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An Evaluation of the 'My Home Life' Leadership Support Programme for Care Home Managers

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Abstract: Care homes are central to the provision of care for older people and it is essential the leaders in this sector are supported to enhance the equality of care provided to these residents, often with multiple and complex needs and co-existing health conditions. The My Home Life Leadership Support program (MHLLS) is an innovative approach that enhances the culture of care in these settings. This study explored the findings of 298 participants who completed the program in England, Scotland, and Northern Ireland. Data were analyzed from two questionnaires which are routinely completed, by participants on the MHL LSP, the Assessment of Workplace Schedule (AWES) and the Perceptions of Workplace Change Schedule (PoWCS). The results were categorized by factors identified by the exploratory factor analysis. This study focuses only on the quantitative findings from pre- and post-questionnaires. The study also provides an updated factor analysis of the AWES and POWCS. The results provide robust evidence of the overall positive impact of the MHLLS program across the three participating countries. The key areas in which MHL participants report significant change within their care homes are recognition and regard for them and their staff, workload, quality of care, and working relationships. Overall, this study has demonstrated a significant positive change in managers' leadership skills and their perceptions of the impact of this on staff, relatives, and residents.

Keywords: Leadership, Care Homes, My Home Life, Quality, Staff, Relationships

Introduction

Strong, effective leadership has been identified by the world health organization as a key priority in meeting the needs of an aging population (WHO, 2015). While many older people are supported to live at home, there are others who either make a positive choice to enter 24 h residential care or for whom their needs are too great to be met elsewhere. Care homes are the main providers of care for these older people and care home managers have a key role to play in ensuring that the care provided to some of the frailest and most vulnerable people in our society is of the highest quality (Backman *et al*., 2017).

The pandemic highlighted the ongoing challenge of providing care for older people within a poorly funded and under-supported sector long since reported by many (Handley *et al*., 2014; Werner *et al*., 2020) and the inequalities in the provision of support to older people and to those who care for them. The combination of multiple and complex needs and co-existing health conditions, along with the experience of moving to a care home, presents older people and their relatives with significant challenges (O'Neill *et al*., 2022). Despite global policy to promote self-expression and identity across the life course (WHO, 2015), there is a strong body of literature that suggests that while communication and a caring partnership between families and staff are key to enhancing the quality of life in care homes, even more can be done to improve the culture of care in these settings (Ryan and MCKenna, 2015; Paddock *et al*., 2019; O'Neill *et al*., 2020). Leadership is key to developing cultures in care homes. This study reports on a quantitative evaluation of an innovative and international leadership program,

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run by My Home Life (MHL), in care homes across England, Scotland, and Northern Ireland.

Leadership as a Catalyst for Cultural Development

Contemporary approaches to leadership are no longer about a single, heroic, individual leader or expert that drives a predetermined change process, but as a participatory and improvisational practice that recognizes the mutuality, reciprocity, and interdependencies within any system (Sharp *et al*., 2018).

The theoretical framework of leadership in the MHL program is informed by a range of studies and draws upon contemporary approaches of transformational, collective, distributed, and authentic leadership theory (Manley and Jackson, 2019; 2020; Manley *et al*., 2018; Martin and Manley, 2018). Leadership that is facilitative and based on relationship-centered values is the key to enabling the empowerment of those giving and in receipt of care (Manley and Jackson, 2020; Dewar and Cook, 2014; Dewar *et al*., 2017). Transformative leaders are compassionate, collaborative, ultimately curious, and visible. They use positive approaches and language, drawing on practical knowledge, including knowledge from lived experience with residents, relatives, and care practitioners. They value ways of knowing that might be expressed in more unconventional, creative ways which build (and build upon) interdependencies. This enables people to understand what they can do by providing value standards and self-confidence to engage in change, perhaps helping to overcome a sense of paralysis or feelings of being overwhelmed by the scale of the challenges (Sharp, 2018; West et *al*., 2015; Dewar and MacBride, 2017; Jackson *et al*., 2021).

Consistent with international research, recommendations from several independent reviews all call for the culture of care within care homes to be more personal and relationship-centered, led by a transformational leader (Department of Health, 2015; Kelly and Kennedy, 2017; NHS, 2019; Ham, 2012).

My Home Life

My Home Life (MHL) is an international initiative that seeks to promote quality of life for those who live, die, visit, and work in care homes (www.myhomelifecharity.org.uk) and is driven by four evidence-informed conceptual frameworks:

1. Developing best practices together, (NCHR and Forum, 2007)
2. Focusing on relationships (Nolan *et al*., 2006)
3. Being appreciative (Reed, 2006)
4. Having caring conversations (Dewar *et al*., 2017)

Developing best practice together reflects all the evidence MHL has gathered over the years on promoting quality of life in care homes. Recently updated, the MHL literature review was originally led by a large group of academic researchers working with care practitioners to examine, what matters to people living and working in care homes and what good practice looks like to them.

Focusing on relationships places the focus on the importance of everyday mutually respectful and positive relationships between people that use services, their families, staff, and managers, and between services and the wider community, underpinned by the 'Senses', a framework for improving care by promoting positive relationships. The quality of the countless daily conversations and connections that take place are at the heart of learning and change and emphasize the importance of working together to co-create jointly desired futures (Dewar and Nolan, 2013).

Being appreciative is a positive and motivating approach to developing practice and enhancing participation. It pays attention to the best in us, not the worst; to our strengths, not our weaknesses; to possibility thinking, not problem thinking. It brings a fresh lens that helps people see old things in new ways, to notice what they value so that new options for decisions or actions become available. It shifts our gaze from the past to what kind of future we want to create together (Sharp *et al*., 2018).

