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## Summary


- A human approach to home care - which treats both staff and citizens as valued human beings - makes for an outstanding service
- Self-management is a way to create a culture and processes of ongoing learning in home care.
- A more human approach to home care requires broader systems change from commissioners - removing the silos between home care and other elements of the health and social care system.


# Wellbeing Teams

## Overview

### Phase One of Wellbeing Teams

At one level, Wellbeing Teams is a home care service. Its purpose is to do whatever we can to support people to live well at home and be part of their community. However, Wellbeing Teams is also more than that - it is an experiment to see how the system of health and social care could change in a place.

To achieve this purpose, there are 5 elements to the design of Wellbeing Teams:

1. Relationship-centred support
2. Focus on what matters to the person and their wellbeing, not just personal care
3. Helping people to be part of their community
4. Recruitment for values
5. Self-management

The first phase of Wellbeing Teams involved working within existing commissioning structures and processes under home care contracts in Wigan and Oxfordshire. The learning from this led to Phase Two, where Wellbeing Teams worked with an existing provider and two local authorities to support the implementation of the Wellbeing Team model.

Wellbeing Teams were supported by the Royal Society of Arts, Manufactures and Commerce (RSA)'s Transform programme in their first operating period (Phase One). The learning that came from this informed the operations for Phase Two. Wellbeing Teams was a case study in Radical Home Care.

Underpinning Wellbeing Teams' operating model is a key commitment to paying colleagues salaries that are above the living wage and which enable them to work in seven-hour shifts. This marks a profound break from the home care norm, where colleagues are commonly paid for contact time

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only, leading to working patterns that are unattractive and unsustainable for many. Common issues include: low pay, lack of (obvious) career progression, zero-hours contracts (lack of employment security), and for working hours that often exceed what for which they are paid.[1]

Wellbeing Teams set out to address some specific issues experiences by care workers in traditional home care organisations:

- Call stacking – a common practice of not including travel time in schedules so that care workers are never provided with enough time to meet the needs of people they support, which often leads to delayed appointments and workers constantly racing to the next person. This in turn can lead to:
- Workers only being paid for contact time and not for the travel time between appointments.
- In addition, providers often must absorb the cost of 'missed' appointments; for example, if someone goes into hospital. This cost is then passed on to workers who are only paid for the work that they delivered.
- Rotas are often developed on a week-by-week basis, preventing colleagues from planning their own life needs around their work life.
- Zero hours contracts.

## Being 'Human' to one another

Wellbeing Teams seek to be 'human' to one another – both to the people we support and our colleagues. We talk about love and developing close relationships (whilst also being aware of boundaries and safeguarding).

### Here are some examples of how we are human with people we support, and responded to what matters to them

- We talk about what matters instead of 'doing an assessment'
- Support is designed around the person, and this has included doing a 3-minute mindfulness session at the end of a visit
- We support people to share their life stories and record this together in a beautiful book
- We think together about gifts of the head, heart and hands and how these can be expressed
- We share the one-page profiles of colleagues with the people they support so that they know what matters to each individual in their team
- When we meet people for the first time, we bring them a gift – we want to show we care, and start building a relationship
- We ask, each month, what is working and not working and think together about how we can change what is not working
- Wellbeing Workers are expected to find ways to 'make people's day', and this is shared and celebrated with colleagues
- We think every shower should be a spa experience, and every application of cream can be a soothing massage
- Team members carry 'pamper packs' to be able to do people's nails, or massage feet

### Here are some examples of how we are human with each other:

- Weekly meetings: Wellbeing Workers use highly structured meetings, based on Holacracy tactical meeting practices. Each week, they review their performance, set priorities, and raise and resolve tensions. This includes a monthly review and root-cause analysis of any incidents or complaints.
- Shared roles: The roles traditionally done by a manager are shared amongst the team.
- Buddies: Each Wellbeing Worker has a linked colleague providing peer-to-peer support.
- Coaching: The Wellbeing Leader provides coaching support to the team.

[1] Atkinson, C.; Crozier, S.; & Lewis, L. 2016. Factors that Affect the Recruitment and Retention of Domiciliary Care Workers and the Extent to which these factors Impact upon the Quality of Domiciliary Care. Cardiff. Welsh Government Social Research.

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- 'Bring your whole self to work' practices: these include one-page profiles; gifts of the head, heart and hands; passion audit; individual work histories; and Wellbeing Action Plans.
- Confirmation Practices: Reflective practice and coaching are anchored into structured routines that use simple statements about what really matters. These help Wellbeing Workers to confirm what's working well and where there are opportunities to improve.
- Group 'Supervision'/'What if' cards: Wellbeing Teams use scenario cards (known as 'What if' cards and derived from real world examples) to explore issues of good practice and to conduct shared supervision.
- Monthly questionnaire through Peakon to help the teams identify what is working and not working (equivalent to a colleague engagement questionnaire).
- Person-centred team review every 6 months to review what is working/not working (based on purpose, values and team agreements) and agree objectives for the next 6 months.

## Optimising for learning rather than control

As self-managed teams we removed command and control and focused on clear processes and expectations, coaching, learning and experiments.

### Here are some examples of how we encouraged learning

- In recruitment, there was a section on reflective practice and giving feedback to each other.
- At induction each team member developed their 'Future Focus' which included how they wanted to learn and grow over the next year and what they wanted to focus on.
- Each team member did their Confirmation Practices to reflect on what they had tried and learned over the last month (or two weeks) in relation to the expectations of their role, and what they wanted to try or improve over the next 2 - 4 weeks.
- The incident and accident forms include space to reflect on what has been learned from this and what needs to change.
- Each month the whole team (in a team meeting) does an analysis of the incidents and accidents and why they have happened, what they have learned and what needs to change - and what experiments may be needed to test this out.
- Metrics were part of every team meeting, and team members were asked what they noticed from them and what could be done to change or improve them.
- At each team meeting there was a 'Living Well' board where Link Workers placed the names of the people they supported as either on track, off track or way off track. This led to a discussion about what was happening, what we could learn from that and what we needed to do next.
- Team meetings were based on raising and addressing tensions together. A tension is defined as something that is in the way of you doing your best work or the gap between where we are now and what you see is possible.
- The team developed their own 'Team Agreements' - their expectations of how they work together. There are reviewed every 4 - 6 months, either through a Confirmation Based Approach or a person-centred team review.
- Each team has a person-centred team review every 6 - 8 months which focuses on what is working and not working on how the team is living the values and purpose, keeping team agreements, learning and developing together. The team then sets their focus for the next 6 months.
- New Wellbeing Teams include which areas of the processes we want to tweak and improve, and what experiments we want to test (for example in the new Camden Teams there are 8 experiments taking place).
- Each week people are encouraged to post on the Slack channel 'Failureandlearning' to share where they have failed over the last 1 - 2 weeks and what they have learned from this. Leaders are expected to post regularly to this.
- Teams have a learning and development budget and a virtual learning help desk.
- Issues that could not be addressed by local teams were taken to the national team to address. There is a clear decision-making

agreement that specifies what decisions get made where, with the majority being made by individuals and teams.

