

EAST AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD: 24 NOVEMBER 2016

MY HOME LIFE LEADERSHIP SUPPORT PROGRAMME – BRINGING OUT THE BEST IN US ALL

Report by Director of Health and Social Care

PURPOSE OF REPORT

1. To update the Integration Joint Board (IJB) on the key learning and outcomes from the My Home Life (MHL) leadership support programme that has been taking place across East Ayrshire.

BACKGROUND

2. In 2016, the MHL programme supported a range of employees from across health and social care to help develop and sustain a positive relationship-centred culture in their respective care settings. The aim was to help improve the quality of life for residents of care homes, people who require support services, carers and families as well as people who work in services.
3. The current collaborative approach to the MHL programme was developed following the success of an earlier programme supporting fourteen East Ayrshire care home managers in 2013-14.
4. The participants include a broader range of twenty-nine partner organisations involved in delivering care to support older people in East Ayrshire. They include care home managers, deputy managers, NHS psychiatric liaison services as well as internal and external care at home staff. Colleagues from the third sector and a commissioner of older peoples' services also completed the programme.
5. The aim and focus of the 2016 MHL programme was to support leaders and employees from across health and social care to create and sustain an improved culture of care delivery through the development of eight best practice themes;
 - Managing Transitions
 - Maintaining Identity
 - Creating Community
 - Sharing Decision Making
 - Improving Health and Healthcare
 - Supporting Good End of Life
 - Keeping the Workforce Fit for Purpose
 - Promoting a Positive Culture
6. Together these themes offer a vision for care settings and a framework to facilitate improvements in quality of life.

IMPACT OF MY HOME LIFE PROGRAMME

7. During the year long programme delegates experienced a real shift from 'fixing it' to working together to change things for the better, through the adoption of an appreciative and collaborative style of leadership.

Delegates have shared examples of how practice has improved over the year including:

- Exploring what matters to residents in order to enable meaningful activities and building of relationships
 - Improved shared decision making
 - Exploration of real feelings and anxieties
8. Improvements are captured in a direct quote from a Care Inspector based on their experience of visiting a number of homes and care settings during 2016. *'You can see the different approach in the care homes that have done MHL, from the front door in. There's a change of attitude and you can see it cascading down and can see a difference in the staff.'*
 9. In terms of outcomes, a more confident group of people have emerged who are able to facilitate group discussion in order to achieve a better experience for all; give meaningful feedback to others; are curious to explore others perspectives; share their own vulnerabilities and seek support to better cope with the emotional demands of leadership.
 10. Participants have encouraged a strengths based "can do" approach. This has given people confidence to explore the perspectives of others giving everyone a voice.
 11. Delegates are happy to share examples of how the adoption of caring conversations have facilitated, developed and improved contexts which were previously very formal. These include areas of practice such as interviews, contract monitoring meetings, return to work meetings and exit meetings. They describe enhanced communication and improved ways of working which are now embedded within care settings.
 12. The peer support during the programme has enabled a high degree of experience sharing and enabled managers to discuss issues they face in a place of safety and security. The appetite for continued peer support is such that an action learning set group has continued to meet beyond the programme.
 13. A national MHL 'T' Party day took place recently and saw care settings across East Ayrshire hosting celebrations to mark ten years of MHL. Visits took place to as many of the participating care homes in East Ayrshire as possible on the day. Senior Manager Angela Shevlin and Service Officer Val Allen were joined by Fiona Cook Independent Practice Development Consultant from MHL as well as a local elected member Lillian Jones. They asked the question "What 10 things make you smile about living, working in or visiting our care home?" Local press and social media captured the day.

CONCLUSIONS AND NEXT STEPS

14. The MHL programme in East Ayrshire has been nominated for a Scottish Care Award for the Training & Staff Development category.

15. The directors of the MHL team have approached East Ayrshire Health and Social Care Partnership seeking to undertake a joint piece of improvement work to better understand what a focus on personal outcomes in care homes entails. Health Improvement Scotland has identified personal outcomes as a core improvement focus with organisations such as the Care Inspectorate supporting this.
16. East Ayrshire was approached in recognition of the enthusiasm of delegates and commitment to relationship-centred care and appreciative enquiry. Local skills in caring conversations were also a factor.
17. A joint proposal is currently being developed by East Ayrshire Health and Social Care Partnership and MHL to take forward work with 'clusters' of three care homes across the three locality areas. The proposal seeks to support care home employees to help residents achieve what matters to them whilst also looking at what matters to staff.

FINANCIAL IMPLICATIONS

18. There are no financial implications arising from this report.

HUMAN RESOURCE IMPLICATIONS

19. There are no human resource implications arising from this report.

LEGAL IMPLICATIONS

20. There are no legal implications arising from this report.

COMMUNITY PLANNING

21. There are no community planning implications arising from this report.

EQUALITY IMPLICATIONS

22. There are no equality implications arising from this report.

RISK IMPLICATIONS

23. There are no risk implications arising from this report.

RECOMMENDATIONS

24. It is recommended that the Integration Joint Board:
 - (i) Note the progress being made following the implementation of the My Home Life Programme; and
 - (ii) To otherwise note the content of this report.

Eddie Fraser
Director of Health and Social Care
24th November 2016

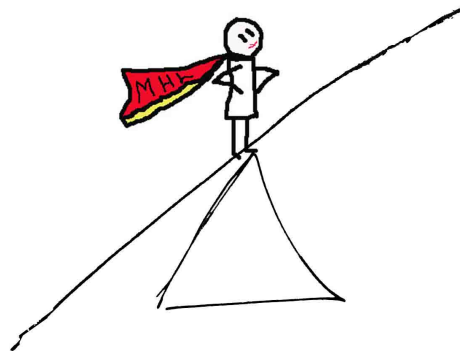
Implementation Officer: Val Allen, Commissioning and Contracts Officer

Bringing out the best in us all

**A report to the East Ayrshire
Health and Social Care Partnership**

***My Home Life*
East Ayrshire 2015-16**

Cathy Sharp, Fiona Cook and Edel Roddy



October 2016

Executive summary

The MHL programme has supported care professionals from across health and social care to create and sustain a positive relationship-centred culture in their care settings where the quality of life of residents, people that use services, relatives, managers and staff can flourish.

'I have seen a bit of difference in my staff team because I'm changing. I'm letting go, trusting people, not doing something myself. I've been letting go and I've been reaping the benefits. I've been managing that service for 11-12 years, but I can still learn and do things better. I'm two thumbs up now, not just one!'

This programme builds on an earlier programme for care home managers in East Ayrshire in 2013-14 and has been devised to support the health and social care integration agenda. Participation reflects the range of partners involved in the provision of care for older people in the area, including care home managers, deputy managers, NHS staff, Care at Home staff from both independent providers and the local authority, colleagues from the third sector and a Commissioner of Older Peoples' services.

Key findings

All the participants say that their leadership and communication skills have increased. Most say that the quality of the management and leadership they are able to offer and their confidence as a professional have increased. Most say that their understanding of how to improve the culture of care has increased, generally by a lot and there are positive changes reported by the majority of participants in relation to the overall quality of practice in their care setting.

'MHL has helped me to change practices and procedures for the better and stop thinking 'if it's not broken, don't fix it', when in fact you're not fixing it you're changing it for the better.'

All participants agreed that the overall quality of care provided is high at both baseline and post programme; however, after the programme, there was a noticeable shift to much more emphatic agreement, with around three-quarters strongly agreeing that this is the case, compared to less than half at the start.

Developing relationship-centred care

There were a number of significant shifts in behaviours that signal a more relational, appreciative and collaborative style of leadership, including knowing how to facilitate a group to get the best experience for all, giving feedback on a regular basis that is meaningful to others, being curious to explore other perspectives and viewpoints, being able to share their own vulnerabilities and seeking support to cope with the emotional demands of leadership and encouraging people to work with strengths and see possibilities.

An important and widely shared change has been a shift in attitude from that which believes that as managers, it is their responsibility to 'do' or 'fix' everything and to solve problems instantly.

Getting feedback and enhancing participation has been taken forward in many different ways, both within and across care homes and in care at home services where there is a more dispersed workforce.

Participants have also been able to use their learning to engage more fully with staff and there are signs of improvements in the interaction between staff and residents or people that use services and with relatives, although mostly these onward changes are of smaller impact. Most report that involvement in decisions affecting them has improved for service users and residents and for the majority of residents, the overall quality of life has improved.

Inquiring appreciatively

The programme has given participants the impetus, tools, confidence and support to explore the perspectives of others much more fully through appreciative caring conversations. Notably, this has given those who do not usually speak up or share their perspectives a chance to do so. Typical types of development include widespread changes to the way that meetings are run, including those with staff, residents and to a lesser extent, relatives. These have altered meeting dynamics in significant ways, changing what is talked about, the way it is discussed and who contributes.

The caring conversations approaches have also been widely used in other contexts that might have previously been quite formal, including Provider's meetings, monitoring visits made by commissioning staff, social work review team meetings, job interviews, return to work and exit interviews and capability meetings. As a consequence, communication is also enhanced more generally as relationships develop and the new ways of working have become embedded into the routines of the care setting.

Beyond meetings, there have also been a number of examples of changes to the way that staff supervision and student mentoring are conducted, often transforming supervision sessions from a chore to a chance to create a more personal, positive and informative two-way dialogue to explore what is working well and what needs to change.

Greater collaboration for change

Beyond these developments, there also is evidence that learning from the programme has extended from the immediate circles of influence to generate ideas for actions, with others, that have led to real change in ways of working. *My Home Life* has helped the participants to implement real change in their ways of working and the ways in which practice in their care setting is able to enhance the Senses of significance, purpose, achievement, belonging, continuity and security.

Ideas for what might change in the care setting are no longer the assumed preserve of the manager. The engagement of staff in particular in using the approaches gives staff confidence

in what they are able to contribute and demonstrates relatively simple ways to engage with residents and relatives.