Having caring conversations helps us to think about and develop our ways of interacting with one another. The framework supports us to celebrate what is working well, consider the perspectives of all those involved, connect emotionally, be curious and suspend judgment, be courageous and take positive risks, collaborate to make things happen, and compromise to focus on what is real and possible (Sharp *et al*., 2018; Dewar *et al*., 2017).

MHL began in England (2006) and quickly collaborated with other partners to spread across the UK Wales, 2008; Scotland, 2012; Northern Ireland, 2013 and is now being implemented internationally in Australia 2016 and Germany 2017. MHL Partners collaborate and share learning from their experience (research, education, and social action) of working with and for care homes and other long-term care settings.

The MHL Leadership Support Programme

The MHL Leadership Support Programme (MHLLSP) aims to provide a safe place for care home managers and other senior staff to develop transformational leadership skills and successfully bring research into practice and encourage learning from experience. The program's central function is pivotal to the delivery of quality service in care homes, providing leadership support to care home managers, who can in turn inspire and support their staff while responding to the needs and hopes of an increasingly frail population. Owen and Meyer (2012) found that participants who completed the MHL programme in England were leading from a starting point of confidence, rather than one of fear. Evidence in Scotland 2017 found

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that participants felt the program had a positive impact on themselves, enhanced their leadership skills, enabled better communication and relationships with staff, and claimed positive benefits for residents and relatives (Dewar *et al*., 2019). A more recent qualitative evaluation of the program in England by Sanford and Anderson (2021) suggests that participants are able to share their challenges, feel supported and learn a variety of tools, skills, and strategies that improve the culture of the care home and quality of life for those within it. These claims are self-reported by care home managers using pre- and post-questionnaires, which are consistent across cohorts and reliably show positive differences over time. This study adds to this growing body of evidence on the MHLLS program, by using factor analysis to describe a process in which the values of observed data are expressed as functions of a number of possible causes in order to find which are the most important.

The MHL LSP was specifically designed to meet the unique needs and aspirations of care home managers and other senior staff by supporting them to improve the quality of life for residents, relatives, and staff. The program helps leaders in care settings to negotiate the complex and often conflicting, emotional stresses of their work while helping them to gather perspective, seek solutions, and protect themselves from the very real risk of 'burnout' (Kelly and Kennedy, 2017).

The MHLLSP typically consists of four days of workshops (two consecutive days, over two consecutive months) followed by half-day action learning sets (monthly, over 8 months). Participants generally comprise a cohort of 16 people who meet as one group for the workshops and then split into two smaller groups for the action learning sets. Over the 10-month period, participants are guided and supported by professional facilitators to advance their leadership skills, engage with the MHL conceptual frameworks and resolve the complex everyday issues that impact the quality of life and care in their homes. The aim of the program is to offer participants the space and support to help them reflect upon and develop their own practice, co-create new ways of working with residents, relatives, and staff, and to engage in a journey of positive culture change within their own homes. The program works with managers at whatever level they find themselves, to facilitate their personal growth as individuals and as professionals leading change.

Aim

The aim of this study was to examine the impact of the MHL LSP from the perspective of participants across three countries in the United Kingdom (England, Northern Ireland, and Scotland) between 2017-2018.

Objective

To examine participants' perspectives on the impact of the MHL leadership support program on:

- Themselves as leaders
- Their staff
- The quality of care

Materials and Methods

Whilst a multi-method approach was taken for the overall evaluation of the program, this study focuses only on the quantitative findings from pre- and post-questionnaires. Qualitative findings of the program, prior to 2017, are reported elsewhere (Dewar *et al*., 2017).

Participants

Participants included care home managers and other senior staff who had completed the MHL LSP in England, Scotland, and Northern Ireland 2017-2018. Participants were representative of a range of urban and rural care homes, some of which were small family-owned homes and others that were part of large multi-site organizations. Although the sample included 298 participants, many more managers (circa. 2,000) have successfully completed the program across the UK and internationally over time. The sample included:

- 148 Participants from England
- 101 Participants from Scotland
- 49 Participants from NI

Data Collection

Data were analyzed from two questionnaires which were routinely completed, following informed consent, by participants on the MHLLSP in the three countries.

The two questionnaires were the Assessment of Workplace Schedule (AWES) and the Perceptions of Workplace Change Schedule (POWCS), (Nolan *et al*., 1998).

Whereas AWES focuses on the work environment and offers a 'snapshot' assessment, POWCS asks for managers' perceptions of the nature and direction of change over the course of the previous year (Dewar *et al*., 2019). AWES is a 36-item scale and is measured on a 5-point scale ranging from 'increased a lot' (5) to 'decreased a lot' (1). AWES contains both positive and negative statements (negative statements reverse coded). POWCS includes 28 items, measured on a 5-point scale, also ranging from 'decreased a lot' (5) to 'increased a lot' (1). Whilst separate instruments, they provide easily comparable and related areas for consideration. Both questionnaires have been used previously to measure the impact of local nursing strategies for change in practice in community-based hospitals, (Nolan *et al*., 1998; Schofield *et al*., 2005).

All participants completed the same questionnaires (AWES and POWCS) at the beginning of the program (pre-) and then again at the end (post-). As individual identifying markers were not used, data were collected at group rather than individual levels. As such this study is

not using a repeated measures approach but comprises a cross-sectional survey.

Data Analysis

All the resulting data were collected in each region using an Excel spreadsheet which was subsequently uploaded to SPSS. Statistical analysis identified normalcy of distribution was acceptable with some minor exceptions at time 2 which may be due to a ceiling effect (Table 2) but all were treated as normally distributed.

