortable or willing to carry out personal and intimate care.

> "*We are seeing more and more new staff members saying they do not want to do [personal care]."* (PSDP facilitator notes: care leader quotation)

Retention was an issue, with care leaders often finding that, once they had identified, inducted and trained new care team members, it was increasingly difficult to retain them if they did not want to work shifts, or at Christmas/New Year or were generally inflexible in their hours. They found it difficult to attract staff when other employment was better paid, and with conditions that were easier than in a care setting. They spoke of some carers being trained and then leaving for another provider, or for better terms and conditions within the NHS. They described it as the 'grass is greener syndrome' and staff "shopping around".

> "*We have lost staff to the NHS. The rewards are more attractive there, there is better opportunities for career progression and that's who everyone was clapping for during COVID."* (PSDP facilitator notes: care leader quotation)

Offering good terms and conditions of employment was considered a crucial factor in recruitment and retention of good care team members. This was even more stark in the political and economic context of a cost-of-living crisis. Care leaders were noticing that the pool of staff who really cared about their work and stayed because they really wanted to be there appeared to be shrinking. There was recognition that the work was complex.

One care leader said:

> *"We expect a lot of low paid people." (PSDP facilitator notes: care leader quotation)*

Retention was a particular issue when there was a change in the COVID-19 vaccination policy and some care providers had to let staff go, even if they were good performers.

Some care settings relied heavily on agency staff. This impacted on the culture of practice, creating anxiety and fear that standards might be falling, and made it difficult to create a cohesive bond as a staff team.

Solutions

Care leaders used the time on their programmes to think about their own strategies and approaches, such as re-configuring roles to include new or additional areas of responsibility and focus, making the new posts both appealing and developmental. They considered new recruitment processes to enable those less confident in their literacy or who were neurodiverse to apply and be supported in their work (e.g. around the use of digital and completing care plans). They saw opportunity for investing in new staff through apprenticeships and supporting staff to complete qualifications in after-work

workshops. Staff appraisals and reward schemes also featured as examples that encouraged staff retention.

Care leaders shared some of the things that helped, or they could envisage helping, with staffing challenges. These included:

- Setting clear expectations for new joiners from the start
- Asking new starters for ideas from their previous employment
- Some homes kept staffing levels at 10% above the norm to cope with staff absences
- Encouraging shadowing of shift patterns
- Ensuring that they gave staff notice of shift patterns and especially of any changes, including sending the Christmas rota in October
- Being robust when implementing new approaches (for example with rotas, their registration status or end of life care forms)

Results from the PSDP Endings Survey showed a positive impact from the programme upon some of these challenges around staffing. They showed that 39% of care leaders found that **staff retention levels had increased (a little or a lot)** and 22% had seen a decrease in staff retention.

3. Supporting teams

The effective management of staff teams was an ongoing challenge for care leaders, particularly given the context that care teams were working in. Through the MHLE programmes, it was identified that care leaders experienced a range of interpersonal challenges related to communication, conflict management, managing up (to senior management and owners), fostering a positive workplace culture, managing resistance to change, and identifying practices, processes and procedures that block quality care. Care leaders often described a struggle with balancing authority whilst also building and maintaining good relationships with their care teams. They frequently had to manage negativity, conflict or poor communication within teams.

Supporting effective team-working

In some care settings there was low "staff morale", "demotivation" and "disempowerment". Some care leaders noted that staff lacked the energy to engage with new initiatives and that there were sometimes team members who used their power inappropriately to set up dissonance in the staff group. Some noticed the disconnect between the night and day staff, recognising that night staff tended to feel forgotten and unvalued. They described how staff with negative attitudes to change undermined team cohesion and disrupted the care setting's atmosphere. Some of this was no doubt a result of the pandemic, of challenges around recruitment and staffing levels and the increasing financial challenges facing team members.

Care leaders often reported that their care staff will tell them "I am *just* a carer" and have a sense that they "do not matter". One manager reported that they were trying to change that narrative, "*I am supporting staff not to see themselves as "just" a carer. I make it clear to staff that they are the most important people, my eyes and ears*." Care leaders often felt that they were not always being valued and appreciated by the owner or employing organisation, and they did not think they were equally valued in comparison to other health and social care professionals.

Care leaders recognised that all senior staff (which included themselves) needed to lead by example; working on shift alongside staff and training all staff to work within all areas of the home. They recognised that this models a 'relational approach to care'. They recognised the changes they had made in their own practice as a result of the programme. Comments from care leaders included:

> "*Praise team involvement, look for solutions together*." (PSDP facilitator notes: care leader quotation)
>
> "*Team, team, team. All decisions and processes where possible should be decided by the team so that they share ownership and are involved*." (PSDP facilitator notes: care leader quotation)
>
> "*I now try and walk about the floors more and share what I do, so staff can understand me more and what I do, but they like me seeing how their days are going*." (PSDP facilitator notes: care leader quotation)
>
> "*It is important to work more closely with the people I don't naturally get on with. I have to find something they do well and go from there – but not just the once – it has to happen often, so they see I am being different. Then there is a (small) chance they may start to change*." (PSDP facilitator notes: care leader quotation)

The leaders considered how to work on team building in their care organisation. Some organised social events for staff. And another tried to implement a change in the handover scheduling.

> "*Doing handovers with day and night staff and changing the days of the meeting is one thing*

we are trying. I want to concentrate now on building the team. It is one step forward and two steps back – sometimes." (PSDP facilitator notes: care leader quotation)

Creating a positive enabling culture

One of the most transformative approaches that care leaders learnt about on the PSDP was "Appreciative Inquiry" (AI). This was seen as being crucial in bringing about change and building upon the good things that people were already doing in terms of their skills or behaviour. Prior to learning about AI, many care leaders agreed that their natural instinct was to focus on 'problems' - what needed to be changed or what needed to be better or different. However, through AI, care leaders were able to identify the benefits of valuing one another, as well as giving and receiving encouragement and praise. They recognised that what you focus on grows. Care leaders sought out the "golden nuggets" in their service, however small. Through doing so, it inspired hope and an increased sense of worth. Facilitators reported that care leaders were often shocked to find that there were indeed good things happening, and that some things were working well in their relationships and in their homes, in spite of all the challenges and frustration. Two care leaders said:

> *"I always appreciate their hard work, but these sessions have amplified this*." (PSDP Positive inquiry feedback pad response)

> "*It helps if someone smiles and notices something positive…I like it if someone does that to me – why don't I do more of it?!*" (PSDP facilitator notes: care leader quotation)

Care leaders recognised that this new approach created a more positive mindset, and they practised reframing negatives into positives. The PSDP Endings Survey showed that **99% of care leaders reported that over the last 12 months, their understanding of how to improve the culture of care had improved** (with the remaining 1% staying the same), and **95% of care leaders stated that their care setting felt like a positive place to be.**

Participants also engaged with the 'Caring Conversations' Framework (Dewar and Nolan 2013). It provides a method for enhancing a facilitative style of communication, supporting participants to ask effective questions to teams to: Be courageous, celebrate, connect emotionally, be curious, collaborate, consider other perspectives, and compromise. Participants became increasingly comfortable in using the open questioning/reflexive questioning approach in their workplace and were quickly encouraged by the positive outcomes they achieved. It improved communication between staff and receivers of care, by encouraging them to have a 'voice'. It also enhanced accountability and delegation.