## Iterations

The commitment to learning rather than control has enabled Wellbeing Teams to develop significantly since their inception, learning and evolving over the Phase One period. Key areas of learning include:

- Wellbeing Teams have demonstrated an ability to learn and adapt rapidly. Our self-managed model, emphasis on bringing the whole person to work, focus on self-care and use of technology to support and spread learning has made it possible for this to happen and for significant changes to roles and structure to be introduced quickly and effectively. Our handbook was rewritten six times in their first eighteen months to reflect the learning over that period.
- Supporting people and families to develop community connections has required a more relational, contextual approach than initially envisaged by Wellbeing Teams. This has led our practice in this area to become emergent, opportunistic and creative; a principle to be maintained rather than a model to be applied.

### Adaptation to Roles, Structures and Practices

Early experiences revealed that it was not necessary to separate the roles of Team Coach and Wellbeing Leader, and we instead introduced the role of Practice Coach. The roles that the teams shared amongst themselves evolved and developed. The nature of these changes could have been difficult to adapt to in a more conventionally structured organisation. However in Wellbeing Teams, where roles are seen as platforms for people to develop their skills and make a contribution rather than as ways to compartmentalise activity, the changes were made rapidly through straightforward conversations and with broad agreement.

Buddying and coaching approaches, anchored to the use of Confirmation Practices, have provided a mechanism for individual Wellbeing Workers to identify and pursue areas of special interest. Individual Wellbeing Workers can act as Champions in their areas of special interest (for example, mental health, end of life and dementia) and use other mechanisms (e.g. the structured team meetings and Slack) to spread learning and good practice.

The role of scheduler (the team member developing rotas) was identified as requiring a greater level of effort and responsibility than other team roles. Wellbeing Teams' emphasis on transparency and responsibility, manifest in our structured meeting practices, approach to decision making and use of IT, allowed this (and other issues) to be surfaced and addressed early. A shared decision was reached to reward the role with an enhanced rate in the larger Wigan teams. Wellbeing Teams' structured ability to raise and address tensions rapidly, combined with our lack of hierarchy (which has put the focus on ensuring that decisions are fair and mutual), has made for quick, flexible decision making.

Our original plan was to offer everyone supported by the Wellbeing Team a Community Circle. It quickly became clear that while Community Circles are a powerful way to support people to make changes in their lives, it was important to start with connections – helping people to meet other people based on shared interests. The focus of the work then moved towards individual community building and connections, social prescribing, and developing a monthly programme of social events that people could join. A significant number of people that Wellbeing Teams supported in Wigan had not left the house for months before being supported by Wellbeing Teams.

## Systems: Wellbeing Teams Phase Two

The progress made by Wellbeing Teams during phase one of our development reveals a model that addresses many of the key challenges facing home

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care in the UK. Far from being a job that is inherently unattractive, the experiences of Wellbeing Workers demonstrate that there is joy to be had in supporting people to live well at home, with the opportunity to be creative and the means to offer immense value.

Our success in recruiting and retaining colleagues from a broad range of backgrounds serves to reinforce this, and to emphasise that many of the enduring problems associated with home care are symptoms of how it has been conceived, commissioned, managed and evaluated but are not native to the work itself. It is interesting to note that Wellbeing Teams' key achievements in recruitment and colleague retention have come at a time when these are significant issues in social care.

At face value, the wider challenge of how to afford a model of home care like Wellbeing Teams can seem like an intractable issue. Commissioners do not have more money to give providers, and without it, providers cannot break from their dependence on zero-hours contracts. In both Wigan and Oxfordshire, however, there were opportunities to more radically rethink this problem by reconceiving the traditional scope of home care.

## Delivering basic health tasks

One of the people supported by a Wellbeing Team in Wigan was also being provided injections by a district nurse. This meant that the person received support from both Adult Social Care and Health, and that both were delivering support around medication, which both increased the cost and the number of people visiting the person. The solution could have been to have the district nurse support the person with their medication (which, when asked, they said was not their job), or to relieve the pressure on district nurses by training Wellbeing Workers to do basic health tasks. There are pilot projects taking place looking at transferring some basic health tasks to care workers; one such pilot is underway in Tameside and showing a 20% saving in nurse time.

It would be possible to go further by investing in wearables and home devices that provide health data, which could then be reviewed and inform decision making. For example, at a regular review, we could both look at what was working and not working from the person's perspective and what their health data was showing, and then make decisions together based on this.

## Reablement

Reablement is usually a separately organised and funded service. People leaving hospital are expected to have up to six weeks of intensive reablement support. Often, people still require support from home care after this period; however, it is challenging for traditional home care providers to continue to maintain these benefits with the pressure of time. It is often quicker to do things for a person than to support them to do it themselves.

The alternative would be to combine a reablement service with care and support at home. This would mean a smooth handover, rather than the person having to get to know a whole new group of people from another organisation and makes it more likely that people can retain the skills that they have regained. This should also help to reduce the likelihood of the person being readmitted in the future.

## Social Prescribing

Loneliness has been recognised as the health equivalent of smoking 15 cigarettes a day. NHS England is investing in a social prescriber for each Primary Care Network to support GPs to refer patients to community opportunities as well as medical interventions. However, this is likely to only benefit 2% of the patient population. Wigan had made an early investment in Community Link Workers, yet none of the 70 older people supported by Wellbeing Teams had ever seen a Community Link Worker.

Embedding a Community Connecting role within a Wellbeing Team means that people can be individually supported to be part of their community (as a social prescriber would do) and could allow us to develop a programme of social events based on the interests of people supported (if these were not already available). It could also act as an additional way to attract team members, by enabling them to share their skills and interests with people on a one-to-one basis or leading a social event each month. This could be a significant preventative service.

Each of these activities represents an opportunity for Wellbeing Teams, and other home care providers, to smooth their schedules by blending time-specific and time-flexible work.