In an initial phase, exploratory factor analysis was conducted on combined pre- and post-intervention datasets to establish a stable factor structure of both instruments prior to further examination. Based on the finding of the exploratory factor analysis, items were examined using cronbach's alpha and summated to the level of the construct. The analysis focused on changes within the constructs of each tool across time and the three geographical regions. Inferential statistics (t-tests and analysis of variance) were used to examine the significance of change. The analysis focused on three stages:

1. The organizational position prior to the intervention and differences between the three countries
2. Changes within the constructs of each questionnaire over the two-time points overall and over time points between countries
3. The organizational position post-intervention and differences between the three countries

To minimize bias, the statistical analysis of the data was conducted by an independent statistician not involved in the delivery of the LSP.

Results

The breakdown of the response rate at each time point is presented in Table 1.

Questionnaires were completed at two-time points, matched by cohorts, but not by person.

Exploratory Factor Analysis

AWES

Initial analysis indicates the appropriateness for factor analysis of the items (KMO = 0.844, Barlett test for sphericity chi-square, 2061.15, df = 210, p = 0.01). Exploratory factor analysis of the items shows that a five-factor model emerged from the data. These include care delivery (8 items); feeling valued (4 items); workload (3 items); staff (3 items) and role of manager (3 items). Overall model explained 52.49% of the variance: Factor 1 = 16.15%; factor 2 = 12.98%; factor 3 = 9.29%; factor 4 = 8.69%; factor 5 = 5.38%. Examination of the measures of homogeneity show that the factors were stable: Care delivery (time 1 = 0.85, time 2 = 0.85); Feeling valued (time 1 = 0.85, time 2 = 0.74); Workload (time 1 = 0.74, time 2 = 0.60); Staff (time 1 = 0.74, time 2 = 0.60) and role of manager (time 1 = 0.56, time 2 = 0.18). It also included 14 additional questions that examined the workplace culture and context.

POWCS

Initial analysis indicates the appropriateness for factor analysis of the items (KMO = 0.948, Barlett test for sphericity chi-square, 6138, df = 190, p = 0.01). Exploratory factor analysis identified an emergent four-factor model that includes impact on the manager (6 items, time 1 = 0.88; time 2 = 0.52); impact on service user (6 item time); leadership (5 items) and stress (4 items). The overall model explained 62% of the variance: Impact on manager = 47.38%; impact on service user = 7.69%; leadership = 3.91%; stress = 3.16%; examination of the measures of homogeneity show that the factors were stable: Impact on the manager (time 1 = 0.88; time 2 = 0.52); impact on service user (time 1 = 0.85; time 2 = 0.57); leadership (time 1 = 0.83; time 2 = 0.79) and stress (time 1 = 0.64; time 2 = 0.70). The questionnaire included 8 additional items that measured the work environment.

Perception of Workplace Change Schedule (POWCS)

The items of the questionnaire were examined across both time points. Examination of skewness and kurtosis showed no deviation from normality of distribution and the data was suitable for analysis using parametric tests. Examination of Table 2 shows that there were statistically significant changes across time points on 26 of the 28 items. For example, job satisfaction and satisfaction with working conditions, and enthusiasm to work in the care sector changed positively and significantly. There were small, positive but statistically significant changes across the items measuring the workplace culture. Items with the largest changes included the amount of time staff spend with residents, managers' own quality of life, and the morale of staff.

Table 1: Response rates across three countries and time points. (T1 = Time 1, T2 = Time 2)

Time point	Location	Pre- (T1) frequency/percentage	Post- (T2) frequency/percentage
	England	133 (48.9)	132 (49.8)
	Scotland	98 (36.0)	94 (35.5)
	Northern Ireland	41 (15.1)	39 (14.7)

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Table 2: Perceived impact of LSP on various factors (managers, service users, leadership, stress, additional comments), according to findings from POWCS

During the last 12 months	Pre-post mean	SD	Skewness	Kurtosis
Factor 1: Impact on manager	2.90	0.78	-0.12	-0.59
	2.42	0.88	-0.50	-0.21
The sense of personal achievement I get from work has	2.87	1.22	0.08	-0.96
	2.11**	1.26	0.86	-0.42
My feeling of being valued has	3.04	1.03	-0.63	-0.48
	2.48**	1.12	0.37	-0.43
My job satisfaction has	2.97	1.10	0.05	-0.60
	2.39**	1.16	0.46	-0.60
My feelings about job security have	2.95	0.93	-0.13	0.45
	2.63**	0.99	-0.17	-0.14
Satisfaction with my overall working conditions has	2.92	0.87	-0.15	0.42
	2.52**	1.03	0.33	-0.28
My enthusiasm for working in the care sector has	2.84	0.95	-0.16	-0.16
	2.29**	1.08	0.43	-0.49
Factor 2: Impact on service users	2.51	0.54	-0.32	0.21
	1.98	0.60	0.26	-0.25
The amount of time staff actively talk with relatives and service users has	2.75	0.83	-0.08	0.37
	2.09**	0.82	0.27	-0.60
The quality of life of my service users has	2.27	0.69	-0.11	-0.45
	1.87 **	0.74	0.49	0.14
Staff's desire to take the initiative in responding to service user's needs has	2.49	0.76	0.10	0.05
	1.98 **	0.69	0.17	-0.41
Service user's active involvement in decisions that have affected them has	2.37	0.69	-0.18	-0.38
	1.94 **	0.70	0.21	-0.53
The quality of interaction between staff and service users has	2.55	0.69	-0.17	0.27
	1.91**	0.76	0.32	-0.74
The quality of interaction between staff and relatives has	2.66	0.69	-0.36	0.77
	2.08**	0.77	-0.03	-1.10
Factor 3: Leadership	2.51	0.64	0.22	-0.30
	1.80	0.62	0.72	0.02
The quality of management and leadership I am able to offer has	2.60	0.95	0.36	0.08
	1.85**	0.91	0.93	0.20
My understanding of how to improve the culture of care has	2.38	0.76	0.02	-0.36
	1.68**	0.75	0.88	0.19
My staff's ability to take initiative has	2.56	0.71	0.01	0.15
	2.06**	0.71	0.48	0.41
My leadership and communication skills have	2.37	0.77	0.08	0.18
	1.58**	0.67	0.90	0.27
My confidence as a professional has	2.65	0.96	0.26	-0.19
	1.84**	0.90	1.01	0.95
Factor 4: Stress	2.33	0.82	0.66	0.80
	3.08	0.94	-0.05	-0.48
The levels of stress I feel has	2.40	1.10	0.70	-0.11
	3.35**	1.23	-0.31	-0.84
My workload has	1.75	0.94	1.29	1.41
	2.39**	1.09	0.38	-0.48
My own quality of life has	3.17	1.19	0.12	-0.59
	2.51**	1.12	0.50	-0.21
Additional statements				
The morale of my staff has	2.82	1.15	0.36	-0.54
	2.07**	0.95	0.81	0.35
The quality of my engagement with my staff has	2.46	0.98	0.40	-0.20
	1.73**	0.79	0.80	-0.10
Satisfaction with practice in the care setting has	2.58	0.87	0.03	-0.36
	2.01**	0.83	0.59	0.09
My satisfaction with the relationship I have with my line manager/owner has	2.75	1.00	0.08	-0.36
	2.49**	1.02	0.14	-0.34
The overall level of quality of practice in this care setting has	2.21	0.71	0.22	0.34