> "*I really like throwing the questions back to staff, for example 'What do you think?' 'What have you already thought of?' 'What have you tried?' As quite often people have the answers." (PSDP facilitator notes: care leader quotation)*

> "*I have worked with staff and explained how to ask questions differently, to ask open questions. Asking residents open questions brings about a completely different conversation*." (PSDP facilitator notes: care leader quotation)

These questions can also be used to gather insights from team members and others about what is working well in the care service – equipping leaders for evidence for use in their inspections.

The approaches helped participants to respond better to team members and to recognise the value that they offer to their service. For instance, one participant noticed that, while some staff work quicker than another, she became aware of the skills that the slower staff member brings and how that too might add quality to a resident's life.

Additionally, some recognised the value in offering more opportunities for professional development and investing in staff through apprenticeships. They described that they were better able to encourage staff retention through staff appraisals and reward schemes. One manager renamed regular meetings with staff 'meaningful conversations' instead of 'supervisions', and generally the quality of their team and individual meetings improved significantly.

Some care leaders wanted to show their appreciation to their care teams through gift giving.

> *"I've bought a big bunch of flowers for each domestic."* (PSDP facilitator notes: care leader quotation)

> *"As Easter is a new beginning, I am giving all my staff a present of daffodils and Creme Eggs."* (PSDP facilitator notes: care leader quotation)

As the programme participants became more comfortable and confident in themselves, there was a noticeable and positive impact on how they carried out different aspects of their leadership role. In the PSDP Endings Survey, **89% care leaders reported that their confidence in their staff's ability to take the initiative has increased (a little or a lot).**

> "*I now have stronger relationships with staff and more understanding*." (PSDP facilitator notes: care leader quotation)

Supporting 'overseas workers'

Care leaders mentioned the importance of supporting and integrating **overseas workers** who have recently joined care teams. The support that was required varied from helping staff to find accommodation, to help with language or understanding cultural and social practices. While acknowledging the value of having these additional staff members, participants found that it could change team dynamics and that there were sometimes challenges with integration, conflict between workers, and a desire amongst overseas workers to work in health services once they had gained their Personal Identification Number (PIN). Care leaders reported,

> *"Some of our staff have reported that they don't feel safe working with overseas workers if they are unable to understand the English language, especially when it comes to medication or accessing emergency services."* (PSDP facilitator notes: care leader quotation)

> "*We are struggling now with so many staff from overseas. They are living together and working together so keep falling out! They will only be with us until they get their PIN, so they don't have as much motivation to get to know the residents or to fit in to the home."* (PSDP facilitator notes: care leader quotation)

The chance to discuss these challenges on the programme gave participants the knowledge they were "not alone" and that they could raise difficulties and speak about these pressures without feeling judged. Care leaders identified the need to recruit staff with the right skills, acknowledged the additional work required in recruiting from overseas but were also encouraged to consider the benefits of doing so. They were encouraged to recognise that, through looking after and valuing their overseas staff members, this could support the workforce development, create a future supply chain of staffing, foster good levels of staff retention, support and celebrate diversity in care, and generally enrich the care service.

Overall, care leaders spoke about positively changing their management behaviours to be more effective and learning new ways of thinking about situations. For example, the programme allowed for

less experienced leaders to learn from those with more experience, but also the more experienced care leaders used the sessions as time to think and reflect on their own practice and their previous established ways of doing things. They found it useful to learn from the "newer, fresher minds" and learnt to appreciate different approaches. The PSDP Endings Survey, showed that **78% of care leaders reported an increase in staff morale over the last 12 months and 96% stated that they had seen an increase in the quality of engagement with their staff over that period**. **34% of care leaders had found that sickness levels had decreased** (50% reported that they had stayed the same). Results from the Assessment of Work Environment Schedule (AWES) in the Endings Survey showed that **88% of care leaders reported that there was now a 'positive feeling of morale amongst staff'**.

Performance management, delegation and boundary setting

Some described challenging relationships with key staff. Pressure points included resistance to change, unhelpful behaviours and attitude. One care leader said,

> "*Really listening and asking open caring questions is hard to do when you are trying to bring around any small change. I have some positive staff, but others aren't*." (PSDP facilitator notes: care leader quotation)

Less suitable staff were sometimes retained due to the demands of the work - limiting the time for difficult conversations, as well as anxieties about whether they could recruit and retain new people if they were to be asked to leave. They noted that taking disciplinary action would likely damage a long-term relationship with a member of staff and create disappointment and implications for the future. One participant talked about a staff member who was not meeting job objectives, despite all the time, energy and resources that had been given to that person. They now recognised that things were not working and had to change. There was a sense of exhaustion and a feeling of being "back to square one". Performance management, particularly in the context of staff shortages, meant that there could be a tendency to overlook shortfalls in performance. For example, one care leader spoke of the challenge of managing a carer who is habitually late but gives very good quality care.

Others talked about the experience of witnessing poor practice and wanting to raise concerns, but feeling unsure as to how best to address the situation, especially if there were complicated team dynamics. There was a balance to be reached in building and maintaining staff relationships.

> "*Managers are getting grief from staff over things they can't control*." (PSDP facilitator notes: care leader quotation)

Some care leaders had risen 'through the ranks' so appreciated the effort and pressures on frontline staff, but then found it difficult to exercise authority. They had to find the right balance in communication - being assertive rather than authoritarian or compliant.

> "*I am learning that it is more important to be respected than liked, but it is hard if you have been promoted from within the organisation*." (PSDP facilitator notes: care leader quotation)

Some described the "loneliness of management", particularly when taking disciplinary action with people they knew well. Participants talked of the challenge of members of the same family working in a team, how family problems 'from home' could spill out in the care home team, and the difficulties of managing this.