Commissioning for a broader range of activities, some of which could be less tied to specific times of day, would enable Wellbeing Teams to retain a salaried workforce and liveable working patterns without the narrow pressure to maintain an average of 85% contact time for home care tasks. Importantly, these additional activities would not require 'new money'. They are already being undertaken in local health and care systems, but not within the scope of home care services. Moreover, integrating these activities with home care – for example, into a 'home care plus' model of delivery – would not only help to address the systemic issues with traditional home care; it may also enable additional benefits, such as: simpler, more joined up and more personalised care; greater opportunity for community building and better support to general practices; primary care networks with social prescribing; and capacity release for clinical staff who are under pressure, such as Occupational Therapists, Physiotherapists and Community Nurses.

## The Role of Commissioners In Catalysing System Change

In both Wigan and Oxfordshire, introducing Wellbeing Teams required much more from commissioners than had been anticipated or than is typical of their work with traditional providers. In some respects, this is unremarkable. Status quo service models and their supporting processes and practices have had years to embed themselves and find an equilibrium. Introducing a radical new model of care such as Wellbeing Teams inevitably leads to disruption.

Perhaps more remarkable then, is that even though this disruption is precisely the point – and the value – of Wellbeing Teams (or any radical new model of care), there was a tendency to treat it as a problem with the model (and therefore something to be smoothed out by adapting how Wellbeing Teams worked), rather than as a problem with the mechanisms of the status quo. To treat the issue in this way was to miss an opportunity to evolve a more sustainable system of care.

Wellbeing Teams' Phase One experience therefore suggests some profound implications for the role commissioners must play in implementing radical new models of care. If traditionally, commissioners have sought to specify scope and outcomes at the outset and then to pass responsibility to providers for delivery while holding them accountable, then introducing new models of care requires commissioners to engage in a much more integral, dynamic and action-learning led way. For example, it requires them to work continuously with their providers and their provider networks, to discover a new scope of service that is viable and effective. In doing this, commissioners have the opportunity to reshape patterns of provision in ways that catalyse wider, emergent and positive system change.

Changing the commissioning of home care requires systemic changes that Wellbeing Teams were of course not able to make, despite the success of the model. Therefore, in Phase Two, we moved from operating as a provider in the system to trying to influence the system in a different way.

We worked with two innovative commissioners in Thurrock and Camden, to get closer to an integrated approach with health (in Thurrock) and to explore the contribution of Wellbeing Teams in Extra Care (Camden).

Wellbeing Teams also started to support existing providers to introduce the five key elements of the model into existing provision (Relationship-centred support; Focus on what matters to the person and their wellbeing, not just personal care; Helping people to be part of their community; Recruitment for values; and Self-management).

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| If traditionally, commissioners have... | Then establishing new models of care requires them to... |
|---|---|
| **Specified scope and outcomes at the outset.** | Treat scope and outcomes as emergent. |
| **Approached implementation as a pilot or project, where a model is conceived, tested and evaluated (in that order).** | Approach implementation as action-learning, where a viable operating model is an outcome of continuous experimentation and where evaluation is baked into that process. |
| **Measured success against predetermined goals.** | Develop new measures and learning mechanisms as goals and focuses emerge and evolve. |
| **Maintained a safe distance to assure independence and objectivity.** | Work hand-in-glove with providers as an integral part of the process of discovery, interpretation, prioritisation and action-learning. |
| **Used accountability to locate and leverage responsibility with providers.** | Emphasise mutuality, shared sense-making, collective endeavour and shared accountability. |
| **Based evaluation and performance management on what providers can directly control or assumed that providers have material control over delivering what matters.** | Maintain a collective and evolving understanding of what really matters across a provider network, enabling interdependencies and system dynamics to be discussed and translated into shared action for improvement. |
| **Aimed to produce generalisable findings and models that can be scaled and spread anywhere.** | Aim to produce context-specific understandings about what has worked here and why in order to inform ongoing innovation. |
| **Acted as the arbiter of what matters, assumed authority over evaluation and rendered definitive judgements of success or failure.** | Act as the guardian of shared principles and values, engaging providers and provider networks in co-production, enabling learning and differences in perspective to come forward and be understood; in short, to act as system stewards. |

**(Table developed by Andy Brogan, inspired by Westley, Zimmerman, Patton "Getting to Maybe" (2006))**

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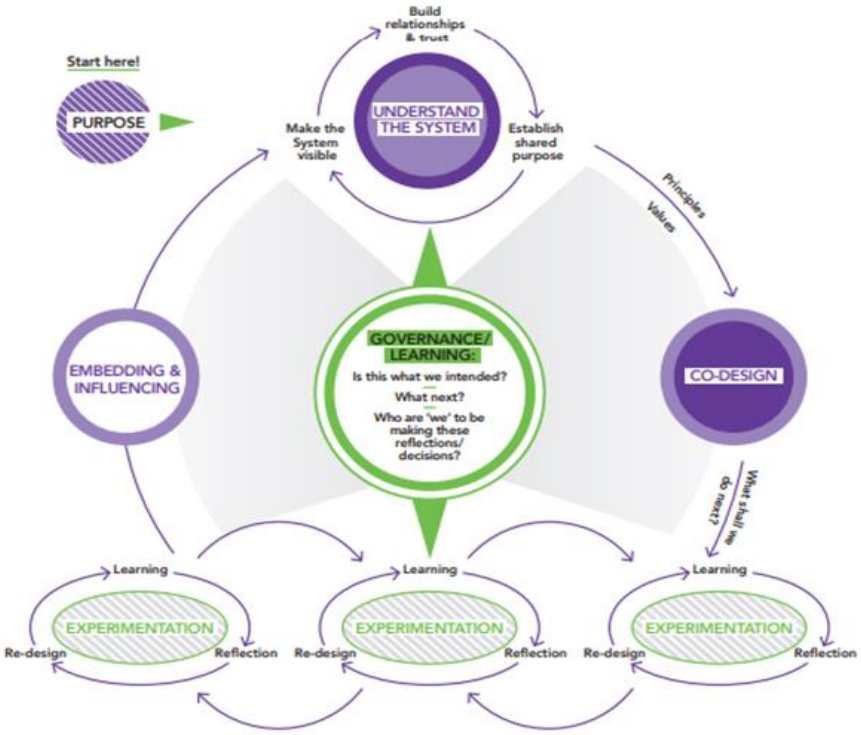
# Story of change




## Starting with purpose

As Wellbeing Teams was a start-up, the purpose was developed by our founder, Helen Sanderson, and used to inform all other decisions in the original design of the first teams. The purpose of Wellbeing Teams is to do whatever we can to support people to live well at home and be part of their community. This reflects perceptions of what is not working in the current system (see below). There were 4 other 'test and learn' sites which led to great learning but ultimately 'failed' before Helen decided to pivot and set up as a provider herself.