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Table 2: Continue

	1.88**	0.81	0.93	1.40
Staff sickness levels have	3.00	0.95	-0.06	-0.19
	3.40**	0.97	-0.14	-0.10
Staff retention levels have	2.88	0.79	-0.03	0.71
	2.97	0.90	0.22	0.35
inappropriate hospital admissions appear to have	3.65	0.88	0.15	-0.87
	3.76	0.89	-0.05	-0.60

Note: In this survey, a decrease in the score is equal to a positive impact (5 = decreased a lot, 1 = increased a lot)
N.B. Time 2 scores are in bold print; * = significant at p<0.05; ** = significant at p<0.01

Table 3: Summary of perceived impact of LSP across countries (England, Scotland, Northern Ireland), according to findings from POWCS

	Impact on managers		Impact on service users		Leadership		Stress	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
England	2.84 (0.76)	2.64** (0.95)	2.52 (0.55)	2.15** (0.61)	2.52 (0.63)	2.01** (0.66)	2.23 (0.80)	2.88** (0.93)
Scotland	2.88 (0.79)	2.18** (0.74)	2.48 (0.55)	1.81** (0.56)	2.45 (0.65)	1.59** (0.51)	2.43 (0.77)	3.30** (0.88)
N. Ireland	3.31 (0.79)	2.25** (0.77)	2.53 (0.52)	1.80** (0.53)	2.67 (0.69)	1.62** (0.53)	2.45 (1.01)	3.21** (1.01)
Overall	2.90 (0.78)	2.42** (0.88)	2.51 (0.54)	1.98** (0.60)	2.51 (0.65)	1.80** (0.63)	2.33 (0.82)	3.08** (0.94)

N.B. Time * = significant at p<0.05; ** = significant at p<0.01

The results were categorized by factors identified by the exploratory factor analysis. Also included are additional statements which although not aligned with factor analysis provide additional insight.

Additional Statements

Whilst the additional statements in Table 2 did not align with specific factors, they all improved at a statistically significant level, (two items staff retention and inappropriate admissions, changed positively but not with a statistically significant change. Notable improvements were reported in statements pertaining to staff morale and staff sickness.

The scores for each factor at both time points across countries are shown in Table 3. Overall scores across the four constructs changed positively and at a statistically significant level.

These findings demonstrate a significant positive change across all four factors in each of the three geographical areas (impact on managers, impact on service users, leadership, and stress).

Impact on Managers Definition: "Feeling of Achievement and Satisfaction with Working in the Sector and Job"

On the construct 'impact on managers', a score of 2.9 reflects a sense of things staying the same at pre-intervention and there were statistically significant differences in scoring between the three geographical areas at time 1 (f = 4.57, df 257,2, p = 0.01) from 3.31-2.84 (Table 3). After the intervention, all scores decreased at a statistically significant level (t = 6.69, df 527, p<0.01) but this change was strongest among participants in Northern Ireland and Scotland (impact on managers t = 6.694, df 527, p = 0.01; Table 2). At Time 2, there were statistically significant differences in scores between countries ranging between 2.64-2.18.

Whist significant changes were seen across the factors, the most significant changes were in the statements on participants' feeling valued with a significant increase of 0.97, and enthusiasm for working in the care sector showing a significant increase of 0.93.

Impact on Service Users Definition: "Level of Engagement and Interaction in Care between Staff and Service Users/Relatives"

Construct scores of 2.51 reflects a sense of things staying the same at pre-intervention. There was no significant difference in scoring across geographical locations in the pre-intervention data. Examination of the scores shows that overall participants scored this construct to have improved across time points at a statistically significant level for the total sample (t = 10.59, df 527, p = 0.01). This change in scoring was statistically significant across time between counties (f = 5.05, df 5,2, p = 0.01). All scores decreased across all three locations, but England decreased at a lower rate when compared to Scotland and Northern Ireland's Impact on service users. Within this factor, the most notable change was around the amount of time staff actively talk with relatives and service users and the quality of life for service users.