Staff have also use the tools and approaches to elicit the perspectives of residents and people that use services. This includes involving residents in shared decision-making about staff recruitment and appraisal, exploring real feelings and anxieties about their own health, exploring what matters to residents in order to enable meaningful activities and build relationships.

A change in attitude amongst participants about what they can do and where they can provide challenge to established ways of working is evident and there are examples of impact for residents and people that use services.

Some of the changes taking place are quite intangible. Many participants talk about improvements in morale and the way that they are calmer and how that influences the atmosphere. This quote below is from a participant and has been confirmed by the Care Inspectorate based on their experience of visiting a number of homes and settings.

'You can see the different approach in the care homes who have done MHL, from the front door in. There's a change of attitude and you can see it cascading down and can see a difference in the staff.'

There are also personal and practical benefits arising from the relationships that have been developed amongst the participants from across sectors, who have often quite different roles, levels of experience and perspectives. These new relationships and understandings arising from the composition of a mixed sector group are a valuable resource for those involved and for the wider health and social care system.

The HSCP has made a significant investment in the MHL programme with positive results, that also highlight some of the more enduring challenges relating to working conditions and the wider context. Whilst most participants report that their own job satisfaction has increased, as might be expected, there is a more mixed picture of change beyond the closest circles of influence of the programme. So, whilst there are signs of positive change in relation to inappropriate hospital admissions, there is little or no positive impact on the indicators of staff sickness and retention, job security, stress and workload.

Twenty-nine completed the programme in August 2016, in addition to fourteen that completed in 2014. There is now a critical mass of colleagues across the partnership who are using the MHL philosophy, tools and techniques to improve the experience of people using care services, staff and their families. The peer support element of the programme has been and will continue to be vital in enabling the participants to sustain their energy and commitment to practice development. There is an appetite amongst both cohorts for them to continue meeting as a peer network¹; beyond this there is scope to look to spread the approaches into related existing forums and meetings.

¹ Cohort 2 wishes to meet as one group; cohort 3 wishes to meet in their 'action learning' sets.

1. Introduction: background and local context

My Home Life (MHL) is a UK-wide initiative bringing together organisations that reflect the interests of care home providers, commissioners, regulators, care home residents and relatives and those interested in education, research and practice development. It aims to promote quality of life for those living, dying, visiting and working in care homes through relationship-centred and evidence based practice.²

There are twenty care homes for older people in East Ayrshire caring for 725 older residents across the East Ayrshire Health and Social Care partnership. All these homes are owned by independent sector providers and range in size from small residential care homes with 15 beds to large care homes offering nursing support with 90 beds.

East Ayrshire Council commissioned an initial MHL programme in 2013-14. Fourteen care home managers completed the programme and there were many examples of the positive impact and outcomes for residents, staff and families.³ The subsequent community development strand of this first programme focused on the development of a digital story published as a DVD⁴. This featured many of the managers from the MHL programme talking about their experience of the programme and their efforts to take forward the approach within each care home. It also includes a number of residents speaking about their home and a relative talking about her efforts to support her family members through a time of transition. It is hoped that this would raise awareness of the positive work of care homes, explain some important elements of the MHL programme and provoke further discussions about how to promote quality of life for those living, dying, visiting and working in care homes. A celebration and launch event was held in Kilmarnock on 30 October 2014.⁵ This was well attended and included care home residents, managers and staff as well as those working in health and social care in the statutory and voluntary sectors, both locally and nationally.

Feedback from the event was very positive and people attending were asked to make pledges to explore the appropriate next steps to extend the impact of the first programme. The overarching theme of the pledges were about how to sustain the momentum created by the programme, including encouraging more managers to take part in a MHL programme, more joint training and sharing of practice issues and to further develop relationships with and amongst health colleagues, bringing allied health professionals and others in to the East Ayrshire MHL network. *My Home Life* Scotland, Scottish Care and East Ayrshire Council committed to exploring the appropriate next steps to extend this impact across the wider health and social care system.

² More information is available <http://myhomelife.uws.ac.uk/scotland/lscd/>

³ Available at: <http://myhomelife.uws.ac.uk/scotland/wp-content/uploads/2014/08/MHL-East-Ayrshire-Validation-Report-Sep-2014.pdf>

⁴ The Digital story is here (scroll down) <http://myhomelife.uws.ac.uk/scotland/making-a-difference/>

⁵ The event included the DVD, a short play 'Seeing Auntie' about the effects of dementia and singing from and with 'Musical Minds'.

This was taken forward by the East Ayrshire Health and Social Care Partnership (HSCP), who were interested in enabling all care home managers in the area to experience the programme for themselves first hand. The national priority of health and social care integration underscored the potential benefit for managers from other sectors to participate in MHL as well. These developments led to the East Ayrshire Shadow Integration Board commissioning a further two cohorts of the MHL programme under the banner of and the further use of Reshaping Care for Older People 'Change Fund' and the 'Integrated Care Fund' in 2015.⁶

Both cohorts were more explicitly structured to support the integration agenda and reflects the range of partners involved in the provision of care for older people in the area. These included care home managers, deputy managers and colleagues of some of Cohort 1, NHS staff, Care at Home staff from both independent providers and the local authority, colleagues from the third sector and a Commissioner of Older Peoples' services. This type of integrated group was a first for the MHL Team and seemed to offer an important positive development for MHL. The extension of the reach to those working in wider care settings has provided a challenge for MHL in terms of some of the language used and descriptions of the settings in which people are working, but there were no changes in the fundamental approach to the programme in terms of content or delivery.

This report details the key learning and outcomes from cohorts two and three of the *My Home Life* Scotland Leadership Support Programme in East Ayrshire. The HSCP has made a significant investment in the MHL programme with positive results. There is now a critical mass of colleagues across the partnership who are using the MHL philosophy, tools and techniques to improve the experience of people using care services, staff and their families.⁷ In total, 32 care professionals commenced the programme in September 2015.⁸ Twenty-nine completed the programme in August 2016.⁹ Participants were drawn from across the sectors and positive relationships were made, hierarchical barriers were broken down and a greater understanding of each other's roles was experienced by all.

2. Our approach to learning and impact

The report draws on the experiences and development work detailed by the participants over the course of the programme. The participants reviewed and analysed the research evidence at dedicated validation events for each cohort, held on 4 August 2016. This report integrates the learning and key messages from both cohorts.

For *My Home Life*, 'evaluation' is an approach to collaborative learning that is part of everything we do. We seek to understand and evidence how we contribute towards changing

⁶ <http://docs.east-ayrshire.gov.uk/CRPADMMIN/2012%20AGENDAS/TRANSITION%20INTEGRATION%20BOARD/26%20MARCH%202015/Item%207%20-%20Change%20Fund%20ICF%20Transition%20Report.pdf>

⁷ Throughout this report we tend to refer to residents; this may mean residents of care homes or people that are using care at home services.

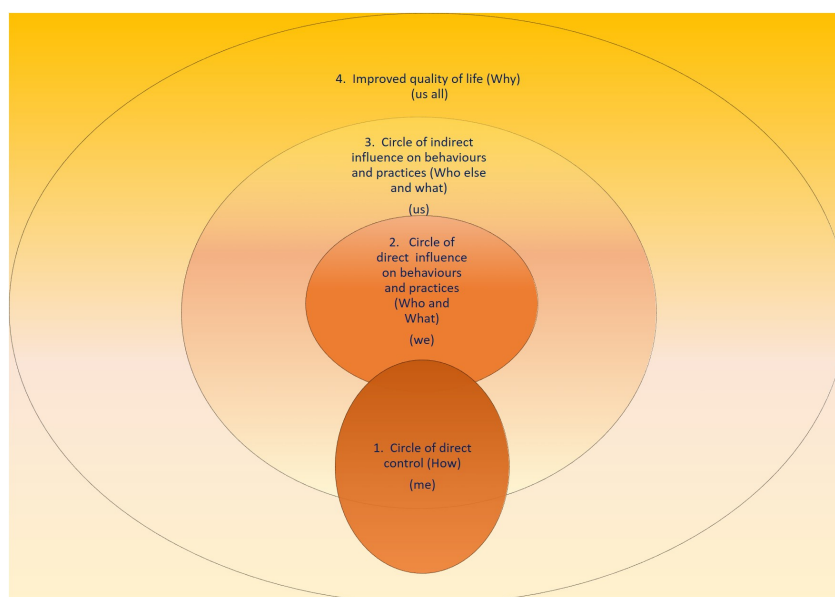
⁸ Not all participants were in managerial roles.

⁹ Fiona Cook and Cathy Sharp co-facilitated the initial workshops for both cohorts; action learning for Cohort 2 was facilitated by Cathy Sharp and Edel Roddy; Cohort 3 by Fiona Cook. Profiles are included in Annex 1.

behaviours that improve the quality of life for everyone in care communities on an on-going basis.

The metaphor of a 'ripple effect' conveys how we expect development to occur and where we might realistically expect to see evidence of influence. This is a shorthand for our 'theory of change' - that developments influenced by the leadership support programme happen through a series of steps or ripples that start with the individual participant. Figure 2.1 shows how their learning influences other individuals, teams and the wider context in which care homes, care providers and professionals operate through a series of 'circles of influence'. These circles can encompass, most immediately, those living in, visiting and working in the care setting.

Figure 2.1: The Ripple Effect



We are confident that the developments generated by the programme can and do make important contributions to learning and outcomes most immediately for programme participants, but also for their staff and the residents and service users and relatives that are connected to the care setting. There are examples reported here for notable changes in thinking and practice, with consequent impacts on the quality of care. Nevertheless, outcomes are also influenced and mediated by organisational policies and procedures, the local community, the wider health and social care system, the regulatory system, public policy and societal expectations. Therefore, we are cautious that, as we move beyond the closest circles of influence, we do not seek to over-claim our own influence or directly attribute change to the programme. In effect, this report is an invitation to close partners in the wider health and social care system to extend the collaboration more broadly and seek to sustain and extend the influence of the programme beyond the formal end in August 2016.