## Understanding the system

As we were trying to explore how key parts of the health and social care system could be different, we first needed to understand some of the key factors in the existing system. This is our original understanding of the system, which informed our purpose and experiments within Wellbeing Teams in the first 3 years.

### Older people and people who need support

Current home care focuses on providing support to help people to exist, not to live well. They support people with medication, meals and personal care. This is the bottom of the hierarchy of human needs. We think that to live well, you need to have purpose, be as busy as you want to be, have loving relationships, have control over any support you get, and feel like part of your community. We defined wellbeing as being safe and well, doing what matters to you, and being connected.

### Team members

Of the 670,000 people employed by home care providers, more than half are on zero-hours contracts. There are around 90,000 vacancies nationally at any one time, and turnover for home care staff is at 36.8 per cent (Skills for Care 2017b). The terms and conditions mean that women (the majority of carers are women) are likely to work/be available for more hours than they get paid for, as typically there are 4 shifts a day. Home care is the only part of the health and care system that is paid this way.

We wanted to pay team members for full shifts, and secure contracts.

### Commissioning

Commissioners typically buy home care in 15-, 30-

or 45-minute slots. They usually require some sort of 'check in and check out' system with providers so that they know how much time they are getting and buying.

Commissioning is task and time based, which naturally means that providers work according to task and time, instead of any understanding of the difference they are trying to make with and for someone in their life or learning.

Individual Service Funds are a way of commissioning for a block of service or time and were introduced to help implement the Care Act (2014). This changes the way that providers are paid, but the result is usually still a version of 'task and time'.

## Separation of health and care

There are a range of services delivered by health or social care that could be done differently. It makes no sense to have a separate reablement function to support people when they come out of hospital and then hand over to a separate home care organisation. It does not make sense to have a social prescribing service to help people connect in their community, that is short term (1 week to 3 months) and disconnected from a service where people are already known and visited every day.

It makes no sense to have district nurses giving medication and dressings, and also have carers coming in to administer medication. We thought one service could do all of that.

In our first teams in Wigan, we developed a close partnership with an existing home care provider in Wigan, **Making Space**. They were losing money on a 3-year contract with Wigan and were at the end of year 1. We agreed that Wellbeing Teams would deliver the remaining 2 years on the contract, and that Making Space would underwrite us to do that. At the end of 2 years, we hoped to either demonstrate that we could deliver something different within the same financial envelope, or to convince the Council that we were offering something very different that could be paid for differently (e.g. from health and social care budgets).

We engaged with the **Council** to explore this with them, specifically the commissioners. We decided to have a 4-6 weekly leadership group meeting to review progress together.

Wellbeing Teams wanted a '**Co-production Partner**' to work alongside Helen to inform developments. Helen Ratcliffe was a carer in Wigan, whose husband used to be supported by a home care agency until his death in 2017. The commissioner recommended Helen to Wellbeing Teams, and asked Helen to become the Co-production Partner for the teams in Wigan. Helen Ratcliffe agreed, and was involved in almost all of the recruitment process for team members and acted as advisor to Helen Sanderson. She also attended the leadership group meetings with Helen Sanderson.

We engaged with all of the other 12 providers in Wigan, as we had a separate agreement with Wigan to provide training and support to all of the providers. We co-developed Progress for Providers in Wigan to be clear about 'what good looks like', and to introduce a bronze, silver and gold system. Wellbeing Teams was designed to already be operating at gold. In reality, this provided a forum for us to share our developments with all of the providers in Wigan.
http://helensandersonassociates.co.uk/wp-content/uploads/2017/09/HomecareWiganfinal.pdf

**The Care Quality Commission (CQC)** had never registered or inspected a self-managed organisation before. They expected an organisation to have managers, and a Registered Manager. Helen used her existing connections with Andrea Sutcliffe, then Chief Inspector with CQC, to explain what she wanted to do. Helen had also met Sir David Behan a couple of times. A colleague of Helen's was in a meeting with Sir David and mentioned Wellbeing Teams. Sir David invited (summoned!) Helen to meet him and explain what Wellbeing Teams were. He committed to CQC being helpful in supporting this, and asked Andrea to talk to Joyce, who was head of registration. It did not go as smoothly as that. Three years later, CQC said that I had 'created my own sandbox' by relentlessly contacting people and talking to them about what I was doing. Wellbeing Teams were awarded

Outstanding in their first inspection, and the report specifically mentioned self-managing teams. https://www.youtube.com/watch?v=2a9XYVoHKjE&ab_channel=HelenSanderson

In November 2020, new guidance was submitted to the CQC Board based on self-managing teams, using Wellbeing Teams as an example.

### Wider community of health, care and interested professionals

Helen has a 'working out loud' practice. From September 2017, Helen recorded weekly films on Linkedin to describe her learning. Her film about CQC registration has been viewed over 9k times. https://www.youtube.com/watch?v=V8Xevt8LDmU&ab_channel=HelenSanderson

## Building relationships and trust

Once we thought we had a good understanding of the factors in the broader social care system, we began to develop a detailed understanding of how the system works in particular places, through building relationships.

Helen Sanderson was already known to the commissioners because of her national work with her consultancy team, Helen Sanderson Associates. Helen and the commissioner Jo Willmott met at a number of events where Helen had spoken about Wellbeing Teams or where Buurtzorg (the inspiration behind Wellbeing Teams) was being talked about. There was a particular event around Buurtzorg in spring 2017, which Jo and Helen both attended. At the end of the event, Jo invited Helen to meet with her to explore Wellbeing Teams in Wigan. At that meeting, she suggested Helen contact the new CEO of Making Space, Rachel Peacock. Helen contacted Rachel and they arranged to meet, and this started the development of the partnership with both Making Space and the council.

Rachel and Helen met, and then Helen met with the Chair of Trustees and this began our partnership with Making Space.

## Establishing shared purpose

One of the ways we tried to clarify a shared purpose was to create a document that looked at what success meant from different perspectives, through the leadership group. This identified a range of perspectives – starting with people, their families, social workers, commissioners and other providers.

## Developing principles, values and behaviours

Helen worked with national values expert Jackie le Fevre to decide on the values that Wellbeing Teams would hold in order to deliver their purpose. They explored the values of Helen as founder, and what she wanted to achieve as well as the expression of the purpose.