Leadership Definition: "Positive Transformative Leadership Through Effective Communication"

Construct scores of 2.51 reflects a sense of things staying the same at pre-intervention. There were no significant differences in leadership across countries at the start of the program. However, a significant difference

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over time for the total sample (t = 12.79, df 527, p = 0.01). There was a significant difference in scoring across time between counties (f = 7.63, df 5,2, p = 0.01). The overall outcome was that all scores decreased across all three locations. The statement with the most change pre and post was staff's ability to take initiative. In addition, participants increased confidence as a professional health professional was noted. Managers' perception of how to improve the culture of care had marginally decreased in T2.

Stress Definition: "Stress, Workload and its Negative Impact on Quality of Life"

Construct scores of 2.33 reflects a sense of stress that had been increasing at pre-intervention. There was no significant difference across countries at the start though a significant difference was noted over time for the total sample (t = -9.74, df 527, p = 0.01) as stress levels decreased. There was a significant difference in scoring across time between counties (f = 0.94, df 5,2, p = 0.01). The participant's own quality of life had the largest shift among all the questionnaire statements aligned to factors, stress, and workload.

Assessment of Work Environments Schedule (AWES)

Examination of the scores for the items of AWES (Table 4) shows small but statistically significant changes in 29 of the 36 items, mostly in a significant manner. These changes were noted on items within the five factors (Table 4) such as a sense of feeling valued and a more manageable workload.

The largest change was in 'I lack confidence in my role as a care professional', this is a negatively framed statement that demonstrates that more participants disagreed with this at the second time point so a significant result:

- The other items with large changes include
- The quality of life of my service users is positive
- Staff are provided with sufficient time to provide the type of care they need
- There is a positive feeling of morale among my staff
- I feel that staff prioritize the service user's quality of life before the tasks of the day

Table 4: Perceived impact of LSP on various factors (care delivery, feeling valued, workload, staff, role as manager, additional comments), according to findings from AWES

Thinking about the place in which I work, I feel that; (1 = strongly disagree 5 = strongly agree)	Mean	SD	Skewness	Kurtosis
Care delivery				
The environment of care for service users is good	4.25	0.78	-0.72	0.90
	4.32	0.71	-1.13	2.27
Staff play an active role in decision-making about resident care	3.76	0.78	-0.23	-0.30
	4.08**	0.95	-1.11	0.82
The overall quality of care provided is high	4.25	0.64	-0.61	1.03
	3.92**	1.21	-0.96	-0.14
I am very satisfied with the level of care practice that staff offer to service users	3.87	0.71	-0.40	0.26
	4.02**	0.93	-0.84	0.11
The quality of life of my service users is positive	3.93	0.67	-0.31	0.29
	3.33**	1.42	-0.29	-1.36
I am content with the quality of interaction that staff have with service users	3.37	0.89	-0.33	-0.84
	3.92**	0.79	-0.80	0.88
I am content with the quality of interaction that staff have with relatives	3.35	0.89	-0.33	-0.84
	3.64**	0.79	-0.80	0.88
The care setting feels like a positive community where service users, staff, and	3.76	0.75	-0.41	0.61
relatives enjoy spending time with one another	4.45**	0.66	-1.10	1.34
Feeling valued				
I am congratulated when I do things well	3.26	0.97	-0.18	-0.53
	3.86**	0.85	-0.50	-0.03
I am given respect by my superiors	3.83	0.88	-0.69	0.56
	4.34**	0.66	-0.90	1.91
I feel valued for the work I do	3.44	0.91	-0.50	0.24
	3.92**	0.85	-0.80	0.85
I have a positive relationship with my line manager/owner	3.98	0.77	-0.38	-0.17
	4.03	0.71	-0.88	1.37
Workload				
The amount of work I am given to do is realistic	3.01	1.02	-0.09	-0.68
	3.52**	1.03	0.45	-0.48
I am able to make sufficient time to support staff to deliver care to service users	3.38	0.86	-0.42	-0.44
	3.90**	0.91	-0.58	-0.24
The amount of time I have to talk to relatives and service users is acceptable	3.22	0.94	-0.25	-0.88
	3.28	1.11	-0.15	-1.05
Staff				
I actively provide space and time to listen to the views of staff	3.95	0.72	-0.42	0.16
	4.54**	0.55	-0.77	0.36