The *Senses Framework* provides a high level conceptual framework for both thinking about and assessing progress towards the creation of an enriched care environment characterised by transformational, appreciative and relational practice and helps to understand the

interdependencies involved in the creation of enriched relational environments.¹⁰ It recognises that all staff, residents and relatives involved in care settings need to experience the same six senses of security, belonging, continuity, purpose, achievement and significance. Although what creates these six senses will vary across differing persons, groups and caring contexts, all 'senses' are nevertheless prerequisites for relationships that are satisfying for all parties involved.

In coming to an overview of the impact of the programme and the nature of the change, we used an established learning framework based on the Authenticity Criteria congruent with the programme ethos and transformational intent. These were used at each validation event to encourage consideration of whether individual learning from the programme has gone beyond generating individual insights and learning about self and others, to a wider emphasis on generating ideas for actions, with others, that leads to real change in ways of working. Furthermore, the criteria ask participants to explicitly consider whether their conclusions about the impact of the programme are fair and balanced; that they are based on evidence that is convincing that the kinds of markers of success reported give confidence that changes are happening.

More information about our approach to learning and impact is available elsewhere.¹¹

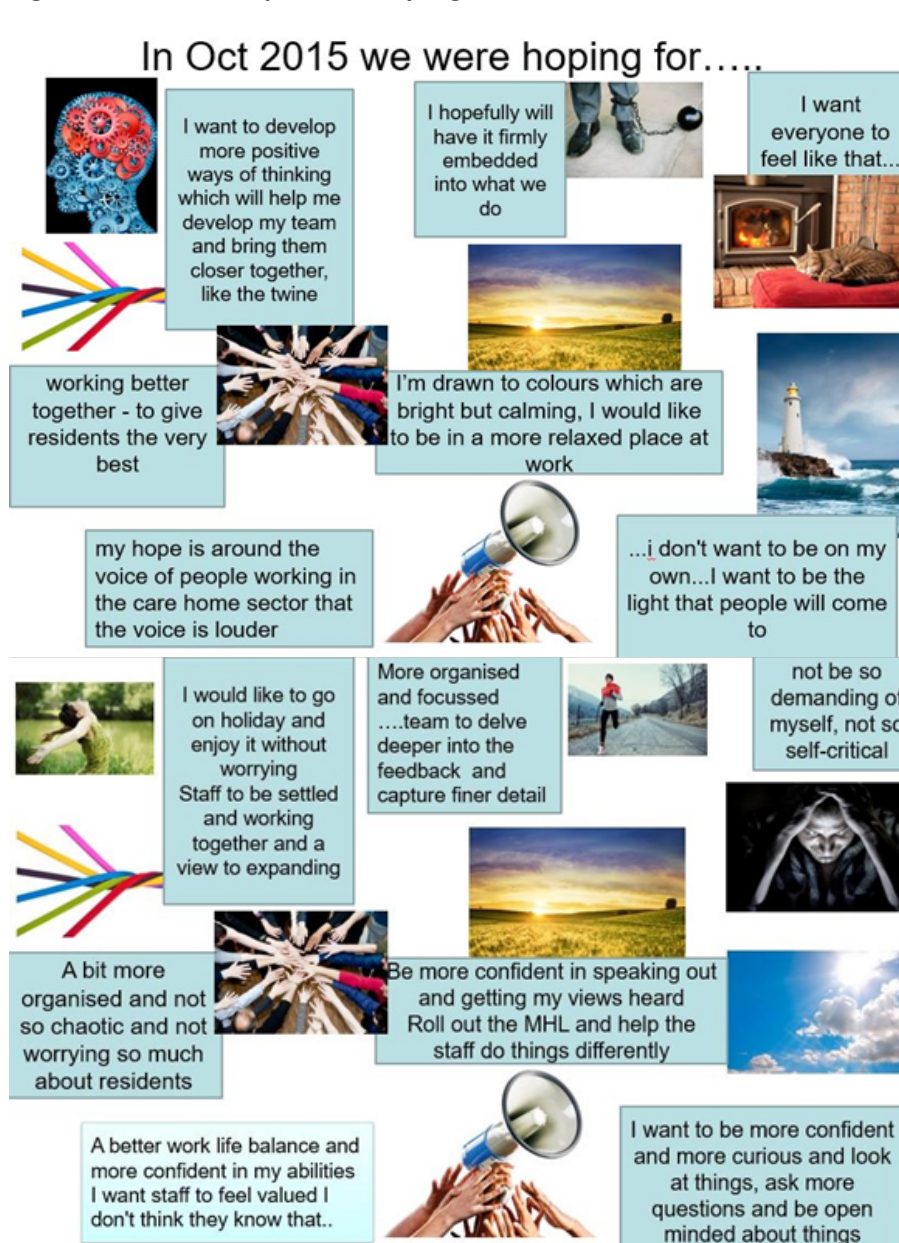
¹⁰ Nolan, M., Brown, J., Davies, S., Nolan, J., and Keady, J. (2006). The Senses Framework: Improving care for older people through a relationship-centred approach. University of Sheffield
http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

¹¹ <http://myhomelife.uws.ac.uk/scotland/wp-content/uploads/2016/03/4-Learning-and-Impact-Framework.pdf>

3. Coming to an overview of the impact of My Home Life

The programme set out to support care professionals from across health and social care to create and sustain a positive relationship-centred culture in their care settings where the quality of life of residents, people that use services, relatives, managers and staff can flourish. Participants hopes for the programme are illustrated in Figure 3.1.

Figure 3.1: Initial hopes for the programme



In coming to a view about the impact of the programme, this report draws on qualitative and quantitative programme data for each cohort. This includes:

- Facilitator field notes, including quotes from the participants themselves and group reflections on learning and change.
- Accounts of practice developments in the homes detailed by the participants including feedback from staff, relatives and residents.
- Images chosen by the participants during the course of the programme to sum up and help to articulate their feelings about particular issues.
- Pre- and post-programme questionnaire data to give an indication of the prevalence and distribution of specific perceptions of change.¹²

This evidence is reviewed collaboratively and synthesised at a dedicated validation event for each cohort.

Key indicators

The final perception of workplace change (POWCS) questionnaire illustrates some common areas of change and is used here to provide an indication of the focus and direction of change rather than a precise measure.¹³ Figure 3.2 shows that over the course of the programme, the most notable positive changes for the people and relationships involved are:

- All the participants say that their leadership and communication skills have increased. Most say that the quality of the management and leadership they are able to offer and their confidence as a professional have increased.
- Most say that their understanding of how to improve the culture of care has increased, in most cases by a lot.
- Most of the participants report that the quality of engagement with their staff has improved.
- A number of indicators show improvements in the interaction between staff and residents or service users and with relatives, although mostly these onward changes are of smaller impact.
- There are positive changes reported by the majority of participants in relation to the overall quality of practice in their care setting.
- Most report that involvement in decisions affecting them has improved for service users and residents and for the majority of residents, the overall quality of life has improved.

Most participants say that their job satisfaction has increased. Figure 3.3 shows a small number of indicators reporting on working conditions and the wider context. This shows a mixed picture of change. Of most note is that:

- Around two thirds of participants report that inappropriate hospital admissions have decreased.
- Trends in workload are varied; a slightly majority suggest it has stayed the same or decreased a little.

¹² Nolan, M, Grant, G, Brown, J and Nolan, J (1998) Assessing nurses' work environment: old dilemmas, new solutions. *Clinical Effectiveness in Nursing*, 2, 145-156

¹³ Given small sample sizes the percentages are not reported here.

- The experience of stress levels is similarly mixed; although half say that their levels of stress have decreased over the last year, for a small number it has increased.
- Feelings of job security have been largely unaffected.
- The experience of staff retention and staff sickness is mixed, although there are more reports of decreasing sickness levels, than of increases.

Figure 3.4 shows selected indicators in relation to the assessment of the workplace environment (AWES); these are the indicators where there is the strongest post-programme agreement. In considering where there is the most notable impact, it is worth highlighting some of the shifts in agreement between baseline and post-programme data:

- All participants agreed that the overall quality of care provided is high at both baseline and post programme; however, at post-programme, there was a noticeable shift to much more emphatic agreement, with around three-quarters strongly agreeing that this is the case, compared to less than half at the start.

The most notable shift between the baseline and post-programme figures were:

- Almost all participants agree that staff prioritise the residents/service user's quality of life before the tasks of the day. At baseline, less than a third of participants agreed with this statement and the same proportion disagreed.
- At baseline, half of participants said they were content with the quality of interaction that staff have with relatives, whilst at the end of the programme, this had also shifted significantly to almost all participants.
- There were also larger shifts in the agreement that there is a good spirit of cooperation between staff and that participants were content with the quality of interaction that staff have with service users.

