

Care Homes 2006 and Beyond

A report on the UK Care Home Sector and Operators' Best Practice Guide

CAREMANAGEMENT
MATTERS



in association with

THE CARE SECTOR TODAY | THE FUTURE OF CARE | CARE BUSINESS FINANCING
VALUATIONS AND DISPOSALS | STAFFING ISSUES | TRAINING AND FUNDING | HEALTH AND SAFETY
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With rising demand and regulation, managing a care home is more challenging than ever before. The Royal Bank of Scotland and Care Management Matters are delighted to present a report which discusses the issues affecting the care home market during a period of unprecedented change, and how to structure your business to take advantage of the opportunities. Our local relationship managers can provide specialist solutions designed to help you grow your business, call

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Foreword

Invaluable insight, compliments of Jonathan Thompson,
Head of Healthcare, The Royal Bank of Scotland.

We are all aware that shifting demographics will increase demand for care homes, but the potential of the sector can only be realised by working with rapidly changing conditions. New regulations must be adhered to, capacity has to be increased and staff must be qualified to meet higher levels of care. The result of this is that in the region of 15,000 residential and nursing care homes are in a period of unprecedented change, which means the best strategy for your business is often difficult to determine.

That's why The Royal Bank of Scotland has sponsored this independent report, written by the leading industry magazine, 'Care Management Matters', which we offer to you with our compliments. I hope that it will provide some real insight into the issues now affecting our industry and helps you structure your business to take advantage of the opportunities.

Restructuring can mean businesses that have only previously required traditional banking services now need more specialised funding options. This calls for financial advice that has a real appreciation of the way the care home sector works.

The Royal Bank of Scotland can offer such expertise. Our dedicated Healthcare teams have unrivalled experience and commitment in the sector and it's

no accident that over a third of UK healthcare providers choose to bank with us*. We understand the needs and issues within the industry and this gives us the ability to assess risk better and offer bespoke solutions.

Many care home providers can be hard-pushed to comply with some of the requirements and recommendations now being noted in CSCI inspection reports, at the same time as managing the staff recruitment and ensuring beds are filled. In these areas, The Royal Bank of Scotland's understanding of the pressures on providers and the risks inherent in their business can help us provide examples of best practice from other operators

and innovative solutions which can help your business overcome any problems.

Whilst there are difficulties, there are also real opportunities, so we are working with customers on many initiatives that take advantage of new thinking in the provision of care and helping them capitalise on it.

Talk to a bank that really cares

I trust you find this report valuable in developing your business, hopefully it will provide you with ideas that require financial backing to make them happen. If this is the case, I would be delighted to hear from you and would welcome the

‘The key reason we chose to do business with RBS is its specialist sector expertise – it's great to know that we're dealing with a Bank that has a team of experts who fully understand the market in which we're operating.’
Christopher Seddon, Director, Seddon Group.

opportunity to tell you how our specialist knowledge can make a real difference to your business. Please call 0800 280 2299** for a preliminary chat – I look forward to hearing from you.

Jonathan Thompson
Head of Healthcare
The Royal Bank of Scotland

*pH Group December 2005
** Lines are open 9am – 5pm weekdays.
Calls may be recorded.

The Care Sector TODAY

Legislation and regulation of the care sector have shaped the system we have today. Les Bright, Independent Consultant explains the regulatory framework and sector trends for the care home market in the UK.

Legislation

There are three key pieces of legislation influencing social care provision in England and Wales:

The National Assistance Act 1948 put in place many of the rules and principles that have shaped the welfare state in which we now live. Despite subsequent legislation this Act remains key to the funding of publicly supported residents.

The NHS and Community Care Act 1990 asserted the need to make links between an individual's need for care and state responsibility to pay for all or part of the planned care as a result of an assessment being conducted. It put in place incentives to encourage the development of the mixed economy of care and established the principle that all sectors should be subject to inspection.

The Care Standards Act 2000 set up the present regulatory framework. It included the creation of new national bodies addressing both facilities provided and the staff who work in them and set out National Minimum Standards for the conduct of care homes.

In Scotland the third of these acts is not in force, instead there is:

The Regulation of Care (Scotland) Act 2001 that has

similar duties and powers to those contained in the Care Standards Act 2000.

Regulation

Each of the three countries has their own regulator:

England: The Commission for Social Care Inspection (CSCI). This will merge with the Commission for Healthcare Audit and Inspection (popularly known as the Healthcare Commission) in 2008.

Scotland: The Scottish Commission for the Regulation of Care (popularly known as the Care Commission).

Wales: The Care Standards Inspectorate for Wales (CSIW).

These bodies each have a broadly similar remit and have set out to produce standards to govern the performance of providers of care services. National Minimum Standards have been devised, in some cases revised or are subject to review, covering all aspects of operation. While each of the sets of standards is written in different ways, their scope is similar. The intention is to create greater consistency into the system but practice continues to vary between inspectors making this aspiration difficult to achieve.