Another reported challenge was operating within employment legislation. For example, one manager talked about dealing with an older member of staff who was not meeting job role expectations and a feeling of "treading a fine line" with the age discrimination legislation. Another said a member of staff had mental health challenges but, although this awareness informed how the manager dealt with

that staff member, the manager did not think the work issue was linked to poor mental health.

Solutions

The programme supported care leaders to set appropriate boundaries in their role. Care leaders felt that they had all learnt from each other and had been able to take ideas away to implement, such as how to handle challenging conversations and conflict. They learnt which situations were within their control and which were out of their control. They learnt to help facilitate communication within the care team, avoiding being drawn into a "rescuer" mode when staff were in conflict.

In order for good boundaries to be put in place, care leaders first had to have belief in themselves that it was OK to do this. Then they were able to be courageous and put this into practice in their own care service. Leaders recognised that a better understanding and implementation of boundaries can influence the culture of a service. Care leaders explored ways to encourage staff to take responsibility within boundaries, supporting them to make better judgements, for example around contacting them out of hours.

> "*I've been pushing back when staff come to me instead of their line manager, and it's working*." (PSDP facilitator notes: care leader quotation)

> "*Boundaries with staff who lack confidence and impinge on my work/life balance. I'm often bothered with things that care managers should be able to manage. But they lack confidence*." (PSDP facilitator notes: care leader quotation)

This new or enhanced belief in themselves and their competency empowered them to undertake their leadership role in a stronger way and with greater clarity.

> "*I now have the confidence to tackle difficult conversations with staff."* (PSDP facilitator notes: care leader quotation)

Care leaders found it valuable to learn the art of delegation and the creation of effective structures within their organisation. Participants shared how they had improved their delegation skills, which had led to their staff feeling empowered and taking more ownership of their actions and decision making. This change had also allowed participants to have more time to focus on leadership tasks.

> "*Before My Home Life I used to do all things, Now I am starting to delegate more of my work to other members of the management team.*" (PSDP facilitator notes: care leader quotation)

> "*Reflecting on my position in the home, I have made changes that allow me to delegate more, to work better as a team rather than feeling I have to be in control of everything!''* (PSDP facilitator notes: care leader quotation)

Through engaging with the programme, participants were able to appreciate that being an approachable, supportive and 'good' manager does not mean that you have to be available to everyone all of the time. They recognised that establishing boundaries and being a very supportive manager were not mutually exclusive. It was important that they led their staff teams more effectively, by being clear about the standards of care they expected, setting boundaries and delegating more.

> "*I'm managing my own space and time and keeping my boundaries*." (PSDP facilitator notes: care leader quotation)

"*I am proud of myself for drawing boundaries with staff issues about their personal squabbles and putting it put it back to them to sort out*." (PSDP facilitator notes: care leader quotation)

Spotlight 2: Overseas workers

In summer 2023, My Home Life England worked with the care sector to create a workshop designed to support leaders to consider promising approaches to supporting overseas workers, recognising the benefits of bringing diverse cultures into their service.

4. Relationships with external individuals and agencies and within the wider provider group

Local health and care agencies

Participants from different care settings each had different experiences of working within the wider health and social care system, some positive, and others who could see the opportunity for things to be done differently. Challenges included building relationships with external professionals, particularly with the NHS and Local Authority feeling "very distant". Another challenge was often feeling undervalued, underappreciated and underpaid for the level of care that they were expected to provide. They wanted a greater appreciation and understanding of what they do and to be praised for their work by the wider health and social care network. Some mentioned the need for better incentives and rewards, especially from government.

Care leaders reported frustrations in communicating their situation and requirements to external stakeholders. Leaders sometimes lacked the confidence to be professionally assertive with people they considered more senior than themselves (owners, providers, medical professionals and other external stakeholders). Leaders reported that the high expectations from external professionals was a source of considerable pressure, and a reoccurring theme was the expectation placed on leaders to be immediately accessible to any demands. Care leaders said:

> "*They (external agencies) think we can drop everything for them like we are waiting for their phone call. They should come and spend a day in a care home, so they understand how many things we are juggling!*" (PSDP facilitator notes: care leader quotation)

> "*It was so difficult to get support during COVID but now they (external professionals) are all over us wanting charts, bloods, paperwork, paperwork. There is so much pressure*." (PSDP facilitator notes: care leader quotation)

Sometimes leaders felt that there was a discrepancy in terms of the services provided to care settings, with some services in certain areas having more access than services in other areas. In terms of the challenges of working effectively with others, often mentioned were social work teams, health teams, hospital teams, assessment teams and safeguarding teams.

Some leaders reported that they felt a great deal of pressure to admit people with high dependency needs from hospitals, despite not having the capacity or necessarily the expertise to manage these care needs effectively. They spoke of unsuitable referrals or discharges from hospital into their care setting, yet also a lack of support for managing service users with such complex health needs, particularly around mental health. One programme participant stated that:

> "*New residents are being discharged to us from hospital with out-dated notes or very little notes at all. We want to be prepared when we take an admission, making sure we have the right staffing ratio and support for example, but we are often taken for granted like 'it's over to you now'!*" (PSDP facilitator notes: care leader quotation)

Programme participants discussed their relationship with CQC, as well as their confidence in advance of and during CQC inspections. Many leaders described the stress of impending inspections and waiting to hear final outcomes, but also supported and shared with each other some practical tips and experience. Some leaders found that adhering to all the rules and regulations, and adhering to the legislative frameworks in social care, was very difficult and "potentially career-threatening" (PSDP facilitator notes).

Post-COVID, some care leaders were particularly concerned that not every detail was in place, because they were still dealing with 'endless COVID-19 related matters'. With COVID -19 outbreaks, absences in the care teams, and a backlog of admin, it was felt that "silly things got missed". If the rating was not as hoped, there was inevitably an impact on manager and staff morale.

Inspections

Leaders considered how they could move towards a more collaborative approach with the CQC, and how to prepare care teams for inspections. They wanted to impact positively on any future CQC inspections and reduce anxiety in the care teams about future inspections. MHLE facilitators provided examples of how staff meetings could be designed to encourage care teams to identify real examples of positive practice in their care setting for each of the five inspection domains (SCREW- Safe, Caring, Responsive, Effective and Well-led). Care leaders reflected on how they might approach inspections:

> "*When the inspector arrives, ensure you are the one that tells them all the bad things and what is not working, then what you are doing about it. No surprises equals well managed*." (PSDP facilitator notes: care leader quotation)

> "*In thinking differently about CQC and seeing it as showcasing our good work, I feel more confident and less stressed about an inspection*." (PSDP facilitator notes: care leader quotation)

As a result of participating in the programme, care leaders talked about their development in leadership skills, and growth in confidence in responding to external agencies, such as asking for what they needed, particularly in their approach to an inspection.