Figure 3.2 Perception of Workplace Change – Key Indicators: Programme Participants, Staff, Relatives and Residents (Post Programme)

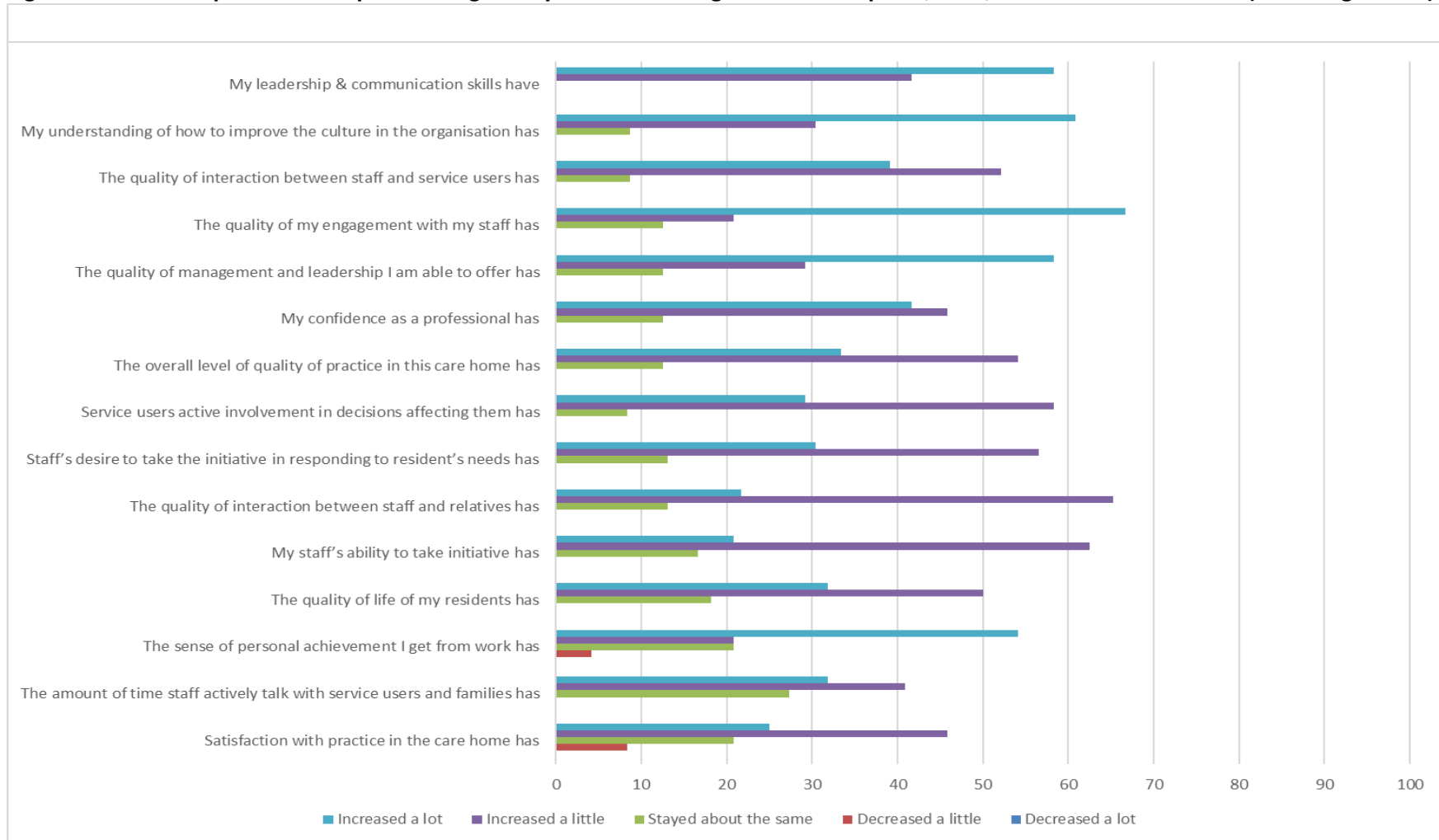


Figure 3.3 Perception of Workplace Change – Key Indicators: Working Conditions and Context (Post Programme)

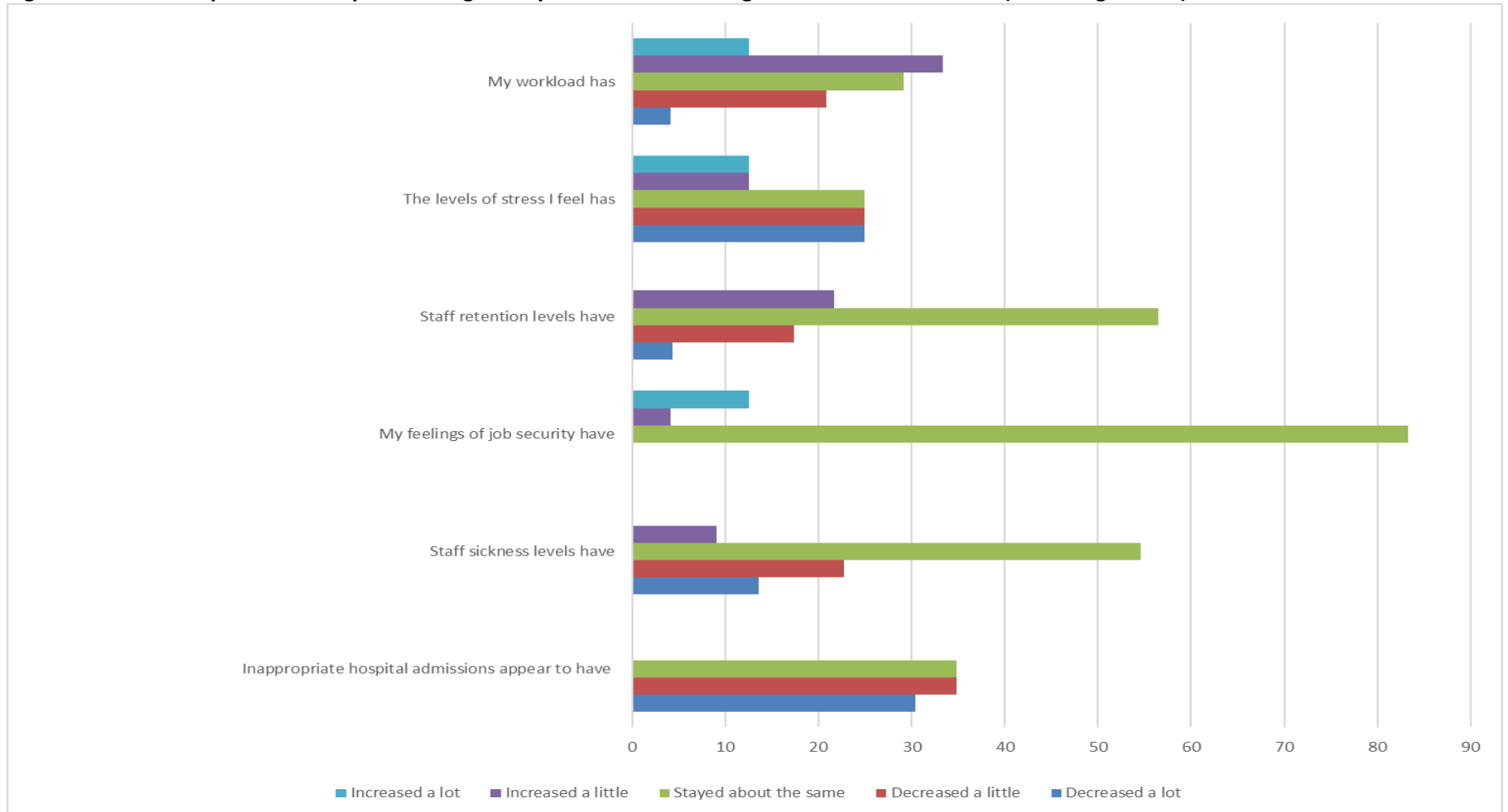
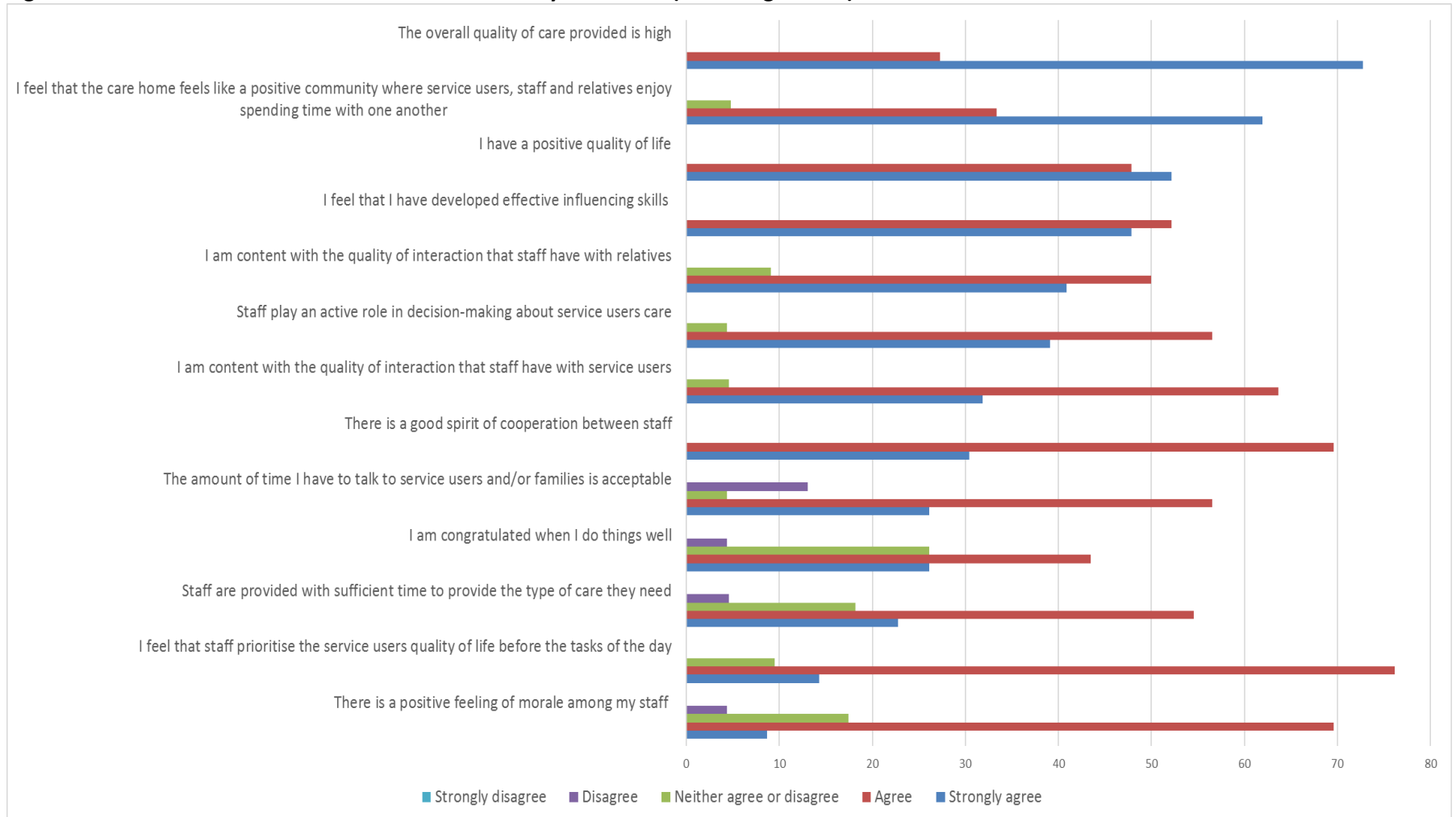


Figure 3.4 Assessment of Work Environment – Key Indicators (Post Programme)



A third questionnaire that explored characteristics of leadership style was also used at baseline and post-programme stages. In terms of where there were significant shifts, behaviours that might be thought of as being signs of being a good ‘manager’ were unchanged. This include having an ‘open door’ policy, being willing to go the extra mile, standing up for the things you believe in even if this feels like taking a risk and balancing being professional and friendly.