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Table 4: Continue

I actively listen to the opinions of my staff	4.12	0.63	-0.28	0.27
	4.47**	0.65	-1.26	2.65
My staff are congratulated when they do things well	4.12	0.78	0.89	1.40
	4.22	0.95	-1.06	0.34
Role as a manager				
I feel that I have the management and leadership skills required to undertake an effective role	3.93	0.65	-0.43	0.72
	4.28**	0.67	-0.79	1.04
I lack confidence in my role as a care professional	2.36	0.91	0.72	0.41
	3.06**	1.35	-0.13	-1.34
I have a positive quality of life	3.72	0.83	-0.57	0.09
	4.39**	2.63	14.24	220.60
Additional Items				
There is a good spirit of cooperation between managers and staff	3.62	0.71	-0.70	0.84
	4.31**	0.69	-0.84	0.79
There is a good spirit of cooperation between staff	3.65	0.77	-0.70	0.41
	4.22**	0.67	-0.75	1.15
Staff can try new ideas without criticism	3.83	0.74	-0.17	-0.32
	4.15**	0.87	-1.07	1.09
Staff are provided with sufficient time to provide the type of care they need	3.41	0.90	-0.40	-0.41
	4.21**	0.78	-0.93	0.76
Staff are actively encouraged to develop their skills	4.08	0.71	-0.74	1.08
	4.58**	0.61	-1.34	1.75
My responsibilities as a care professional are too great	3.36	0.87	0.11	-0.50
	3.27**	0.93	0.05	-0.62
Staffing levels are adequate for the workload	3.50	0.98	-0.55	-0.30
	4.08**	0.86	-1.07	0.88
I typically experience high levels of stress	3.64	0.93	-0.38	-0.19
	3.52	0.95	-0.18	-0.90
There is a positive feeling of morale among my staff	3.36	0.77	-0.38	-0.17
	4.16**	0.71	-0.88	1.37
I currently get a positive sense of personal achievement from my work	3.93	0.76	-0.79	1.35
	4.33**	0.68	-1.11	2.51
My understanding of how to change the culture of care is limited	to 2.92	0.89	0.11	-0.44
	3.10	1.80	0.12	-1.28
I feel that I have developed effective influencing skills	3.66	0.77	-0.33	-0.16
	4.06**	0.79	-0.95	1.26
My general feeling at present is that: Staff sickness levels are an ongoing problem	3.50	1.14	-038	-0.77
	3.02**	1.13	0.04	-0.99
Staff retention levels are an ongoing problem	3.16	1.08	-0.03	-0.93
	3.20	1.12	-0.27	-0.90
I feel that staff prioritize the service user's quality of life before the tasks of the day	3.19	0.95	-0.13	-0.39
	3.99**	0.78	-0.83	1.06

N.B. Time 2 scores are in bold print; * = significant at p<0.05; ** = significant at p<0.01

Table 5: Summary of perceived impact of LSP across countries (England, Scotland, Northern Ireland), according to findings from AWES

	Care delivery		Feeling valued		Workload		Staff		Role of a manager	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
England	3.76	3.54	3.67	3.97	3.11	3.29	4.12	4.16	3.72	3.42
Scotland	3.75	4.34	3.62	4.11	3.27	3.83	4.01	4.65	3.81	4.23
N. Ireland	3.82	4.36	3.48	4.10	3.37	3.85	4.02	4.68	3.85	4.56
Overall	3.77	3.94	3.63	4.04	3.21	3.57	4.06	4.41	3.77	3.88

There were no significant differences according to the country on all four construct scores prior to the intervention, indicating that all regions experienced similar work environment issues, Table 5.

Care Delivery Definition: "The Positive Work Culture Promoting the Provision of Quality Care and Interaction for Service"

There was a small, statistically significant difference in scores for the total sample across both time points (t = -3.52, df 533, p = 0.01). Scores increased from 3.77-3.94, (Table 5). Examination of the scores according to country across time shows significant differences in scoring across countries across time (f = 10.56 df 5,2, p = 0.00). Similar patterns in scoring were reported across the factor 'feeling valued' 'workload' 'staff' and 'role of a manager'. Within this factor the scores went down for two statements 'quality of care provided is high' and 'quality of life for service users' though the latter was a small decrease of 0.8. However, a significant shift was

noted in the care setting 'feels like a positive community' and that the participant is content with the 'quality of interaction between staff and service users'.

Feeling Valued Definition: "Appreciation and Recognition from My Line Management"

There was a statistically significant difference for the total sample across time (t = -6.93, df 533, p = 0.01) and a significant difference in scoring across countries across time (f = 2.095 df 5,2, p = 0.00), (Table 5) All scores increased at a similar rate across time points across all three locations. A feeling of being valued and respected scored higher after the intervention though a small decrease was noted in the positive relationship with line managers.

Workload Definition: "Time to Support Residents and Staff"

A statistically significant difference for the total sample across time (t = -5.44, df 533, p = 0.01) was noted, and a significant difference in scoring across countries across time (f = 3.84 df 5,2, p = 0.02), (Table 5). All scores increased across all three locations. Within this factor, the largest shift was 'the amount of work I am given to do is realistic' similar to 'I am able to make sufficient time to support staff to deliver care to service users'.

Staff Definition: "My Impact and Interaction with Staff"

A statistically significant difference for the total sample across time (t = -7.07, df 533, p = 0.01) was recorded, and a significant difference in scoring across countries across time (f = 21.43 df 5,2, p = 0.00), (Table 5). The most notable change in this factor was for the statement 'I actively provide space and time to listen to the views of my staff'.

Role of a Manager Definition: "Skills, Confidence and My Own Quality of Life"

No statistically significant difference for the total sample across time (t = -1.39, df 530, p = 0.17) but a significant difference in scoring across countries across time (f = 17.11 df 5,2, p = 0.00).

Whilst an increase was recorded in the score for the statement about managers confidence this is a negatively worded statement and so demonstrates a reduction in confidence. Additionally, a significant increase was noted in leadership skills and managers having a positive quality of life.

Additional Items

Additional statement items which did not align with factors are included in Table 4 and add additional insight into the results of the intervention. Whist staff retention problems continue to be a concern as do appropriate staffing levels staff sickness levels are less so. Participants report increased confidence in personal achievement, changing the culture of care, and effective influencing skills. Also, stress levels are lesser following the intervention.

Discussion

The results provide robust evidence of the overall positive impact of the MHLLS program across the three participating countries. The results concur with the findings by Dewar *et al.* (2017) who reported positive changes when comparing the questionnaires pre- and post-intervention and qualitative data of the MHLLSP in Scotland alone (Dewar *et al*., 2017). This suggests that the LSP is of value across national contexts. The study also provides an updated factor analysis of the AWES and POWCS questionnaires.