Some leaders used the programme to talk about challenges they faced within the wider organisation in which they managed a service. Some reported feeling unsettled and sometimes confused by the differing views and expectations of senior management when presented with new ideas.

> *"You feel like you have a grip on things and then a new (senior) manager will arrive and change things again. They forget we know our service and our residents better than anyone*." (PSDP facilitator notes: care leader quotation)

Some care leaders described that, before the programme, they found it difficult to be assertive with senior leaders or owners of the home about their own needs, their staff's needs and the needs of the people living in the care setting. They found support in the facilitated groups on the programme, to develop confidence and the language to speak to senior colleagues.

> "*I found my courage to be a little more direct with the home manager after the first ALS. I used the [Caring Conversations Framework] and took my courage and called the manager and said we had to discuss quality monitoring and what we are doing about it.*" (PSDP facilitator notes: care leader quotation)

Communicating with relatives

One consistent challenge reported by care leaders was the notable difficulty they had in communicating effectively with relatives. There were lots of discussions about how they could better integrate family involvement. Care leaders on the PSDP spoke about how they now had stronger relationships with families, because they had developed their listening skills and made time for them, which had a knock-on effect on building trust and engagement. They also spoke about having more confidence in dealing with challenging relatives. One manager was quoted as saying:

> *"As long as relatives are 70% reassured, then that is OK – I get 70% better sleep and feel 70% better*." (PSDP facilitator notes: care leader quotation)

Care leaders recognise the value of having a culture of transparency in the care setting. They welcome the idea of holding events where families and friends could join in and encouraged families to just turn up. One care leader said:

> *"If you support the family and encourage them to turn up at the busiest time in the home, that is the best time for them to see how the home really is."* (PSDP facilitator notes: care leader quotation)

Keeping in regular contact with relatives was important and COVID-19 saw changes in the way this was facilitated. Virtual meetings were a good way of maintaining connections, particularly for geographically dispersed families.

> "*Keeping in touch remotely with relatives, particularly those far away or who cannot visit, has been something we still are encouraging even though lockdowns are lifted*." (PSDP facilitator notes: care leader quotation)

Other effective communication methods included monthly newsletters and social media posts, which included celebrations and memorial posts. These shared news from the care setting but also stimulated interest and engagement.

The PSDP Endings Survey reflected this positive communication. **82% of care leaders said that the quality of interaction between staff and relatives, partners and friends had improved over the last 12 months, and 91% said that there was an increase in the overall feeling of being a positive community for people using this service, such as relatives, partners, friends and staff.**

Spotlight 3: Supporting integration

A key aspect of My Home Life England's work relates to facilitating stronger, more trusting relationships with the wider health and social care system.

In Essex, MHLE supported positive conversations between care homes and their local health partners in relation to the roll-out of the Enhanced Health in Care Homes Framework.

In Sefton, a summit was organised that helped bring stakeholders together to explore how they could work better with one another. More information on the summit can be found here.

5. Driving forward innovation

Care homes are under enormous pressure from multiple directions, including a demand to keep up with new practices, new technology, and to consider new ways of operating. They are juggling immediate priorities, whilst also trying to create the time for change and engagement with innovation. There are frequent legislation changes and a need to respond to the subsequent guidance. Care leaders were keen to see change, development, progress and innovation in their homes, but also recognised that constant change can lead to care teams feeling overwhelmed, exhausted, undermined and unsettled. They reflected "Am I going too fast?" and also considered the impact the fast pace and need for constant change was having on their own wellbeing. Another care leader recognised the importance of change:

> "I like change, it's for the better. I'm excited by change and if you're excited the team will see it." (PSDP facilitator notes: care leader quotation)

One key area of innovation related to the introduction of new technology into the care setting. Although care leaders recognised the potential value of new technology, they also recognised that it took resources to implement, required training the care team to develop competency, has cost implications, and that they needed the care setting owners to buy into the benefits of tech adoption.

Through the "Technology is your Friend" workshops, care leaders gained the confidence to use new tools and develop skills and strategies (such as creating digital champion roles) to aid them in addressing these challenges in their care setting. Technology was identified as a potential enabler, with care leaders and community and primary care practitioners working together on how technology can work to support quality for the individual person, team and wider system.

Despite the pressure, participants of the programme were always keen to learn from one another and to implement new ideas. Here are some of them:

In some of the programmes, an additional session(s) was delivered to support participants to take forward quality improvement projects. Participants focused on different topics, including increased hydration, oral care, end of life care and encouraging newly recruited staff to voice their ideas. Some of their innovations are shared below:

- Introducing a hydration station from which people can drink, resulting in UTI (urinary tract infections) levels decreasing
- Introducing fluid balance charts for people that needed specific encouragement with fluids, with positive feedback from staff saying how this makes life a little easier for them
- Enhancing communication among teams when working with someone at end of life
- Enabling families to be more engaged in end of life care planning
- Creating a file named "My resident is unwell", so that paperwork was near-to-hand with laminated GP contact details in order to respond swiftly if the person's health worsened
- Enabling families to stay in the care setting if their loved one is receiving end of life care, and providing "swan boxes" or "comfort boxes", which included essential toiletries, water, snacks and puzzle books, if they needed to stay at short notice
- Developing creative activities and opportunities for social engagement, through getting to know each individual living in the care setting – creating "little worlds" for each person
- Delivering a 'resident of the day' programme - getting to know people's stories and what matters to them.
- Creating informal spaces for staff to relax with people living in the home
- Increasing the number of outings and creating connections between the home and the outside world

- Identifying staff strengths in helping develop relationships with the outside community, including pen pals with the local schools
- Engaging a local high school specialising in performing arts to put on a show at a home. This resulted in students coming back on a weekly basis to give singing concerts and ballroom dancing shows. This contributes to creating community and promoting positive culture.
- Recruiting an activities coordinator with a specific brief to provide person-centred activities tailored to the individual, rather than group sessions. The care leader said, *"Not everyone wants to do things in a group just because they're living in a care home."*
- One leader had recently held 121 conversations with everyone living in the home to understand the emotional and personal aspects of their journey into the home. Each person's story is now shared with those who care for them, helping to create stronger relationships and links with their previous lives.
- Another leader had created a workspace in the home for a gentleman living with dementia who had previously held a senior role in social care and believed that he was still at work. She invited his ideas and expertise, and he helped create a poster which is on display in the home and is regularly used as a communication tool. This contributes to maintaining his identity and sense of purpose.