The biggest shift was in knowing how to facilitate a group to get the best experience for all; at baseline about a quarter suggested that they felt that this was part of their leadership style ‘most of the time’, at the end of the programme four-fifths suggested this was the case.

Other significant shifts also occurred in behaviours that signal a more relational, appreciative and collaborative style of leadership. These include, but are not confined to:

- Giving feedback on a regular basis that is meaningful to others
- Having curiosity to explore other perspectives and viewpoints
- Being able to share vulnerabilities
- Supporting people by starting from where they are at, rather than imposing your starting point
- Knowing yourself well and know something about others
- Trying and see possibilities rather than joining in the negative talk
- Recognising and seeking support to cope with the emotional demands of leadership
- Encouraging people to work with strengths
- Helping others to understand direction of travel
- Keeping assumptions at bay and be open to surprises
- Knowing when to let things go
- Being thoughtful and considerate -not necessarily responding immediately to one person’s feedback but using this to consider the whole experience for all involved
- Being creative

Qualitative feedback and insights

The Leadership Support Programme has helped each of the participants to implement real change in the way things are done in their care setting. Examples of changes in behaviours and perspectives, both individually and collectively, are highlighted here.

Knowing more about me: new insights into ourselves in our role

In relation to themselves, participants talk about feeling more confident and curious, less likely to jump to conclusions, being better at listening and more likely to ask questions of others. In the past they might have avoided particular people or conversations, whether consciously or otherwise. Now they are much more prepared to talk about how they are feeling and by being vulnerable themselves in this way, have been able to open up dialogue with others about what is important to them.

‘I used the emotional touchpoint process with a member of staff that I’d had a difficult conversation with. We picked words to describe how we were feeling at the moment. I told her I was upset with the way things had been left. She was surprised as I normally keep a

stony face and don't let people know how I feel. She felt listened to when we had the conversation and had not realised what was going on for me. It's led to a better relationship. We're having better conversations and she is more flexible and is volunteering more of herself.'

'The 7Cs can be used a million different ways, it's not just for good times it's to help you through the bad times. The structure of the 7Cs makes me less wary to have the conversation, I might have thought before, 'what if they greet?' This makes it easier. I'm in touch with my own emotions.'

'By using the tools and inviting more participation and feedback from others about various subjects, including how others view me, it has given me food for thought about how I handle different situations. It has also helped me realise strengths that I have that I didn't really use effectively.'

'I always felt there was a barrier between myself and my boss. No matter what I did, it was never enough or not quite right, which made me feel worthless.... he kept on telling me 'I must improve'. I questioned my ability to do my job and asked was I good enough? [eventually] I brought the emotional words, 7 Cs and the images to a supervision session. I asked him what I did well and connected emotionally by telling him how I felt when we'd had previous conversations and encouraged him to ask me questions. I learned that neither of us had communicated well in the past and I got a better understanding of how he was feeling. By the end, I felt very valued and that he was proud of what I had achieved. We both became emotional. Things are much better now, we communicate regularly and enjoy connecting emotionally about our own lives and goals.'

They are more aware of their own role, their strengths and how they may influence others:

'[I used to.....] take what I did for granted, now I see more value in what I already do, using skills and seeing them as skills to be passed on.'

'I have seen a bit of difference in my staff team because I'm changing. I'm letting go, trusting people, not doing something myself. I've been letting go and I've been reaping the benefits. I've been managing that service for 11-12 years, but I can still learn and do things better. I'm two thumbs up now, not just one!'

An important part of their influence on others has been the influence that seeking and giving positive feedback has within the care setting:

'[one of the personal benefits has been] to offer support and thanks to my staff, to praise my staff for their hard work which then offers a positive, bright, happier place to work which gives me a personal sense of achievement'

An important and widely shared change has been a shift in attitude from that which believes that as managers, it is their responsibility to 'do' or 'fix' everything and to solve problems instantly.

'I have encouraged joint decisions to make changes/improvements where required, giving issues back to staff to come up with ideas of how to change for the better outcome.'

'I used to try and solve everybody's problems and now I work with them to resolve issues.'

This 'letting go' includes the previously unthinkable idea that the manager need not cancel their own holiday when the Care Inspectorate (CI) visit:

'..it was really hard not to go in, but I'd already booked my annual leave [and] I know that my staff can do it . My senior was begging me not to have a holiday during the CI visit. I spent lots of time with her to give the confidence and she's delighted - she said it was a really good day. The Inspector was impressed that the manager wasn't there for 2 days of the visit. I trusted her to be the front person during the inspection, because I've been thinking more about my job and reflecting more. In one of the MHL workshop days you said 'we want you to come even if the CI show up' and I thought I'd never do that. But I did!'

There are also many examples of more creativity in response to issues, taking a more relational and often, collective approach, rather than immediately reverting to formal procedures:

'I had a call from one of the care staff about a communication difficulty with a manager. This kind of gripe is not unusual. But my response was to arrange a team meeting on the theme of communication, to give people a chance to hear and consider other perspectives. At the end, the 'Postcards of Gratitude' page was passed around where each person wrote something about other team members. The manager was in tears afterwards! It helped to bring the team a bit closer. I felt it worked well, even though I was exhausted afterwards! I think I achieved something without having to use formal processes - it felt as if we were working together. One person said to me 'you've brought them together, rather than tear them apart – a disciplinary would have split them apart. Your approach made them feel part of a team.'

Knowing more about others: new insights

Getting feedback and enhancing participation has been taken forward in many different ways; some of the participants are based in care homes, where it is normal practice to hold meetings of different types. Others are working with a more dispersed workforce in care at home settings, whilst some tend to work largely on their own and visit different settings depending on their liaison or commissioning role.

The programme has given participants the impetus, tools, confidence and support to explore the perspectives of others much more fully. Notably, this has given those who do not usually speak up or share their perspectives a chance to do so. A number of broad types of development that seem to be particularly significant in terms of how participants have developed their knowledge of others are summarised here.

There are widespread changes to the way that meetings are run, including those with staff, residents and to a lesser extent, relatives. These have often involved the participants 'modelling'

the behaviours they wish to see in others, by asking more open questions, seeking information about the positives, not being defensive, sharing their feelings and respecting other’s ideas. Such meetings have often used images to open up conversations. These approaches alter meeting dynamics in significant ways; they change what is talked about, the way it is discussed and who contributes. They reveal a greater depth and a wider range of information amongst those present. There also seems to be a knock-on effect outwith those meetings, that communication is enhanced more generally as relationships develop.

Speaking Up

Staff are often reluctant to speak at meetings, in supervisions and appraisals. We started to have more informal, smaller meetings amongst staff groups and used image cards. We found it helped staff to speak up and tell us their thoughts and feelings. Now staff don’t wait until meetings are held, but are more open and communicate better and more freely than before. We also used the images at resident’s meetings. Now, we want to encourage the staff to hold their own meetings with each other and with residents in this way.

[Using the images and the PIT at a staff meeting] It took a bit longer but it was a better quality of meeting. And the discussion of the issues took place within the meeting, rather than outside. It seemed that people felt freer to speak.

Staff meetings were about me telling staff what they were doing wrong. I was becoming more anxious about the meetings and staff did not want to attend. I introduced the images to the staff meeting and asked them to pick one that helped them talk about why they had chosen ‘care’ as a profession. I also asked them what we did well and what we could do even better and I introduced the ‘Pause Button’ if things became heated. Staff were keen to put their ideas forward and solutions for the issues raised. They have told me that they felt their ideas were valued. I’ve noticed that staff are far more likely to come to my office with ideas on how we can make things even better in the home, and I have been told I listen to their ideas and act on them.

The Caring Conversations approaches including using images have also been widely used in other contexts that might have previously been quite formal, including Provider’s meetings (companies and owners of care homes and care at home services), monitoring visits made by commissioning staff, social work review team meetings, job interviews, return to work and exit interviews and capability meetings.

Exploring difficult feelings

There had been an End of Life care issue, where there’d been a poor assessment. The relative didn’t want to make a formal complaint, but wanted us to learn from her experience. We were able to explore it in greater comfort. Using the [image] cards and the 7Cs amongst us as a staff team. We were courageous and honest and able to be open that that the local authority had made a poor assessment.

I had a conversation with the owner of the Home. It started with negativity from him. So I

was courageous and asked him what I was doing well. And through the conversation we both became emotional. At the beginning I was anxious, angry, tired and unappreciated and by the end we were moving forward.

Things in the home have been chaotic and stressful with lots of changes. I wanted to try and improve the morale of the staff and help them feel a sense of significance and to know they were valued. I started using the images at appraisals and supervision sessions to encourage staff to be honest about how they are feeling. I invite them to pick an image which helps them describe what they think they are doing well and also what they think they could improve and I do the same. I discovered that people are not always as confident as they appear and confidence was masking the feeling of vulnerability. I am more confident that I can help myself and others to express how they are feeling and that showing vulnerability is not a sign of weakness.