The key areas in which MHL participants report significant change within their care homes are recognition and regard for them and their staff, workload, quality of care, and working relationships. Penney *et al*. (2017) found that the action learning workshops based on the MHL program for care homes in Australia gave participants the 'opportunity to harness their own collective wisdom' and ultimately improve resident care. Evaluations of the MHL program across Scotland found participants developed not only their confidence in leading change but also, motivation for further change and ultimately the development of positive cultures (Dewar *et al*., 2017; Sharp *et al*., 2018). Appreciative Inquiry (AI) is a central component of this program which enables participants to explore what is working well and what matters to people living, working, and visiting care homes.

Reed describes the basic premise of AI as "a simple but radical approach to understanding the social world. Put simply, AI concentrates on exploring ideas that people have about what is valuable in what they do and then tries to work out ways in which this can be built on" (Reed, 2006).

Perhaps unsurprisingly as the program is hinged on supporting managers to develop their leadership skills, the findings highlight a real change in participants 'self-worth and self-belief'. They also identified that participants believed that the quality of care for their residents had improved at the end of the program, as had their relationships with their staff. Interestingly, the perceived impact on the quality of interaction between staff and relatives had decreased at T2 and is worthy of further exploration.

Three distinct areas of improvement are identified across both questionnaires: Impact on participants, perceived impact on other staff, and perceived impact on quality of care.

Impact on Participants

People within leadership roles within care homes often feel like they wear many different hats with legal, managerial, and commercial responsibilities and answer

to more than one overseer (Owen and Meyer, 2012; Orellana *et al*., 2017; Owen *et al*., 2012). They are answerable to the care home owner and also to the regulator and those commissioning beds, be that health and social care staff or family members. It can be difficult to ensure that each of these stakeholders always has their needs and requirements met (Owen *et al*., 2012). Being an effective and competent leader in a care home is crucial not only for the ultimate requirement of safe effective care delivery but also, for the well-being of the leader themselves (Orellana *et al*., 2017; Rokstad *et al*., 2015; Penney and Ryan, 2018; Havig *et al*., 2011; Castle and Decker, 2011; Bowman and Meyer, 2017).

Participants recorded notable changes, particularly in feeling valued and enthusiastic about working in the care sector. The MHL LSP encourages participants to value themselves, as well as, residents, relatives, and other staff in their care homes. A significant portion of the initial workshops is based on 'leading self' which facilitates a discussion around participants' own self-worth. Dewar identified that participants "learned more about themselves and that this, in turn, helped them to develop as leaders" (Dewar *et al*., 2019). The resulting enthusiasm for working in the care sector may well be related to the value they grew to place on their own contribution, through the use of MHL evidence-based inquiry tools, such as caring conversations. This tool supports participants to encourage and sustain genuine curiosity for themselves and others, deepen inquiry, explore values, and acknowledge and expressing emotion without dispute or judgment. It also helps users to acknowledge achievements, encourage better listening and so make room for more contributions. It supports a different attitude to risk-taking, devising new approaches to problems, and ultimately feeling more confident in translating the MHL evidence base into practice (Dewar *et al*., 2019).

With its emphasis on leadership, the MHL LSP uses different strategies to develop the leadership skills of participants, encouraging them to explore how appreciative inquiry can help focus on taking positive action. A key element of the program involves looking at how participants lead not only their team but also facilitating them to unpick their own leadership style, using a strong theoretical foundation of appreciative inquiry. An essential element of the program is empowering participants to consider how they enable their staff to take initiative. Haunch *et al*. (2021) identify this as a key component in enhancing care delivery. This was recorded as a significant and positive change within the study. Results also identified increased confidence in participants as health professionals and a feeling of being valued and respected scored higher after the intervention. Indeed, staff perception of autonomy is directly related to a positive experience in resident care (Bennett *et al*., 2015; Jacobsen *et al*., 2018).

Results showed a significant increase in leadership skills and managers having a positive quality of life. Although results showed an increase in the score for the statement about managers' confidence, this was a negatively worded statement where an increased score demonstrated a reduction in confidence. It is possible that this score may be directly related to the findings on stress. The most notable change in the factor (stress) was for the statement 'I actively provide space and time to listen to the views of my staff'. This may contribute to the staff's ability to provide quality care as staff are given more opportunities to discuss any concerns and are more involved in decision-making. It has been noted by several authors that when staff feels recognized and valued there is a better outcome for residents (Eldh *et al*., 2016; André *et al*., 2014).

The COVID-19 pandemic, whilst highlighting the exceptional care provided by this sector, also identified a significant gap in support and the lack of prioritization for the residents and staff in care homes (Gordon *et al*., 2020; Thomas and Quilter-Pinner, 2020). Work in the care home sector is often recognized as a stressful occupation (Islam *et al*., 2017) and the COVID-19 pandemic highlighted again the differences felt between care home staff and their colleagues in hospital settings (Blanco-Donoso *et al*., 2021), Nonetheless, (Marshall *et al*., 2021) identified that local communities ''valued care homes, their staff and the work that they do' and that care home managers were central to ensuring continuity of care. This was especially in the early stages of the pandemic, when (Ryan and Moore, 2023) also identified staff pride in their work.

This myriad of stressors stems from poor media coverage, lack of recognition as key or frontline workers, and lack of training opportunities to name only a few (Oliver, 2020; Trinkoff *et al*., 2017; Han *et al*., 2014; Eldh *et al*., 2016). At the end of the MHLLSP participants rated their own quality of life as better than the baseline and this item had the largest shift amongst all the questionnaires statements aligned to factors. Stress and workload items also changed significantly in a positive manner for participants which in turn are likely to have contributed to their own quality of life. A possible explanation is that although many of the stress-provoking factors (workload demands, staff turnover, etc.,) remained unchanged, engagement with the MHL LSP may have enhanced participants' ability and resilience in dealing with these stressors.