The values are Compassion, Responsibility, Collaboration, Curiosity, Creativity and Flourishing. Helen and Jackie wrote a blog that describes how the values were developed. https://www.linkedin.com/pulse/values-beliefs-what-mean-wellbeing-teams-helen-sanderson-frsa/

Helen, with her colleague Michelle who was the first Wellbeing Team coach and therefore the first employee, co-developed the way that Wellbeing Teams would work to achieve their purpose and express their values. Here is the animate of how Wellbeing Teams work: https://www.youtube.com/watch?v=HV9pjYsqUic&feature=youtu.be

They realised that finding people to deliver this would require recruiting people who resonated with Wellbeing Teams' values and could be taught the skills required. This led to designing a recruitment process called values-based recruitment.

The values of Wellbeing Teams were 'operationalised' to describe behaviours that you would expect to see that reflected the values, and behaviours that would be considered outside of the values. These were part of two handbooks – the

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'How we work' 'green' book that described the procedures for the team around delivering compassionate, person-centred care, and the Wellbeing Workers handbook that described roles and self-management. Each team built on this to create their own list of 'team agreements' that reflected how the team wanted to show up and work together. These were reviewed through a 'person-centred team review' every 6 months, and through Confirmation Practices every 2 weeks (these include role-based Confirmation Practices). Team members also chose roles that reflected their strengths. They were coached in their roles from induction through to the end of probation. The Wellbeing Leader acted as coach to the team and also ensured that the team could deliver the requirements of CQC. The nature of this role – coach rather than manager – was central to the way the team worked.

## Design

There are 5 elements to the design of Wellbeing Teams:

1. Relationship-centred support
2. Focus on what matters to the person and their wellbeing, not just personal care
3. Helping people to be part of their community
4. Recruitment for values
5. Self-management

We expressed the design as a number of questions that guided our experiments and learning:

### People:

Can we deliver home care that gives as much choice and control as possible to people who receive it?

Can we work in ways that reflect what matters to people and support them to have better days?

Can we intentionally connect people within their communities?

Can we use technology to support people to be safe and well, and to connect people?

Can we use a reablement and prevention ethos?

### Team members:

Can we deliver home care through self-managing teams, paying above the living wage, on salaries?

Could people work in shifts, rather than being only paid for contact time (which usually leaves people with hours during the day when they are not required)?

Can we recruit people for values, instead of experience or qualifications?

Can we support people to bring their whole selves to work?

Can we support people to grow and develop at work?

Can we work in teams that feel like teams, where people feel connected?

### Providers and Commissioners

Could we deliver care through self-managed teams in a way that CQC accepted?

Can we deliver our service within the same commissioning process, e.g. price per hour?

## Experimentation

See Appendix A for the list of experiments, and what we learnt.

## Embedding and Influencing

Wellbeing Teams sought to influence other people and the system in a range of ways:

### Locally

- Through the local leadership team, sharing what was working and not working every 6 weeks and seeking ways to address what was not working together (and build on and share what was working).
- Sharing learning and examples through the provider programme, influencing the ways other providers worked.
- Through a Co-Production Partner, Helen Ratcliffe, who was well connected to other carers and attended other council meetings.
- Through team members posting on Facebook, as there was a team member with the role of

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'storyteller' who looked for stories and examples with the team to share on Facebook.

### Nationally

- Through being part of groups – for example, Social Care Future and Think Local Act Personal.
- Through Helen sharing learning every week via a 2-minute film on Linkedin and sharing through a range of social media platforms (Facebook was a central part of Values-Based Recruitment).
- Through a podcast – 'A Cup of Teal', with Helen Sanderson.
- Through people connecting and asking to visit (including Cornerstone and Sir David Behan).
- Through Open Teams, where Wellbeing Teams and other health and social care self-managing teams globally freely share what they are doing around self-management.
- Through partnering with another start-up – Bellevie – to assist them to use the Wellbeing Teams approach and eventually to take over the Oxfordshire teams.
- Working with the RSA as part of their Transform programme https://www.thersa.org/blog/2019/03/finding-purpose-and-skin-in-the-game-helen-sanderson-on-transformational-health-and-social-care
- Through further demonstration sites, this time in partnership with local authorities – in Thurrock with two teams, and in Camden with four teams in Extra Care.

## Governance and Learning

The governance process was based on the work of Andy Brogan, who is the national improvement advisor to Wellbeing Teams.

There were local teams (four in Wigan and one in Oxfordshire) who were supported by a national team, with leads for key areas and administrative support.

Governance included metrics that were looked at in every team meeting, and these informed the actions of the team. Every month, there was a review of learning from accidents, incidents, etc, and this was done collectively at a team meeting.

There was a clear decision-making process, and if a decision was outside of the sphere of influence of a team because it would require changes to other teams, then the national team would be involved in decision making.

For more detail on the structure and decision making within teams, including Confirmation Practices, see this blog with Lisa Gill. https://www.linkedin.com/pulse/4-common-myths-self-managing-organisations-part-1-lisa-gill/?published=t

The decisions and review of learning took place at **team meetings**, which used a Positive and Productive tactical meeting approach. This was informed by the self-management process called Holacracy. Team members were expected to raise and address tensions in team meetings, and to review whether the people they were supporting were on track, off track or way off track. This would lead to decisions and actions by the team to keep people 'on track'.

We also have a different approach to policies and procedures which is summarised here: https://www.youtube.com/watch?v=dCWAFi0N4sA&feature=youtu.be

This shows how traditionally there is no opportunity for learning about procedures in a formal way, because of the way we think about policies and procedures as being together and fixed.

The governance process was based on the promises we make to the people we support (6) and to colleagues (10), and the information and metrics required for us to know how well we were doing and learning.

The governance process for CQC was developed separately, going through every single KLOE and demonstrating how Wellbeing Teams addressed it, including learning around this.

## Achievements

Although Phase One has identified challenges for Wellbeing Teams, there have also been clear achievements:

- Wellbeing Teams have made strong progress towards our purpose and vision while acting in line with our values and our ten promises to our colleagues. We deliver high quality care and an outstanding place to work. The typical churn in home care is 67%, suggesting that home care workers tend to move around different home care companies. In Wellbeing Teams, this was less than 5%. The feedback on Peakon benchmarked Wellbeing Teams against other organisations (outside of health and care) and consistently scored highly.
- We have demonstrated creative use of technology and a practical determination to work beyond the traditional scope of home care where this has provided opportunities for added value.
- We have demonstrated that self-managed models of care are congruent with and supported by current regulatory practices (Footnote: Wellbeing Teams CQC Report).
- We have demonstrated that it is possible to attract high quality colleagues into home care and to retain them, improving in this area by a quantum that is potentially transformational for the sector. Only 10 - 15% of Wellbeing Workers came from other home care organisations, and 60% had never worked in health or care at all. The turnover rate was less than half of the national average for home care. Wellbeing Teams' innovative approach to values-based recruitment meant that we did not take CVs and did not do interviews.