The PSDP Endings Survey reflected some of the improvements in the quality of care that care leaders had noticed over the last 12 months. 42% noticed a decrease in unplanned hospital admissions**. 87% reported that they found the quality of experience for people using the service had increased, and 83% felt that the quality of interaction between staff and the people they support had increased. 96% of care leaders felt that the quality of experience for people using their service was positive.**

6. Maintaining personal resilience and growing professional confidence

Care leaders hold roles which are characterised by constant change and adaptation. They have a role in balancing commercial interests whilst maintaining quality of delivery standards. Some of the organisational challenges faced by care leaders included changes to the service, such as renovations and construction work, as well as changes in ownership or even closure. Care leaders were often overburdened by administrative tasks and by striving to ensure consistency in the way these duties were carried out across the care team.

The challenges that care leaders faced on an individual level included managing their workload, lack of confidence, self-awareness, resilience, and a lack of self-prioritisation. One facilitator wrote about the participants on their programme:

> "*Most were exhausted, some quite numb at the beginning of the programme*." (Pioneers Programme: Facilitator notes)

Working in the care sector is incredibly complex and challenging, yet staff and care leaders often feel undervalued by society, and even by the wider health and social care system. The expertise and knowledge of people working in care homes and other care settings often goes unrecognised.

> "*It's still hard for us to be respected by health professionals, we know the people best, but our opinion isn't respected*." (PSDP facilitator notes: care leader quotation)

This lack of recognition and poor perception of social care had a negative impact upon quality staff recruitment, retention, and staff morale.

Many of the participants reported feeling overwhelmed by their workload at some point. Reports of staff shortages, inadequate resources, high levels of administration, compliance requirements, frustration with technology, combined with a personal sense of duty, meant that 60+ hour weeks were not unusual. There was a general feeling that there were not enough hours in the day, or days in the week, to do their jobs properly. It was therefore important that care leaders learnt to look after their own wellbeing before they risked 'burnout'. Care leaders often reported that they were "running on empty" and that there was an expectation that "every box was ticked". They had to learn to tolerate just being 'good enough'. Participants' resilience levels were challenged by multiple factors including preventable deaths, dealing with their own and others' strong emotions, the length of hours worked, restrictions on usual ways to relax and restore, and the stress of decision-making in a volatile and uncertain environment. One of the care leaders, despite having a well-run home, reported waking at night with their "stomach in a knot". Other care leaders stated:

> "*I've started to hate my job*." (PSDP facilitator notes: care leader quotation)

> "*I feel physically sick when I think I haven't done something*." (PSDP facilitator notes: care leader quotation)

> "*I'm drowning and don't know how to get up again*." (PSDP facilitator notes: care leader quotation)

Several care leaders shared how their workload affected their sleep, level of self-care and personal relationships. More than one talked about family sacrifices made for the job. Often they worked long days and did not always take annual leave or breaks. Care leaders often prioritised others over themselves, did not practice regular self-care and perhaps lacked the self- awareness of the importance of doing so. It was important for care leaders to recognise how personal issues could

impact on the success of meeting their work goals. Through the programme, they were able to appreciate that practising self-care is not selfish but will actually also benefit everyone around them and contribute towards better outcomes for people they support.

> "*I have realised that the care home is not my whole life, but I still feel guilty about not working or being readily available*." (PSDP facilitator notes: care leader quotation)

> "*I hadn't realised how much I did. Now I do*." (PSDP facilitator notes: care leader quotation)

Improving self-care

The programme held care leaders to account for the little things that they said they would do to reduce their stress (such as, turn off the phone at bedtime, to eat lunch or not to do emails after at 7pm). In this supportive atmosphere, participants could reflect on why they had not felt able to care for themselves, even when they had identified it was important. The programme also helped care leaders to explore the psychological process of "letting go", which is about mentally releasing something, which for care leaders might be about 'control' or old patterns of thinking, and exploring what happens if you do let go - Is there anything left of you? Who are you when the role is taken away?

As participants became more comfortable and confident in themselves, there was a noticeable and positive impact on how they carried out different aspects of their leadership role. One of the most powerful benefits from care leaders engaging with the programme was acknowledging the importance of prioritising themselves and practising self-care, and that it was OK to acknowledge when they weren't feeling able to fulfil the expectations of being the 'strong leader'. The PSDP Endings Survey results showed that care leaders who completed the programme reported that, over the last 12 months, **56% of care leaders saw a decrease in their stress levels**. Care leaders described taking more care of themselves since taking part in the programme; leaving work on time (if not every day, at least some days a week), not working in the evenings, sleeping better, putting boundaries around the hours to spend more time with children and families, booking holidays in advance, and recognising the value of recovery time in order to build resilience. Care leaders shared through the action learning groups what "simple pleasures" they were trying to incorporate into their everyday lives. These included:

> "*I need to trust more and go home earlier … have more of a home life. Otherwise, how will staff develop and me start to trust them?*" (PSDP facilitator notes: care leader quotation)

> "*I don't forget about myself. I find some 'me time'. I have a better work-life balance*." (PSDP facilitator notes: care leader quotation)

> "*I take time for me. Taking time for yourself is not a negative and gives you far more than you previously imagined*." (PSDP facilitator notes: care leader quotation)

> "*I had been juggling cards - juggling home and work. My path is more beautiful now, I lead others towards it, and I go more with the flow*." (PSDP facilitator notes: care leader quotation)

> "*This programme has really given us permission to look after ourselves and do self-care*." (PSDP facilitator notes: care leader quotation)

As a result of the trusting relationships that were built during the course of the PSDP, participants said they could be more honest about their feelings. They spoke about how these impacted on them in a personal way. The programme gave them the opportunity to reflect, develop confidence and

belief in themselves and their abilities as a leader. They were able to receive helpful, constructive, and non-judgemental feedback from colleagues, which felt supportive and reduced feelings of isolation. Care leaders fed back that:

> "*We all have struggles and it's good to know there are others going through similar things. This is so supportive. There's hope out there*." (PSDP facilitator notes: care leader quotation)

> "*I used to feel lonely. Now I know that while the role can be isolating, other managers feel that too and there is a network for support*." (PSDP facilitator notes: care leader quotation)

> "*I learnt a lot from other colleagues; networking is very important, sharing your feelings, you are not alone*." (Pioneers Programme Facilitator notes: care leader quotation)

> "*One of the biggest things you get from the programme is the support of knowing you are not alone. Before I joined the programme I felt like I was playing football and everyone else was playing rugby*." (PSDP facilitator notes: care leader quotation)

The results of the PSDP Endings Survey showed really positive results from care leaders, with **75% seeing an increase in their own quality of life, 85% seeing in increase in job satisfaction, and 74% reporting an increase in enthusiasm for working in care settings over the last 12 months**.