Perceived Impact on Other Staff

Whilst there was a correlation between the impact of the program on all staff within the care home and the quality of care provided, it is important to identify that the quality of care is achieved through the staff's ability to provide the care competently and compassionately. Orellana (2014) reported that staff can only achieve this when the leaders in the care homes are supporting,

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encouraging, and most importantly actively facilitating culture change. These are all components that are explored in the MHL LSP. As the managers' own leadership approach is critical to ensure this happens, this program can help develop these essential leadership qualities. Other studies have identified that a care home manager's approach can directly impact the culture within the home (Orellana, 2017; Dewar *et al*., 2017; Sharp *et al*., 2018).

Some participants on the MHL LSP identified that at the beginning they feel an often-overwhelming burden to oversee or micro-manage all aspects of care, but by the end of the program, they feel a sense of achievement and pride in their staff's newfound ability to use initiative and become leaders of quality care themselves individuals (Dewar *et al*., 2017; Sharp, 2018; Dewar and MacBride, 2017). A notable change was in 'I actively provide space and time to listen to the views of my staff'. Studies show the use of innovation and being prepared to listen to staff is essential for effective leadership (Jagosh *et al*., 2015; Backman *et al*., 2017). The results also appear to suggest that when managers become more engaged with their staff, this in turn can influence the way in which staff engage with residents and relatives, as communication between staff and residents was perceived to have improved significantly in this study.

The impact of the MHLLSP creates an evolution of interaction or ripple effect (Bushe and Kassam, 2005) of good practice. Although only managers attend the program, it is possible that their role modeling of appreciative inquiry may have a ripple effect on the way in which their staff interacts with residents. Sharp *et al.* (2018) identified the ripple effect within the MHLLSP particularly with people being more open to sharing how they feel (Dewar *et al*., 2017). The ripple effect is central to the MHLLSP, as how individuals see themselves impacts all those they interact with. Within the MHLLSP participants also engage in action learning methods (Cooperrider *et al*., 2003; Dewar and Mackay; 2010; Dewar, 2011) and embrace new ways of communicating through the acquired skills of caring conversations (Dewar and Nolan, 2013; Poels *et al*., 2020). It is also possible that these new ways of working enable them to reflect on their own practice and impact the quality of care provided in their care homes. During their action learning sessions, managers identify what they feel they do well, how these things could happen more of the time, and what they might improve upon (Penney *et al*., 2017). As reported by Dewar *et al*. (2019) the results of this study suggest that the MHLLSP resulted in a change in managers' perceptions of their self-awareness, leadership communication, relationship skills, and development of positive cultures (Dewar *et al*., 2019). This transformational leadership is directly linked to increased staff-wellbeing, higher job satisfaction, decreased intention to leave, and decreased burn-out rate (Poels *et al*., 2020; Rokstad *et al*., 2015).

Perceived Impact on Quality of Care and Quality of Life

Participants reported an increase in the amount of time staff spent with residents and this can be linked to several components of the MHLLSP. Participants are encouraged to reflect on interactions with residents and how their staff can be enabled to provide high-quality interactions. A key phrase used within the program is to think about 'doing things differently, not looking for different things to do'. The belief is centered on finding new ways to work. Managers may be role-playing this approach and actively encouraging staff to engage. Whilst no additional funds were available for extra staff hours this increased time was found within existing provisions hinging on the notion of doing things differently instead of doing lots of new different things.

Participants rated the perceived quality of life for residents as higher post-intervention. This could be explained with reference to different components of the program. A central aspect of the MHLLSP is the use of action learning where individual participants have an opportunity to discuss, explore, and action issues they would like to change. This is facilitated using appreciative inquiry and includes the framework of caring conversations (Dewar, 2011; Dewar and Nolan 2013). Within this supportive arena, many choose to discuss various aspects of care delivery. During action learning many approaches and ideas are shared amongst the group with a willingness to try a new approach embraced by most participants who also reported an improvement in how staff prioritized the resident's quality of life before the routine tasks of the day.

Participants reported, post-intervention, that staff spends more time talking with residents and relatives and an increase in their perception of residents' quality of life. A key component in the MHLLSP is the exploration of interaction with residents' relatives and the program encourages participants to reflect and explore how this could be done differently. This appears to be achieved by participants as evidenced by the perceived improvement in the interactions with residents and relatives.

Conclusion

Whilst the findings demonstrate a significant positive change in the impact of the MHLLSD program, not only on managers and their leadership but also on residents' quality of life in the care home, it is not easy to determine a true cause and effect relationship due to the variety of methodological complexities at play. Further research is therefore needed to explore the views and experiences of residents, relatives, and staff in order to determine the true impact of the program on developing leadership skills and culture change within the care home. The evidence from this study also provides useful

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benchmarking for the effectiveness of the tools used to measure the impact of MHLLSP.

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Author's Contributions

Sarah Penney: Contributed to the study design. Data analysis. Drafted the manuscript.

Assumpta Ryan and Paul Slater: Contributed to the study design, Data analysis and critically revised manuscript for important intellectual content.

Julienne Meyer, Belinda Dewar, Tom Owen and Brighide Lynch: Critically revised manuscript for important intellectual content.

Ethics

As this study was conducted in independent care homes, ethical approval was granted by the Ulster University filter committee and within each host/providing country, city university London and University West Scotland. All information about participants and all data emerging from the study was confidential and stored on a password-protected computer. All methods and protocols were carried out in accordance with Ulster University guidelines and regulations.

Informed consent was obtained from all participants who were provided with a participant information sheet.

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