There are also other examples of efforts to enhance communication amongst people in ways that can be easily embedded into the routines of the care setting.

Checking in using emotional touchpoints

Staff would come into work and sometimes not even speak to nurses as they were task orientated. I implemented emotional touchpoints in the form of 'Emojis' which are in the nurse's stations. Myself and the care staff compiled a selection of emoji images and paired them with emotional words. Staff now come in at the start of their shift to choose an image to describe how they feel. They repeat this at the end of the day. I've learned that involving staff in changes allows change to happen more easily. Hopefully we will continue to reflect on our emotions in this way.



A further kind of development is illustrated by a number of examples of changes to the way that staff supervision and student mentoring are conducted.

Opening Up Supervision

The supervision process was repetitive, both in its' process and topics of discussion and paperwork was bland, boring and unwelcoming. I used My Home Life colours, questions and emotional connection theory and approach with the aim of creating positive supervision for both the supervisor and supervisee. I took on changing the appearance and process of supervision and was given the go ahead from my manager – she also attends MHL so is an added support to facilitate change. I've used 'what works well for you?' (What makes your day a good day?) 'What can we do to make it better?' And for the final section, I chose one of the emotional touch points for a topic "Caring for the Residents" and got them to choose the words to enable them to discuss it. They picked

words like 'annoyed', 'frustrated', for example, with time constraints, with staff that don't pull their weight and so on.

The staff said this approach was amazing, much more positive, as the questions were more about them compared to the old style supervision. In the past, they used to discuss amongst themselves, in advance, what to write and so they'd all say the same thing. This time, I did nine supervisions and across them all the words they picked were different! This all opens up my eyes to what's actually going on the floor. Initially it was a trial but the response was productive, so it's now filtered across the home. I feel a sense of achievement and pride. I hope to continue to use this approach. I'll keep the process under review to hopefully enhance the experience.

Changing staff supervision in home care

The home care workforce is dispersed within the community and staff supervisions are the only time we really get to speak to staff. We developed a 26-week employee engagement programme, which means that care staff have a face to face weekly meeting or have a conversation on the phone, even just to ask how things are. Staff say they feel more involved and appreciated. I feel a sense of achievement that we have a more involved workforce. The challenge for the future is to keep it going.

No longer a chore

Incorporating the tools has made me a better mentor which I sometimes find a chore. They have helped me improve the way I relate to the students and has helped them take more responsibility for their learning. They have also helped me be vulnerable and share how I feel with students which helps me work with difficult situations.

Transforming supervision sessions

The same questions were always asked in supervisions and it had become a paper exercise with the answers always the same. I began to use the Positive Inquiry Tool which asked the questions 'what's going well?' and 'what can we do together to improve the experience?' Sometimes I would use the images and emotional words as well to help open up the dialogue. I was keen to find out how they were feeling in their role. I began with the registered nurses and they in turn are now using the same techniques with junior colleagues at their supervision sessions. I noticed that conversation flowed more freely and was much more in-depth, staff seemed to be more relaxed as there was no more formality. Feedback has been positive and the information gained was productive in terms of how to help and support each other to develop.

There have also been a number of examples of encouraging staff to use the tools and approaches to elicit the perspectives of residents and service users. This includes involving residents in shared decision-making about staff recruitment and appraisal, exploring real feelings and anxieties about their own health, exploring what matters to residents in order to enable meaningful activities and build relationships.

Involving residents in staff recruitment and appraisal

Potential new members of staff were introduced to one or two residents on a walk-round of the unit and the person was assessed on how they interacted. We asked the residents what questions they wished to ask potential members of staff, printed them out and wrote responses down. We have also introduced using image cards to assist the residents to give their feedback on staff. Residents are more involved and valued at being part of this process. It's their home, so this gives them a sense of belonging and purpose and that they are important in the decision making process and that their opinions matter. They are also involved in staff supervision and appraisals on their key workers and primary nurses. We want to continue involving residents as much as possible in the running of the home and look at other ways to continue this and other areas that residents can be involved in.

Exploring feelings

We would ask residents how they were feeling but would often get 'OK' or 'fine' as an answer. So instead the senior care staff used image cards to explore their feelings. It became apparent that one resident was very anxious and worried about his health deteriorating and having to use a hoist. Our solution was that the resident joined in with the moving and handling training, watched staff using the hoist with each other and joined in. He is no longer anxious. I think that most staff now realise the importance of taking that little bit of extra time to discover how residents are really feeling and thinking.

Quality time

We used the images with residents and it worked well. It stimulated memories. They were telling stories from the past, their holidays and family history. It was good that staff realised importance of simple things. They learned [more] about their lives. And the staff could see they can do it – it was something simple that we can do. For me, it's nice to get the staff to spend quality time with residents.

I used the Positive Inquiry Tool to look at activities with the residents. We thought they enjoyed a big bus outing, but they felt actually felt rushed. So a few of us went out with four residents to a Garden Centre. And that worked well. They said they felt special and had a sense of significance.

Our residents did a collage about summer together which is displayed in the hall. They loved doing it and there was such a buzz.

We used the reflective writing/poem exercise with staff and residents and invited them to write about what life in the care home is like for them. We then created poems together which are also displayed in the hall.



Ideas for what might change

The way that participants have taken on the adaptation of many of the MHL tools shows considerable creativity and confidence in understanding the principles of the approach to learning and change, which is necessary to more fully embed new ways of working within care settings.

An important part of their ability to do this has been the expectation of the programme that participants will try out the approaches in their own settings, with their staff and others. Of course, people have progressed these efforts at different paces and their attempts have not always worked successfully, certainly not always the first time. The peer support which has enabled a high degree of sharing of experience and enabled the managers to discuss the issues they face in a place of safety and support.

The chance to reflect with others and the ideas and confidence from the other members of the cohort have been invaluable.

'Group discussion has provided new ideas from other providers to implement in my home.'

'MHL has helped me through the group work and active learning to give me ideas and interesting new ways of working. These ideas have helped me promote change.'

My Home Life has also provided a positive challenge by suggesting that even if things are already working well, there might be still be scope to changes things for the better:

'MHL has helped me to change practices and procedures for the better and stop thinking 'if it's not broken, don't fix it', when in fact you're not fixing it you're changing it for the better.'

'It has provided me with time to look at my own practice and how I want to be better and achieve more.'

Importantly the ideas for what might change in the care setting are no longer the assumed preserve of the manager. The engagement of staff in particular in using the approaches gives staff confidence in what they are able to contribute and demonstrates relatively simple ways to engage with residents and relatives.

'It provides the tools for everyone to be involved in the generation of ideas and gives everyone a voice, providing us all with ownership.'

A further aspect of thinking differently about what might be possible has come from exposure to the different perspectives amongst the mixed sector group itself. For example, the third sector did not make any distinction between someone they may be supporting being in a care home or their own home, so that *'services don't stop at the front door of the Care Home'*.

Real change in the way we do things

My Home Life has helped the participants to implement real change in their ways of working and the ways in which practice in their care setting is able to enhance the Senses of significance, purpose, achievement, belonging, continuity and security.

Whilst the evidence base for My Home Life encompasses eight best practice themes, in many ways, the focus is largely on the themes of transformation; keeping the workforce fit for purpose and promoting a positive culture. If these elements are in place, positive relationships enable the other themes to be enacted more readily and on a continuous basis. In particular, the focus on staff and the relationships amongst staff, residents and relatives highlights the importance of all these parties to maintaining identity, creating community, sharing decision-making, managing transitions, improving health and health care and supporting good end of life care.

‘Already changes are happening. Support staff are more open, there is less conflict between shifts, support staff recognise their feelings/thoughts on the day ahead can influence their work.’

Some of the changes taking place are quite intangible. Many participants talk about improvements in morale and the way that they are calmer and how that influences the atmosphere. This quote below is from a participant and has been confirmed by the Care Inspectorate based on their experience of visiting a number of homes and settings.¹⁴

‘You can see the different approach in the care homes who have done MHL, from the front door in. There’s a change of attitude and you can see it cascading down and can see a difference in the staff.’

Using the 7 Cs in practice

Staff expect me to have all the answers and at times I feel frustrated. I’d been asked for help in assessing a resident who was saying she wanted to die and was also becoming verbally aggressive with staff. The lady was 81 and had recently been admitted following a decline in her physical health, increasing frailty and decreased mobility. Before that, she had been fully independent, still driving and had been very involved in her community.

When I spoke to her, I used the 7Cs. We talked together for an hour; I used open questions and she was able to say how she felt and why she was becoming angry. She was feeling worthless, no-one was trying to listen to her and she was becoming increasingly dependent. She felt that staff were treating her like a child and she was missing emotional contact. I felt sad when she told me she didn’t think staff saw her as an individual.

After my visit, I sat down with the four members of staff and told them how she felt about how they were treating her, to try and help them understand how her life had changed since coming into their care home. I invited the staff to speak to her about her life, her loss of independence, home and contents and really consider her perspective and understand her feelings and

¹⁴ Two local Inspectors attended the latter stages of the validation events.

behaviour. On my next visit I could see that staff were spending more time with her, were reading her poetry at her request and were connecting emotionally with her. On another visit, I used emotional touchpoints and she was able to tell me she was feeling happier and that staff were treating her like an individual.

A change in attitude amongst participants about what they can do and where they can provide challenge to established ways of working is also evident.

Using community resources while in a care home

Residents in care home have historically not been allowed to use our community resources at the day hospital due to a combination of both policy and convention. It was felt that as the local authority fund some of their care in the care homes and the NHS provide medical input, then any other resources should be provide by the care home. My feelings were that this mind set did not provide an individual method of providing care and while I accepted that it was not for everybody, I felt that the care homes should be offered this service.