## Bringing their Purpose, Vision and Values To Life

- Wellbeing Teams have demonstrated an effective, practical approach to "doing whatever it takes to help people live well at home and be part of their community" through the integration of social prescribing activities and Community Connectors in their work, and by supporting people to be part of monthly social events in their community in Wigan. The monthly programme included regular groups like the community knitting group, and sessions with local artists based on the priorities of the people supported.
- During weekly team meetings, Wellbeing Workers review how the people they are supporting are getting on, identifying who could benefit most from extra support. This has helped us to target our capacity intelligently and to share creative approaches to supporting people, individually and as a team.
- A practice of finding and supporting "the little moments that matter" exists, brought to life in the culture of Wellbeing Teams through team meetings and through the use of Slack, where stories are routinely shared about the different ways Wellbeing Workers have found to deliver compassionate, personalised support. Examples of this include the use of Life Story Books and a demonstrable commitment to ensuring that "every shower can be a spa experience and every cream application can be a massage". In support of this, Wellbeing Workers carried a pamper kit to be able to paint people's nails or offer hand massages.
- Feedback from the people supported by Wellbeing Teams is excellent, and their voice is reflected throughout the organisation's practices. This included having a Co-Production Partner who had been a carer, and whose husband had received home care before he died. She acted as advisor to the Wellbeing Leader and actively supported the values-based recruitment process, contributing to the recruitment workshops.

## Delivering on their Ten Promises and Key Commitments

- Team member engagement has remained strong throughout Phase One and this continues. Peakon – a system used by Wellbeing Teams to gauge colleague engagement and to make it easy for colleagues to surface tensions – is approached systematically with good rigour in ensuring that issues and actions are followed through.

- Strong engagement with team meetings, buddying and the use of Confirmation Practices all provide evidence of Wellbeing Teams living our commitment to self-management and supporting this effectively.
- Although the operating model has come under significant pressure (this is explored in detail under Areas of Friction), Wellbeing Teams have maintained our key commitment to paying team members' salaries and co-designing shift patterns that support their wellbeing.

## Rated CQC Outstanding

As the first self-managed social care provider in England to be inspected, Wellbeing Teams received an overall rating of Outstanding from the health and care regulator (CQC). This included an outstanding rating for the 'Well Led' inspection component, which has provided validation that radical models of care, including those based in self-management, can be accommodated within and supported by the UK's regulatory approach. It is notable that the overall CQC rating of Outstanding has only been awarded to 4 % of providers in England. Most of these other providers only serve the self-funding market. It is also highly unusual to receive an overall Outstanding rating in the first year of operating.

## Award Winning Recruitment Practices and Industry Leading Retention

- Despite having no Human Resources department and not employing external HR support, Wellbeing Teams won a Guardian Public Services Award for our innovative approach to values-based recruitment. This has attracted numerous applicants from outside the traditional sphere of home care, including childminders, an MBA student, van drivers, hairdressers, shop workers and teaching assistants. This has also included many people who were not currently employed, and parents coming back into the workplace. Wellbeing Teams employed two people who were receiving disability benefits, who subsequently came off these.
- Wellbeing Teams' most recent recruitment campaign to set up two new teams resulted in two workshops, each with 25 potential workers, and ended up offering roles to 35 people. In a sector which routinely struggles to attract applicants, currently one in ten jobs are unfilled.
- We deliver high-quality care and an outstanding place to work. The typical churn in home care is 67%, suggesting that home care workers tend to move around different home care companies. In Wellbeing Teams, this was less than 5%. The feedback on Peakon benchmarked Wellbeing Teams against other organisations (outside of health and care) and consistently scored highly.

# Barriers and Tensions

Whilst Wellbeing Teams have made significant organisational achievements and worked to ensure that all changes identified from our learning in Phase One were implemented swiftly, the first phase of the journey presented key challenges. Some of these were highlighted in Radical Home Care: https://www.thersa.org/blog/2019/03/finding-purpose-and-skin-in-the-game-helen-sanderson-on-transformational-health-and-social-care.

- The Wellbeing Teams model has not been 'plug and play'. Benefiting from their introduction requires both tailoring to each local context and tailoring of each local context. This requires commissioners to play a crucial role as system stewards (an emergent term where commissioners are less prescriptive in outcomes required from a provider but are there to enable a system that can learn and adapt from the experience of those within it) and leaders, where new models and ways of commissioning must be explored.
- It has not been possible to achieve the benefits of the Wellbeing Teams model within the cost profile of traditional home care. This points to a systemic issue with how home care services are conceived, commissioned, managed and

evaluated rather than an obvious limitation in the Wellbeing Teams model.

## Adaptation In Context

In Oxfordshire, Wellbeing Teams were commissioned to provide care to people over 65 years of age in Abingdon. Maintaining this scope became challenging:

- There were tensions between the service that had been commissioned in Oxfordshire (working in a specific geographical location) and social work teams' allocation of people to Wellbeing Teams. A large number of people were outside of Abingdon, which immediately had an impact on travel time for colleagues and on the number of people they were able to support due to the knock-on effect of this increase in travel time.
- Wellbeing Teams were given a high percentage of 15-minute visits outside of Abingdon (nine in one day, on one occasion), which was financially unsustainable.
- The cancellation policy in practice in Oxfordshire meant that late notice cancellations resulted in team members being paid by Wellbeing Teams, but Wellbeing Teams were not paid for the time that had been allocated.
- Our commitment to paying colleagues for full shifts meant that there were hours that were available but did not fit with the timings of the care packages offered to Wellbeing Teams. The team members used this time to provide extra support to the individuals they were supporting, but we were not funded for this.

The commissioners worked with Wellbeing Teams to see if it was possible to adapt schedules to improve the percentage of time team members spent delivering care, but they were not able to make a significant change.

Consequently, it was not possible to maintain a financially viable model on the commissioning model of an hourly rate for task and time, which meant that Wellbeing Teams were not able to continue to operate. '

This raises important questions about the role of commissioners in supporting new models of care. For example:

- If local practices have evolved to provide a stable operating environment for traditional models of care; and
- If these same operating environments prevent new models of care from working as intended; then
- Should commissioners' bias be towards reshaping new models of care until they fit, or towards reshaping the status quo operating environments?