Professional Confidence

Care leaders saw a growth in their confidence as a result of the PSDP and were able to demonstrate this in their roles. Two leaders stated:

> "*When I first started the programme, I felt a little out of my depth but now I have grown more as a person, and I push myself more. I delegate more now at work. I have confidence to do all the staff supervisions, I ask open questions with staff, I challenge professionals and I am very clear about my duty of care to the people we support*." (PSDP facilitator notes: care leader quotation)

> "*The programme has enabled me to believe that I have something worthwhile to say – that could include moving goalposts, challenging people or sharing ideas*." (PSDP facilitator notes: care leader quotation)

Some of the care leaders on the programme said that they had been contemplating leaving social care prior to commencing the programme, primarily as a result of feeling undervalued. This increased confidence meant that some care leaders felt that they could now apply successfully for promotions, or jobs with other providers. For others, the increased confidence encouraged them to stay in their current post and know that they could fulfil that role successfully.

> "*I think I was bluffing and just getting by…. now I have confidence in my own decision making*." (PSDP facilitator notes: care leader quotation)

> "*I used to wonder if I was doing a good job as a manager. Now I feel confident that I am a good manager and look after the needs of my staff and residents as well*." (PSDP facilitator notes: care leader quotation)

For some leaders the overall impact of the programme had positively influenced their capacity to stay working within social care.

> "*Before joining the programme, I was very closed off but now I have a different perspective. I*

was looking for another job and a way out but I'm not now. The support from colleagues has helped me turn things around. I have changed my mind-set. I think I can be in control." (PSDP facilitator notes: care leader quotation)

"*Before joining the programme, I was really wavering about social care and whether I would leave. Joining the programme showed me that people valued what I had to offer and that I was an OK manager. Without the course I would have left social care*." (PSDP facilitator notes: care leader quotation)

The results from the PSDP Endings Survey showed that **91% of participants said that they had an increased sense of personal achievement from work and 80% reported that they had an increased feeling of being valued. Significantly, 91% said that over the last 12 months that their confidence as a professional had increased.**

7. Overall outcomes of the programme

The Professional Support and Development Programme introduced a variety of tools, skills and strategies which the care leaders could implement in their service, with the aim that this in turn would impact upon care teams, those who they cared for and their loved ones, as well as the overall culture of the care service.

In addition to the outcomes around resilience and professional confidence mentioned earlier, care leaders reported in the qualitative responses for the PSDP Endings Survey the things that they had learnt about themselves. The dominant themes emerging from this data was that care leaders felt that they:

- Had improved and positive communication
- Had developed better listening skills
- Felt more positive
- Had learnt how to value others better
- Had developed strong leadership and management skills
- Had developed a more open form of communication
- Knew how to delegate better
- Had learnt how to have adult-to-adult conversations.

The Endings Survey also showed that:

- **86% of care leaders found an increased ability to make sufficient time to support staff.**
- **98% of care leaders reported that the quality of management and leadership that they were able to offer had increased.**
- **96% care leaders found that their leadership and communication skills had increased**.

The programme offered a safe and confidential space, and an open, invitational and non-judgemental environment which celebrated achievements and supported risk taking. This gave space and time to reflect and assess old behaviours, process new ideas and try different ones. Feedback on the course included:

> "*I felt it has been a safe environment for me to express myself freely. I also got the feeling that people have been listening with an open mind and non-judgemental attitude*". (Pioneers Programme Facilitator notes: care leader quotation)

Care leaders considered how they implemented the skills they had learnt on the PSDP into their everyday work practice:

> "*I have used the tools and do reflective sessions with senior staff each week, encourage them to spend time reflecting on themselves and to bring this to supervision. I used the MHL tools on the seniors away day, the cards, and they get staff to open up. It was a disjointed team*." (PSDP facilitator notes: care leader quotation)

> "*I will plan for my supervisions, try not to speak without thinking off the cuff. To break the brick walls that may have grown up between me and staff but to do this brick by brick*." (PSDP facilitator notes: care leader quotation)

Ripple effect on teams and service-users

Care leaders often valued the opportunity within the programme to take time to listen and to pause, which enhanced their communication and active listening skills in the workplace. They noticed that this new approach had a knock-on effect on service-users. Care leaders were now modelling relationship-

centred care with staff, who therefore felt more listened to and more supported. In turn this created a stronger culture of engagement between the team and service users. Care leaders reported:

> "*I learned that we should always be considerate of the feelings of others. Also, listening to the people around us makes a big difference and it makes them feel valued*." (PSDP Endings questionnaire response)

> "*I am learning to listen to what people say, I learned from this that we need to share, to listen and to see what happens, not always jump in quickly*." (PSDP facilitator notes: care leader quotation)

> "*The thing that has stood out for me is that the group has taught me how to listen properly. Before I kept butting in when someone was speaking, now I am more self-aware and found I can be a good listener*." (PSDP facilitator notes: care leader quotation)

In the AWES section of the PSDP Endings Survey, the results showed that **81% of care leaders - when thinking about their place of work – felt valued for the work that they do. 88% felt that they could try out new ideas without criticism, 85% felt that they were encouraged to develop their skills, and 91% of care leaders felt that they currently got a positive sense of personal achievement from their work**.

Conclusion

Care leaders do an incredibly important, complex, and socially significant job, which they feel is often undervalued. The My Home life England Professional Support and Development Programme offered an opportunity for care leaders to come together in a safe space to share expertise and learning, collaborate, support one another, as well as showcase their good practice.

Care leaders on these MHLE programmes benefitted from the opportunity to discuss their own feelings about, and experiences of, change in their care setting. This positively impacted on their thinking about how to lead on change and how to engage everyone in the process. Moving forward, it helped them to think about how to introduce cultural or procedural change and innovation, and how to improve the practices in their care setting.