Attitudes seemed set in stone and there seemed to be no scope for moving forward. I felt very frustrated and powerless to change this. I had a particular lady in mind who had been admitted to the care home as a vulnerable adult after an incident in which she got lost and was taken in by the Police out of hours. She had lived at home despite her cognitive impairment and had enjoyed a relatively active social life, including walking and activities at her local church. Her brother described her house being chaotic and she had been unable to maintain the house or attend to her personal care. Her nutritional intake had been poor and this was reflected in her weight. The lady was saying that she wished to go home and I felt that a complete holistic assessment would be beneficial, as perhaps a care home might not be the most suitable option for her. Attending the day hospital would allow her to be assessed weekly, have health checks, have therapeutic interventions, including group work and 1-1 interventions. A scan showed that she had Alzheimer's disease, so the consultant agreed that an admission to day hospital would be beneficial to her. Myself and a charge nurse arranged that hospital transport would collect her from the care home and return her at the end of the day. This is often an issue but this is the best solution as a nurse from the day hospital is always present on the patient transport.

She is enjoying her time at the day hospital and participating in activities and therapies. She is enjoying spending time with other patients and while she is there, assessments are being carried out which will help determine a plan of care for her future. The lady was becoming very low being stuck in the care home with very little communication with the wider community and this outside contact has certainly lifted her mood and gave her a more positive outlook on life. She will continue to attend meantime and the enjoy the benefits that the day hospital can offer.

I learned how important it is to speak up for someone. The resident feels valued and that something is being done for her. This is the first time that a resident from a care home has attended the day hospital. I feel I have achieved something that makes a difference and which could benefit other care homes residents who might be isolated. I am now much more determined to keep trying to make people realise the role of the care home in the community.

A resident moving out of the home

We had a resident admitted to the home as an emergency under Vulnerable Adult procedures. She was only 59 and had an early dementia and was being abused by her partner. I was shocked because of her age and she stood out in the care home because she was so independent. I used an emotional touchpoint story with her to find out how she was feeling about being in the home. She picked sad and lonely and through our discussion I realised she did not want to live in the home. It was clear that she could not return to her previous home, but I wondered what we could do. I spoke to her Social Worker who was amazed at the conversation we'd had and I also contacted a colleague in my MHL action learning set to discover how we could get a care package in place, if we found her alternative accommodation. Working together with the resident and her social worker, we found supported accommodation locally which she liked and arranged a care package to support her and she is now successfully living alone with support in her community.

There are also benefits arising from the relationships that have been developed amongst the participants from across sectors, who have often quite different roles and levels of experience.

'Years ago you wouldn't have the NHS with private sector, having caring conversations happening in the room! This has achieved much more with having all the sectors together. It's softened the relationships between us. No hostility! [Whose achievement is it?] It's ours - there always has been a 'them and us', in the past, even between nursing homes, there would be rivalry. Now we talk openly, and share ideas between nursing homes.'

Participants share this new sense of a collaboration, despite competition, amongst them.

'[We used to...] not communicate with each other, now we have no qualms about ringing each other up, we're still in competition, but I don't feel that, there's a camaraderie.'

This mix and new relationships have had practical impact:

'I was involved in an emergency situation and had to get someone into a place of safety. I was using the 7 C's; being courageous to speak up on behalf of the person, and considering other perspectives, such as the social work staff. I found I got on better with the social work staff, 'changing yourself', not going in with 'guns blazing' and knowing you don't have to take it all on yourself. The outcomes are much better for the person because you're not putting your stress onto the other person, and not entering into blaming. Having different agencies in the MHL group helped with that. Getting everyone's ideas! Our goals are the same.'

'Before I would not have called a senior person in the area, but now I know we are all a bit of the jigsaw and I could phone anybody. I didn't hesitate to call C (senior manager) one day.'

In making their assessment of the impact of *My Home Life*, the participants speak with confidence about how they see their own role, changes in their attitudes and actions. Many have had feedback from their own staff, sometimes in the moment.

'[I am confident that our assessment is fair and balanced based on] the positive feedback from others who have embraced what we have been trying to achieve, and just looking at the effect of the changes we have implemented and the change in the general feeling of the Home.'

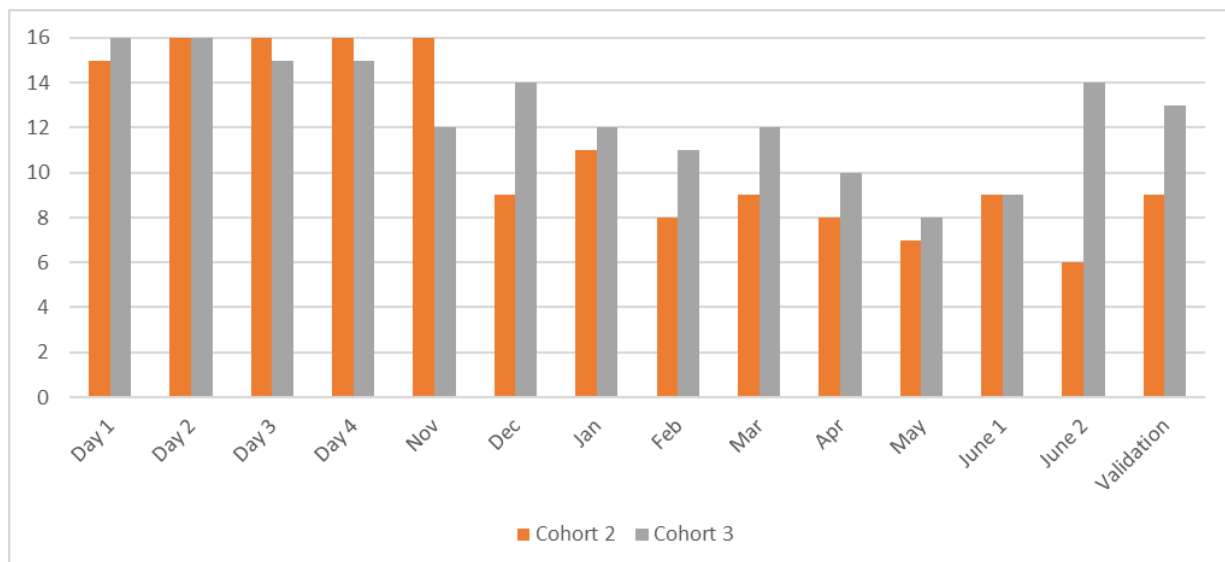
They cite better supervision practice that enable staff to be honest, to open up and be listened to as a significant factor in building new relationships based on staff feeling valued. This makes them more willing to help and improves their own interactions with residents.

Learning from the process of action learning

Each cohort met as a whole group for the four day initial workshops, then divided into two action learning sets for nine sessions of 'action learning', with around eight people in each set.

Figure 3.5 shows the attendance across the two cohorts. Thirty-two people joined the programme of which 30 attended all of the four-day initial workshops. In Cohort 2, two people dropped out after the first action learning session, one for personal reasons and one for unknown reasons. In cohort 3, one person dropped out due to ill-health.

Figure 3.5: Cohorts 2 & 3 – attendance



The action learning sets were constructed so that participants who had a direct working relationship with each other were in different sets. It is worth noting here that although not all participants were known to each other beforehand, there were longstanding, existing and shifting relationships amongst these two cohorts, as commissioners, employers, colleagues, fellow professionals and sometimes friends, all working within the same location. The nature of professional networks and of employment within health and social care highlight the importance of trust and confidentiality within a group learning situation. In the initial workshops, each cohort developed their own ways of working or 'group agreement'; these typically include how they wish to work together to create an environment where everyone can contribute and in which there is a

balance of support and challenge. These agreements were updated by the successor action learning sets once these were underway, and at times, returned to if there were issues emerging that had not been anticipated.

Each action learning meeting, would typically start with an icebreaker, then participants would share updates about their own efforts to implement the caring conversations framework within their settings. These discussions typically also highlighted wider systemic issues and barriers to change in the wider context in which they are operating. Some of these were issues of local policies, for example in relation to the payment for specialist equipment in care homes, whilst others were about wider issues such as the National Living Wage and the National Minimum Wage.

The second half of each meeting was dedicated to formal action learning, with participants taking turns to present a particular issue or challenge that they were facing to the group on a confidential basis. MHL uses the process of action learning within the programme to help participants apply their theoretical learning of Caring Conversations into practice learning and collaborative development.¹⁵ Action Learning is an experiential learning process of reflecting in a group with others to learn, with a resolve to take action on the issue presented to transform practice. This approach provides all members of the group with a chance to reflect and rehearse asking open questions and to help each other to explore the issues, emotions and behaviours at play without resorting to explanation or analysis, and to broaden possibilities for moving forward without rushing in with solutions or opinions.¹⁶ Reflection at the end of each session about the process helped to generate further insights and lessons for more skilled questioning and listening, transferable to their own efforts within the Homes.

Figure 3.6 summarises the types of issues that the two cohorts in East Ayrshire have presented about during the programme.

Figure 3.6: An overview of Action Learning issues

My role	Staffing	Relatives, Residents/clients
<ul style="list-style-type: none"> ● Being isolated as a manager ● Going back to work ● Delegating to others ● Confidence issues ● My room/space – getting stressed ● How I see my future at work ● Data Protection Issue – getting to the bottom of it 	<ul style="list-style-type: none"> ● Disciplinary meeting ● Difficult conversation with a member of staff ● Speaking to the owner ● Speaking to the manager ● Meeting with night staff ● How to get others on board ● Integration of the companies’ new guiding principles ● Upcoming meeting re 	<ul style="list-style-type: none"> ● MDT team working re a resident admission to hospital ● Getting feedback on a large scale ● A forthcoming relatives meeting ● Pain management/palliative care ● Managing medication – different policies ● A failed discharge – recent incident of

¹⁵ McGill I, Brockbank A, (2004) *The Action Learning Handbook* Routledge Falmer London

¹⁶ Notes were not taken of the detail of the presentations.