The risk and implication is clear. Commissioners can choose to treat the introduction of new models of care as catalysts for wider system change, or risk regression to the mean – a situation where well-intended adaptations result in the homogenising of new models of care back to the status quo.

## Cost of Provision

In both Wigan and Oxfordshire, the Wellbeing Teams approach has proven to be unaffordable within the traditional commissioned scope of home care using an hourly rate model. This is attributable to a mismatch between how Wellbeing Teams are paid (including what they are paid for) and how Wellbeing Workers are paid. In essence:

- Wellbeing Workers have been paid salaries for shifts, during which they deliver to a broader scope than the traditional narrow tasks of home care; but
- Wellbeing Teams have been paid at an hourly rate, and only for delivered home care visits.

While Wellbeing Teams strived to maintain an average of 85% paid contact time, this was unachievable in practice. In Oxfordshire, in order to maintain our key commitment to pay colleagues salaries for liveable working patterns, Wellbeing Teams funded the financial shortfall from our own reserves. In Wigan, a partnership with Making Space (a national charity providing health and social care services) provided top-up funding for the pilot phase. Oxfordshire decided not to proceed beyond the pilot period, and in Wigan, Wellbeing Teams

served people until the end of the Making Space contract with the council. While the challenge of how to fund the Wellbeing Teams approach is real, it does more to highlight systemic issues in the home care sector – including how home care is conceived, commissioned, managed and evaluated – than it does to identify an obvious problem with the Wellbeing Teams model.

### For example:

1. Since the narrow scope of home care as performing specific tasks creates capacity pressures at predictable times of day (morning, lunch, dinner, bedtime); and
2. Since payment for 'time and task' means that providers lack the financial bandwidth to retain colleagues for when demand flexes up and down within these times, hence the use of zero-hours contracts; and
3. Since the primary measure in use for the viability of a home care service is its ability to deliver within the hourly rate for traditional home care;
4. Providers default to the use of zero-hours contracts and split shift working patterns so that they can maintain access to care capacity without carrying the financial risk as an organisation.

De facto, traditional home care commissioning therefore passes financial risk from institutions to individual care workers, putting pressure on a group that are amongst the lowest paid in UK society to accept working patterns that are deeply problematic for most and for very little reward. Little wonder then that today's home care market is fragile (CQC 2017) and faltering (Local Government and Social Care Ombudsman 2016; Humphries et al 2016; NHS Digital 2016).

# | Appendix

## Wellbeing Teams – experiments and learning

### Wellbeing Teams Phase One Experiments and Learning

Wellbeing Teams' strategy for our first phase of development was anchored to a set of 'test questions' that we wished to explore and answer:

### For People we Support:

- Can we deliver home care that gives as much choice and control as possible to the people who receive it?
- Can we work in ways that reflect what matters to people and support them to have better days?
- Can we intentionally connect people within their communities?
- Can we use technology to support people to be safe and well and to connect people?
- Can we use a reablement ethos and prevention?

### For Our Colleagues:

- Can we deliver home care through self-managing teams, paying above the living wage, on salaries?
- Could people work in shifts, rather than being paid only for contact time (which usually leaves people with hours during the day when they are not required)?
- Can we recruit people for values, instead of experience or qualifications?
- Can we support people to bring their whole selves to work?
- Can we support people to grow and develop at work?
- Can we work in teams that feel like teams, where people feel connected?

### For Providers and Commissioners:

- Could we deliver care through self-managed teams in a way that CQC accepted?
- Can we deliver our service within the same commissioning process, e.g. price per hour?

HUMAN LEARNING SYSTEMS

# People we support

| What we tried | What we learned | Our Conclusions |
|---|---|---|
| **Can we deliver home care that gives as much choice and control as possible to people who receive it?**<br><br>Instead of an 'assessment', we had a strengths-based initial conversation to find out what matters to people and their priorities. We designed how they wanted to be supported with them and developed detailed care and support plans. | We were able to personalise how people wanted to be supported and reviewed this through monthly catch-ups with their Link Wellbeing Worker, and at a more formal 6- monthly person-centred review.<br><br>We wanted to go further than this and for people to have choice over their team, and the times that they wanted support.<br><br>We could not offer people a choice of who they wanted to support them, due to the availability of team members who would already be scheduled. If someone wanted to change a team member, we always achieved this, but we wanted to go further than that and let people choose their team.<br><br>We could not offer people a choice of when they wanted their service due to the constraints of the schedule; we could only offer people the times that we had available. | ■ We can enable people to co-design plans for how they want to be supported but need to find ways for people to be able to choose their team. |
| **Can we work in ways that reflect what matters to people and support them to have better days?**<br><br>We learned about what matters to people, what they would be interested in doing in the community and what would make a better day at home. We used this to either connect people to what was already available where we could, or to set up groups like Knit & Natter. | We learned and recorded what matters to people.<br>To support people to have better days, we built up the beginnings of a resource library (robot cat, jigsaws) that we could lend to people.<br>We made each 30-minute visit go as far as possible, and the team had 'pamper kits' of nail varnish, hand cream, etc, to be able to use a spare 3-5 minutes to paint nails. We have an ethos of 'make every shower a spa experience' and 'every cream application could be a massage'. Team members have spa music on their phones.<br>We introduced professionally produced Life Story books to capture stories.<br>We had a Slack channel called 'moments' | ■ We can take some steps to support people to have better days; however, being able to offer a 'social prescribing approach' with the capacity to connect people to community associations and activities would enable this to happen. |

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| What we tried | What we learned | Our Conclusions |
|---|---|---|
| | We used our time as flexibly as we could (e.g. supporting a man to place a bet on horses, something he used to do and missed doing), but we were not able to support people to join community events and groups within the hours that we were commissioned. We used the Community Connectors' time to set up new groups that we supported people to attend like Knit & Natter, etc. | |
| **Can we intentionally connect people within their communities?**<br>We employed a Community Circle Connector to work with the team to introduce Community Circles, where friends, family and neighbours meet informally with a volunteer Community Circle Connector around an area that the person wants to change about their life, or a goal. | People told us that they did not want a Community Circle.<br><br>We then used the Community Circle Connector's time to connect people through shared interests by setting up activities (see above) and used this as a social prescribing role instead in Wigan. We were funded by The Big Lottery to set up the 'Abingdon' Circle in Oxfordshire.<br><br>Therefore, instead of intentionally connecting people through Community Circles, we connected people through common interests, and hoped that this would lead to connections. | ■ We can take small steps to intentionally connect people within their communities through shared interests by creating groups, and we could take this forward using the Circle approach being used by Rochdale HMRC. |
| **Can we use technology to support people to be safe and well and connect people?**<br>We used electronic care and support plans via an app, which meant that families could log on and see the plan and our learning and communication logs (completed after every visit). We introduced a robot cat and used Virtual Reality with someone around pain relief.<br>We gave each team member a smart phone and data allocation. | Families told us they valued being able to see the learning and communication logs in real time.<br><br>The person who used the VR headset reported an improvement in her pain, and we have photos that show the joy that Felix the robot cat bought.<br><br>We started a trial with MySense, to look at how to use wearables and devices around the house. | ■ We used technology by having electronic care and support plans and enabling families to see learning and communication logs. We have made early steps in using technology with MySense. There are significant opportunities to use wearables and home devices. |