Participants noted that, as a result of attending the programme, there was an indirect effect on those they cared for, and the wider care team. They described that, through now modelling a relationship-centred care approach with care teams, their staff felt listened to and felt more supported. In turn, this created a stronger culture of engagement between the team and service users. This new approach also encouraged care leaders to become more professionally confident in engaging with stakeholders in the wider health and social care system. By participating in My Home Life England programmes, care leaders were able to share their challenges, feel supported and, ultimately, learn a variety of tools, skills and strategies that impacted them as professionals, but had a ripple effect in improving the overall communication and culture in their care settings.

Recommendations

1) Workforce recruitment and morale

The long-term effects of the pandemic are still present for many within the care sector, with a knock-on effect on recruitment and long-term staff morale. This lack of value is reflected in the high turnover of staff in the care sector; according to the recent Skills for Care "State of the Adult Social Care and Workforce report", 390,00 people left their roles last year with around a third leaving social care completely.

a. As acknowledged in the DHSC paper "Next steps to put People at the Heart of Care", the social care workforce needs to be recognised as a professional sector, with continued efforts to profile the sector to regain public trust and to attract future workforce.
b. Initiatives that support and develop care workforce are now emerging but need to be aligned. The workforce strategy needs to be bold, courageous but also realistic and achievable. As the 'Messenger Report' notes: "A well led motivated , collaborative, inclusive and resilient workforce is the key to better care outcomes and investment in people must sit alongside other operational and political priorities".
c. The language adopted within care services particularly in relation to how it describes work-roles needs to be explored, to professionalise, add value and move away from the phrase: "*I am just a carer*".
d. Through leadership development programmes, the sector has the potential to buck the trend; Skills for Care note that employers with a turnover of less than 10% said their success in relation to recruitment and retention was founded on the following four areas: investing in learning and development, embedding the values of the organisation, celebrating the achievements of the organisation, and involving colleagues in decision making.

2) Acknowledgement and utilisation of the skills and professionalism demonstrated within many care services

a. There is even greater need for the wider health and social care system to recognise the expertise of the sector, which was particularly demonstrated during the pandemic, and to engage with such services as equal trusted partners with an important perspective to share on the solutions to the problems within the system.
b. Greater access for care practitioners at all levels to receive regular professional development and independent supervision should be given the highest priority, to help them to feel valued, process the emotional content of their complex work and to support quality. While CQC requires a well led service to create "an inclusive and positive culture of learning and improvement", emotional well-being needs particular emphasis.
c. Vacancies in social care have fallen over the last twelve months because of successful overseas recruitment programmes. Greater attention should be given to helping these key workers be recognised for the skills and strengths that they contribute, which includes the culture that they bring with them.

3) Care service overload and burnout

The report indicates that care leaders and their teams remain very challenged in terms of the complexity of their roles and the lack of support they receive.
Overall, many of the above recommendations rely heavily on the time, resource and resilience of care service managers/ leaders. There is often reliance on single individual managers to cover a huge range of roles, which has an impact on their resilience, on their engagement with external and internal issues and their ability to attend sessions that support their own personal and professional resilience.

"Loneliness of management" was described. While there is no short-term solution to this, the need for resources and capacity to develop stronger dispersed leadership within teams must clearly be a medium term goal across the care sector. Demands/ requests of care services from external agencies need to be reasonable and proportionate, recognising what might be a priority to them may not be a priority for the care service. Insights from NHS England on what was achieved when the different parts of the system worked together during the pandemic, need to be used as the basis for making effective integration a reality.

4) Care service workload

The care provided within social care has changed beyond recognition since the MHLE programme began. This requires new skills and approaches to ensure that managers are enabled to proactively engage with multiple stakeholders, apply ever-more strategic advocacy techniques and deal with pressures around rapid hospital discharge, and new technology enabled approaches to health and care, such as the roll out of virtual wards. This should continue to be at the forefront of development of the social care workforce.

Appendices

Perception of Workplace Change Schedule (POWCS)		Percentage / Number
During the last 12 months the sense of personal achievement I get from work has	Increased a lot	62.75% 64
	Stayed about the same	5.88% 6
	Decreased a little	0.98% 1
	Increased a little	28.43% 29
	Decreased a lot	1.96% 2
		N.102
During the last 12 months the levels of stress I feel has	Increased a lot	11.76% 12
	Increased a little	12.75% 13
	Stayed about the same	19.61% 20
	Decreased a little	34.31% 35
	Decreased a lot	21.57% 22
		N.102
During the last 12 months my feeling of being valued has	Increased a lot	37.25% 38
	Increased a little	43.14% 44
	Stayed about the same	15.69% 16
	Decreased a little	1.96% 2
	Decreased a lot	1.96% 2
		N.102
During the last 12 months staff morale has	Increased a lot	35.29% 36
	Increased a little	43.14% 44
	Stayed about the same	13.73% 14
	Decreased a little	4.90% 5
	Decreased a lot	2.94% 3
		N.102
During the last 12 months the quality of management and leadership I am able to offer has	Increased a lot	66.34% 67
	Increased a little	31.68% 32
	Stayed about the same	0.99% 1
	Decreased a little	0.99% 1
	Decreased a lot	0.00% 0
		N.101
During the last 12 months my job satisfaction has	Increased a lot	46.00% 46
	Increased a little	39.00% 39
	Stayed about the same	7.00% 7
	Decreased a little	6.00% 6
	Decreased a lot	2.00% 2
		N.100
During the last 12 months the quality of my engagement with staff has	Increased a lot	70.00% 70
	Increased a little	26.00% 26
	Stayed about the same	3.00% 3
	Decreased a little	1.00% 1
	Decreased a lot	0.00% 0
		N.100
During the last 12 months my understanding of how to improve the culture of care has	Increased a lot	69.00% 69
	Increased a little	30.00% 30
	Stayed about the same	1.00% 1
	Decreased a little	0.00% 0
	Decreased a lot	0.00% 0
		N.100
	Increased a lot	34.00% 34
	Increased a little	29.00% 29
	Stayed about the same	30.00% 30