	<p>change agenda</p> <ul style="list-style-type: none"> • Teamwork between manager and admin staff • Talking with staff about the CI visit. • Decision re letting staff member go • Previous difficulty with a colleague • Retirement of a longstanding staff member 	<p>distress for a client</p> <ul style="list-style-type: none"> • Handling a visitor who might pose a risk
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These issues cut across all the eight best practice themes of MHL. Nevertheless, staffing issues were the predominant concern. In discussing such issues, trust amongst the group members is vital to create safety for people to share their challenges and dilemmas as openly as possible within the group. The participants discussed their own group dynamics and issues of safety within the set. The challenges and dilemmas of action learning experienced by both cohorts were in no way unique to these groups in East Ayrshire and include the following issues:

- Action learning was largely an unfamiliar process to most participants. Some participants said that they had not appreciated the different expectations of this style of learning, compared to more traditional training courses.
- Experiential learning can be personally challenging as it asks that individuals are prepared to be open with others about their ways of thinking and being and to trust others enough to be able to share their own feelings.
- Sharing positives and successes can feel unfamiliar and at times, awkward and it takes time for people to both notice and be prepared to share in this way.
- It took time for the sets to develop a mutual understanding of what the agreed ways of working actually mean in practice.
- Most participants found it difficult not to give advice, particularly so in the early stages.
- Participants are often dealing with their own personal challenges including personal tragedy and loss, their own ill-health and that of close family.
- The role of the action learning facilitators in modelling and supporting positive inter-personal interactions and group dynamics in a congruent way to guide, challenge and support the group to share their insights and address their questions of mutual concern.

It was noticeable that by the final set meetings, participants were much more skilled at open questioning; the pace of questioning was slower; participants were noticing body language; they were much more explicitly considering other perspectives and exploring the positives in a situation; they were much more comfortable with expressions of emotion and following them up; and consequently were much less likely to give each other (unsolicited) advice.

4. Conclusions and next steps

The MHL programme has supported care professionals from across health and social care to create and sustain a positive relationship-centred culture in their care settings where the quality of life of residents, people that use services, relatives, managers and staff can flourish. There were a number of significant shifts in behaviours that signal a more relational, appreciative and collaborative style of leadership

The programme has given participants the impetus, tools, confidence and support to explore the perspectives of others much more fully through appreciative caring conversations. There is evidence that learning from the programme has extended from the immediate circles of influence to generate ideas for actions, with others, that have led to real change in ways of working. A change in attitude amongst participants about what they can do and where they can provide challenge to established ways of working is evident and there are examples of impact for residents and people that use services.

My Home Life has helped the participants to implement real change in their ways of working and the ways in which practice in their care setting is able to enhance the Senses of significance, purpose, achievement, belonging, continuity and security.

Sustaining the ripples: what we want to see happen now

The HSCP has made a significant investment in the MHL programme with positive results that also highlight some of the more enduring challenges relating to working conditions and the wider context. Positively, there is now a critical mass of colleagues across the partnership who are using the MHL philosophy, tools and techniques to improve the experience of people using care services, staff and their families¹⁷. Beyond this there is scope to look to spread the approaches into related existing forums and meetings.

The peer support element of the programme has been and will continue to be vital in enabling the participants to sustain their energy and commitment to practice development and social care integration. Both cohorts are keen to continue to meet; Cohort 2 as one group and Cohort 3, remaining in the two action learning sets.

Participants have made a number of recommendations:

- a) The course could be adapted to be a shorter course, aimed at support and care staff.
- b) Given the clear advantages of these mixed sector cohorts, it might also be worthwhile to involve other professionals, including social workers and the Care Inspectorate.
- c) There should be more advertising to encourage greater public awareness of the excellent work of the care sector.

¹⁷ See Annex 2 for a list of cohort 2 and 3 participants.

Community development strand

The Community Development strand of *My Home Life* recognises that many of the factors impacting on quality of life within care settings depends upon the quality of relationships with the wider health and social care support system and the local community. The strand seeks to bring together key organisations and individuals committed to enhancing the quality of care and provides a platform to discuss the issues raised by the MHL participants, to strengthen local relationships, and to agree mutually beneficial community development work going forward.

In many respects the integrated Cohorts 2 and 3 are a product of the community development work undertaken with cohort 1. All cohorts are now engaged in further community development work and have identified the issue of *Relationship Centred Planning for Transitions: How can we make transitions for families as good as it can be?*

The work to date has identified the key transitions across health and social care as:

1. From residential schools to residential care
2. Coming into residential care – perhaps after acquired brain injury, stroke or with learning difficulties
3. From residential care to independence and/or employment and training
4. Acceptance of care for families at any stage
5. To care at home from independence
6. From home with care at home to hospital and back
7. From home with care at home to respite and care packages /step up/step down
8. From home (with or without care at home) to a care or nursing home
9. From hospital to a care or nursing home
10. From a care or nursing home to hospital

Discussions to date have encompassed:

- Support and information for families – acceptance of care and coming to terms with changed circumstances
- The role of the voluntary sector in easing transitions – need to map the assets
- How to plan for smoother transitions
- Genuine shared decision making between families and professionals – who’s in control?
- Making best use of available resources
- Minimising/eliminating emergency admissions
- Getting a better press/public understanding for the care sector
- Reducing stigma, enhancing choice and control – putting people first

Further meetings are underway to develop a mutual and more specific focus for this work and it is expected to be complete by early 2017.

Personal notes of thanks and tributes

When you are involved in facilitating *My Home Life* in different places you are privileged to witness learning in action, both in the room and over time as people take it on and find the courage to try things out in their own setting. Everyone goes at different paces and I find myself having to curb my eagerness that people should 'get it'. Once I keep that in check, one of the many things I love to see is the way that people use the principles and adapt the approaches in ways to make them work in their own setting. What we've seen here is real growth and immense creativity as people have worked out what they can do. And that has been immense. We've all been able to benefit from the sharing of what has worked well and what hasn't and from the willingness to try again. It's also been fascinating to see how an integrated group can work and the massive benefits for the wider health and social care system of bringing people together in this way. So although *My Home Life* has officially ended, I'm confident that it's not over.

Cathy Sharp

I echo everything Cathy has said above. It has been a privilege to work with such a committed and passionate integrated group. We've shared laughter and tears and learned together through it all! I am proud of the many achievements documented within this report and many we had to leave out as there were so many. I am confident that the participants are using the tools and techniques of MHL, underpinned by its value based philosophy, every day in creative ways, which is helping to transform the culture and therefore the experience of staff, users of the service and families in a range of care settings. The ripple effect keeps rippling and having an impact. Well done to you all and I wish you all the best as you continue to live and work in this way.

Fiona Cook

A sincere thank you to the group, and Cathy and Fiona, for welcoming me in to your My Home Life journey. I have found it very inspiring to witness first-hand the impact that My Home Life has on participants and those they work with.

It has been really insightful to hear the participants' stories and experiences which convey the energy and dedication that each one brings to their role. I have been really struck by the innovative ways in which participants have made the My Home Life resources their own, incorporating them in to their services in a way that is meaningful for everyone. I hope that the relationships forged through the My Home Life programme will continue to flourish and be of support and encouragement.

Edel Roddy

September 2016

Annex 1: Facilitator Profiles

Cathy Sharp is a *My Home Life* associate facilitator. Cathy established *Research for Real*, an Edinburgh based action research consultancy in 2002. She is particularly interested in how action research can be used to support reflection on 'custom and practice' and to support work-based learning, building on what is already good and effective and what people care about to achieve positive outcomes for people and communities. This includes finding ways to capture evidence of the small and local changes that happen through developing stories of change. Cathy worked with the first East Ayrshire MHL cohort and also with groups in Edinburgh, Erskine and for HC One in Scotland and England. She has also been part of the wider evaluation of *My Home Life* in Scotland and has co-authored publications based on the programme and on appreciative action research. Her other work includes several leadership development programmes to support the integration of health and social care and asset-based and appreciative approaches to community development and health improvement.

Fiona Cook is a *My Home Life* associate facilitator and is an acknowledged practice development leader across Scotland and the UK. She has extensive leadership experience in the NHS, in a career spanning over 35 years, as both clinical practitioner, nurse teacher and project manager.

She is an experienced, flexible, highly motivated and enthusiastic health care professional with excellent leadership, managerial, organisational, and educational skills who holds a firm commitment to both practice and professional development. She is a skilled communicator and facilitator, comfortable working at all levels of organisations to enable, encourage, inspire and empower individuals to maximise their full potential.

Fiona has facilitated a number of MHL groups across Scotland and more recently also in England and enjoys the learning and transformation that happens when people change the way they do things with such positive personal and professional outcomes.

Edel Roddy is a Trainee *My Home Life* Facilitator. She previously worked in nursing and is currently undertaking a PhD in the University of the West of Scotland entitled '*Enhancing the Experience of Inspection in Care Homes, from the perspective of all involved, using Appreciative Inquiry*'. She is particularly interested in the role of reflective dialogue in generating new learning and the use of creative methods to empower people to tell their stories. This is her first time being part of a *My Home Life* group.

Annex 2: The East Ayrshire My Home Life Community 2015-16



Cohort 2

Eleanor McCaffer	EAH&SCP
Linda Johnstone	Care Home Liaison (NHS)
Susan Orr	Thorntoun
Gail McClure	Doonbank
Elsy George	Howard
Angela Dick	Constance Care
Lesley O'Rourke	Argyll House
Darryl Marshall	ILS Mears
Sally Scott	Nightingale
Christine Malcolm	West Park
Marie Gavienas	EAH&SCP Care at Home
Roberta Campbell	Kirklea
Ina Slack	Doonbank
Annie Brown	Bee Busy

Cohort 3

Val Allen	EAH&SCP
Allison Chan-Rae	Care Home Liaison (NHS)
Heather Taylor	Crossgates
Caroline Duncan	Glebe House
Rhona Gibson	Thorntoun
Catherine Thomson	Nightingale
Catriona Barr	EAH&SCP Care at Home
Gillian Black	Burnfoot
Jeanette Willsden	Constance Care
Gillian Docherty	Lizdean
Susan McLean	Torrance Lodge
AJ Cushi	Hallhouse
Suman Joshi	Bute Care Home
Bethann Neil	Westpark
Helen McHarg	Springhill Care Home