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| What we tried | What we learned | Our Conclusions |
|---|---|---|
| **Can we use a reablement ethos and prevention?**<br>We trained someone in each team to be a Trusted Assessor, which meant that they could assess for aids and adaptations.<br><br>We built a reablement/capacity ethos into the way we trained and coached team members. We used the 'Support Sequence' to co-design support, which means that we looked at self-care, technology, aids and adaptations, support from family and friends, and community resources to deliver support or help the person with their priorities. | We were not able to work with Local Authorities' OTs around reablement, and it remained a very separate service.<br><br>Using the Support Sequence meant that we were able to think more creatively about support options, and this included training family members to help deliver support (which they welcomed). | ■ We were not able to make progress with reablement. These are separate services. There are significant opportunities to integrate home care with reablement and prevention. |

HUMAN LEARNING SYSTEMS

# Colleagues

| What we tried | What we learned | Our Conclusions |
|---|---|---|
| **Can we deliver home care through self-managing teams, paying above the living wage, on salaries?**<br>We paid people above the living wage.<br>We employed a coach to support the team to self-manage.<br>We included training and support on self-management in induction.<br>We paid people to contribute to a 2-hour team meeting each week (this is where self-management happened).<br>The roles that managers would have done were shared amongst the team. In our first teams, the roles were: Scheduler, Recruitment Coordinator, Meeting Facilitator, Storyteller, and Reporter/Recorder. | We learned that we did not need a Team Coach to support self-management, because the team meetings (developed based on Holacracy Tactical Meetings) were where we saw self-management. Team members did need some coaching, but we did not need a specific role for this.<br><br>We created the role of Wellbeing Leader to combine the Team Coach role and the original idea behind the Practice Coach role. The Wellbeing Leader coached the team in self-management and ensured that the expectations of the Registered Manager were delivered by the team.<br><br>The team meetings were central to self-management, and we introduced Confirmation Practices (by Andy Brogan) to enable the team to reflect on their practice. Each team meeting started with a Living Well at Home board to review how people we supported were living and whether they were on track, off track or way off track. This led to actions for any one who was off track. At the team meeting, people raised and addressed tensions.<br><br>We also learned that the Scheduler role was significantly more time consuming and carried more responsibility than the other roles, so we developed this as a role to be paid at a higher rate.<br><br>We brought the Practice Coach into the team, and their role was expanded to cover holidays and sickness, along with taking a quality assurance role as they met and supported everyone and were in a position to have conversations and check care and support plans. They also supported new team members and coached them. | ■ We have demonstrated that home care can be delivered through self-managing teams. Paying people above the living wage, on salaries, requires a **different financial arrangement with commissioners.** |

HUMAN LEARNING SYSTEMS

| What we tried | What we learned | Our Conclusions |
|---|---|---|
| **Could people work in shifts, rather than being only paid for contact time (which usually leaves people with hours during the day when they are not required)?**<br>We paid people in shifts. This meant there was usually an hour in most shifts where we did not have paid work but still paid people (e.g. between 11 and 12 pm, no one wants breakfast or to be supported to get up and it is too early for lunch). We asked people to work on their roles or to deliver extra support to people in this time (e.g. doing Life Story books). | We struggled to find paid work to fill the gaps in the schedule (e.g. 11 - 12 pm). The solution is to make them 'Wellbeing Visits' that can be allocated at team meetings based on the Living Well at Home board.<br>This works for the team and the people we support, but not financially. | ■ Paying people to deliver support in shifts, as we did, requires a **different financial arrangement with commissioners.** |
| **Can we recruit people for values, instead of experience or qualifications?**<br>We developed a values-based recruitment process which did not involve CVs or interviews and was based on conversation and a workshop. | We are multi-award-winning for our values-based recruitment (four awards in 2018).<br>We have demonstrated bringing people from retail, customer service and education into care.<br>We have three disabled people working with us, including someone who was able to come off disability benefits.<br>We recruited 10 people in Oxfordshire, which has almost zero unemployment.<br>In Wigan, we had a waiting list of people wanting to join us. | ■ We have demonstrated successfully recruiting people for values, instead of experience or qualifications. |

HUMAN LEARNING SYSTEMS

| What we tried | What we learned | Our Conclusions |
|---|---|---|
| **Can we support people to bring their whole selves to work?**<br>We did this through people sharing what matters to them in one-page profiles and sharing their histories in induction. | We measured engagement on a monthly basis through Peakon. This gave us scores and anonymous comments. These were shared with the team at a team meeting, and the team decided what actions to take.<br><br>Statements related to being yourself at work scored highly. | ■ We supported people to bring their whole selves to work, and to use their talents and interests in the workplace. |
| **Can we support people to grow and develop at work?**<br>We invited people to choose roles based on their strengths, or an area they would like to develop. We supported people to qualify for the Care Certificate and Level 2 medication. We introduced Individual Development Plans. | Initially, people developed through their new roles, and through the Care Certificate and medication training.<br><br>We developed 'champion' roles for people with specific interests; for example, we had an end of life champion and a mental health at work champion.<br><br>We introduced Individual Development Plans (our new equivalent) after probation, and we are testing a new approach that focuses on the future in relation to the experiences people would like to have, along with how they want to grow, develop and contribute. | ■ We supported people to grow and develop at work and can go further in this area. |
| **Can we work in teams (that feel like teams and people feel connected)?**<br>People worked in teams of no more than 12. Teams had their own channels on Slack (we used this app to keep in touch), and had their own team meetings and roles.<br><br>Each person had a Buddy, and there was a 'get the party started' budget of £10 for their Buddy to arrange a birthday celebration that the team was invited to. | Peakon scores and comments suggested that people felt connected. | ■ We are confident that people felt connected at work as part of a team. |