During the last 12 months my satisfaction with the relationship I have with my line manager/ owner has		
	Decreased a little	4.00% 4
	Decreased a lot	3.00% 3
		N.100
During the last 12 months my own quality of life has	Increased a lot	30.00% 30
	Increased a little	45.00% 45
	Stayed about the same	18.00% 18
	Decreased a little	4.00% 4
	Decreased a lot	3.00% 3
		N.100
During the last 12 months my ability to make sufficient time to support staff has	Increased a lot	44.00% 44
	Increased a little	42.00% 42
	Stayed about the same	11.00% 11
	Decreased a little	1.00% 1
	Decreased a lot	2.00% 2
		N.100
During the last 12 months the quality of experience for people using this service appears to have	Increased a lot	52.00% 52
	Increased a little	35.00% 35
	Stayed about the same	12.00% 12
	Decreased a little	1.00% 1
	Decreased a lot	0.00% 0
		N.100
During the last 12 months my leadership & communication skills have	Increased a lot	68.00% 68
	Increased a little	28.00% 28
	Stayed about the same	3.00% 3
	Decreased a little	0.00% 0
	Decreased a lot	1.00% 1
		N.100
During the last 12 months my confidence as a professional has	Increased a lot	69.00% 69
	Increased a little	22.00% 22
	Stayed about the same	7.00% 7
	Decreased a little	1.00% 1
	Decreased a lot	1.00% 1
		N.100
During the last 12 months my enthusiasm for working in care settings has	Increased a lot	49.48% 48
	Increased a little	24.74% 24
	Stayed about the same	20.62% 20
	Decreased a little	3.09% 3
	Decreased a lot	2.06% 2
		N.97
During the last 12 months the quality of interaction between staff and the people we support has	Increased a lot	45.45% 45
	Increased a little	37.37% 37
	Stayed about the same	16.16% 16
	Decreased a little	1.01% 1
	Decreased a lot	0.00% 0
		N.99
	Increased a lot	44.44% 44
	Increased a little	37.37% 37
	Stayed about the same	17.17% 17
	Decreased a little	1.01% 1

During the last 12 months the quality of interaction between staff and relatives, partners, friends has	Decreased a lot	0.00% 0
		N.99
During the last 12 months my confidence in staff's ability to take initiative has	Increased a lot	35.35% 35
	Increased a little	53.54% 53
	Stayed about the same	10.10% 10
	Decreased a little	1.01% 1
	Decreased a lot	0.00% 0
		N.99
During the last 12 months staff sickness levels have	Increased a lot	6.06% 6
	Increased a little	10.10% 10
	Stayed about the same	49.49% 49
	Decreased a little	28.28% 28
	Decreased a lot	6.06% 6
		N.99
During the last 12 months staff retention levels have	Increased a lot	14.14% 14
	Increased a little	25.25% 25
	Stayed about the same	38.38% 38
	Decreased a little	17.17% 17
	Decreased a lot	5.05% 5
		N. 99
During the last 12 months the overall level of quality of practice in this care setting has	Increased a lot	50.00% 49
	Increased a little	38.78% 38
	Stayed about the same	9.18% 9
	Decreased a little	2.04% 2
	Decreased a lot	0.00% 0
		N. 98
During the last 12 months my overall feeling of being a positive community for people using this service such as relatives, partners, friends and staff has	Increased a lot	57.14% 56
	Increased a little	33.67% 33
	Stayed about the same	8.16% 8
	Decreased a little	0.00% 0
	Decreased a lot	1.02% 1
		N. 98
During the last 12 months unplanned admissions to hospital appear to have	Increased a lot	2.04% 2
	Increased a little	7.14% 7
	Stayed about the same	48.98% 48
	Decreased a little	26.53% 26
	Decreased a lot	15.31% 15
		N. 98

Assessment of Work Environment Schedule (AWES)		Percentage / Number
Thinking about the place in which I work, I feel that I currently get a positive sense of personal achievement from my work.	Strongly Agree	49.48% 48
	Agree	41.24% 40
	Neither Agree or Disagree	7.22% 7
	Disagree	2.06% 2
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that I play an active role in decision making about the care of people using this service.	Strongly Agree	65.98% 64
	Agree	29.90% 29
	Neither Agree or Disagree	4.12% 4
	Disagree	0.00% 0
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that my manager provides space and time to listen to my views.	Strongly Agree	36.46% 35
	Agree	39.58% 38
	Neither Agree or Disagree	18.75% 18
	Disagree	4.17% 4
	Strongly Disagree	1.04% 1
		N. 96
Thinking about the place in which I work, I feel that I can try new ideas without criticism.	Strongly Agree	38.14% 37
	Agree	49.48% 48
	Neither Agree or Disagree	11.34% 11
	Disagree	1.03% 1
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that I am encouraged to develop my skills.	Strongly Agree	49.48% 48
	Agree	35.05% 34
	Neither Agree or Disagree	13.40% 13
	Disagree	2.06% 2
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that I typically experience high levels of stress.	Strongly Agree	17.71% 17
	Agree	34.38% 33
	Neither Agree or Disagree	26.04% 25
	Disagree	19.79% 19
	Strongly Disagree	2.08% 2
		N. 96
	Strongly Agree	26.80% 26

Thinking about the place in which I work, I feel that I am supported through difficult situations.	Agree	50.52% 49
	Neither Agree or Disagree	18.56% 18
	Disagree	1.03% 1
	Strongly Disagree	3.09% 3
		N. 97
Thinking about the place in which I work, I feel that I feel valued for the work I do.	Strongly Agree	32.99% 32
	Agree	48.45% 47
	Neither Agree or Disagree	13.40% 13
	Disagree	4.12% 4
	Strongly Disagree	1.03% 1
		N. 97
Thinking about the place in which I work, I feel that There is a positive feeling of morale among staff.	Strongly Agree	23.71% 23
	Agree	63.92% 62
	Neither Agree or Disagree	9.28% 9
	Disagree	3.09% 3
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that I have a positive relationship with my manager.	Strongly Agree	39.18% 38
	Agree	41.24% 40
	Neither Agree or Disagree	15.46% 15
	Disagree	4.12% 4
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that the quality of experience for people using this service is positive.	Strongly Agree	47.42% 46
	Agree	48.45% 47
	Neither Agree or Disagree	4.12% 4
	Disagree	0.00% 0
	Strongly Disagree	0.00% 0
		N. 97
Thinking about the place in which I work, I feel that this care setting feels like a positive place to be.	Strongly Agree	45.36% 44
	Agree	49.48% 48
	Neither Agree or Disagree	5.15% 5
	Disagree	0.00% 0
	Strongly Disagree	0.00% 0
		N. 97
	Strongly Agree	50.00% 7
	Agree	35.71% 5
	Neither Agree or Disagree	14.29% 2

Thinking about the place in which I work, I feel that this care setting feels like a positive place to be.	Disagree	0.00% 0
	Strongly Disagree	0.00% 0
		N. 14