From April 2006 in England the CSCI changed the frequency

with which they inspect care homes. All services will receive at least one key inspection between April 2006 and June 2007. After then the CSCI will inspect at least once in every three years. This enables inspectors to pay more attention to services that put people at the greatest risk.

The Market

Impact of social policy

The thrust of Government policy, in particular a commitment to maintaining people's independence – as measured by their ability to live in the community in property they own or rent – with support from staff, adaptations to their home environment and increasing investment in the use of new technology, has not had

as big an impact on the sector as had been anticipated. Although in 2005 there were 17% fewer places than in 1996, the level of occupancy was higher, at around 91% (Laing & Buisson, 2005).

The long-term care market is diverse, with a number of developments taking root and developing as an alternative to traditional care homes. The level of spending on care in people's own homes has been growing year-on-year, although the increased spending is on fewer service users as services are being targeted on more highly dependent users, as a strategy designed to delay or prevent admission to a care home. However, as life expectancy



TOTAL NUMBER OF HOMES AND BEDS IN THE CARE SECTOR

Type of care	No of establishments	No of places
Care homes	10,922	229,979
Homes with nursing	5,053	226,592
Total	15,975	456,571

Source: various, extracted from Government and commercial publications (2005).



FUNDING OF LONG-TERM CARE PLACES

A substantial proportion of care home residents are reliant on local authorities to meet the whole or part of the cost of their place and a further group of people in need of 'continuing care' are supported with funds from the NHS. Together these two groups account for 70% of residents.

In many areas the fee levels that local authorities are prepared to pay are below the average cost of a care home place and so it needs 'topping up' – meeting the difference between the weekly cost and the amount the local authority will pay. The Office of Fair Trading estimated that 33% of publicly funded residents were dependent on some form of third party top-up to continue living in their chosen home (OFT, 2005). There is anecdotal evidence that those who are required to fund their own care are in some cases charged higher fees to cross-subsidise the lower level of payment made by local authorities on behalf of those people whom they place in the home.

grows, bringing with it increased incidence of dementia and the accompanying demand for more specialist residential facilities, it seems unlikely that residential provision will shrink any further.

The number of places in care homes for older people and people with physical disabilities in 2005 was estimated as being 476,000 with a further 35,000 living in extra care housing – where a combination of adapted housing and the availability of care staff closely mirrors the sort of support found in some homes.

When the Green Paper on adult social care in England was published in 2005 (DH, 2005) it outlined a new determination to reduce the number of care homes by explicitly stating the intention to offer people 'the right not to choose a care home'. However it was not followed up within the White Paper that followed in January 2006 (DH, 2006).

Market position

From a position of oversupply the market has now undergone a correction with the rate of closures slowing and new registrations continuing. Demographic trends suggest that any further contraction would be countered by the demands arising from growth in numbers of older people.

Developing other forms of service

• *Housing with care*

Around 80% of the places in 'extra care' (or 'very sheltered') housing are provided by not-for-profit bodies, generally housing associations using a combination of public funds available (in England) from the Housing Corporation or the Department of Health working in partnership with social services, health and housing. Such schemes are not subject to the same regulatory regime as residential services, though the provider of domiciliary services

has to register and is inspected by the regulatory body.

Extra care housing is a concept rather than a housing type, incorporating particular design features including:

- Flexible care, 24 hour support, access to meals, domestic support, supporting social and leisure opportunities.
- Individual flats are seen as 'home', design allows for a range of social activities, progressive privacy is built in for residents.
- Joint assessment and allocation, balance of dependency levels, positive approach to mental health, step up and step down places, home for life (Fletcher et al, 1999).

• *Care villages*

The concept of a 'care village' is new and not yet widespread in the UK (Croucher, 2006). This approach is seen as being attractive for its ability to respond

to an individual's changing needs – the relatively fit person moves into accommodation that they maintain without recourse to a third party. As their situation changes they are able to draw on other services, before moving on to a model of closer care, perhaps culminating with the support provided by a care home with nursing support. Homeowners are able to maintain their interest in property for longer than they may have, while housing association tenants can also move on without the need to change either their landlord or the location of their flat.

Consumer Views

Government interest and interventions

In 2005 The Office of Fair Trading (OFT) published the outcome of its formal inquiry into care homes for older people in the UK, launched in the wake of a 'Supercomplaint' lodged by the Consumers Association and a consortium of

campaigning charities (OFT, 2005).

The 'Supercomplaint' – a provision of the Enterprise Act 2002 – arose from frustration felt by agencies advising older people at the way the market appeared to be working against the best interests of service users.

The principal findings were:

- Lack of awareness of the range of sources of information about moving into a care home;
- Confusion around the duties and responsibilities of local authorities in relation to people meeting their own fees;
- Lack of transparency around fees and the services provided;
- Too many contracts appeared to have unfair or unclear fee related terms;
- Low level of awareness of systems for complaint and redress.

The Government has put increasing emphasis on the importance of consulting with users and carers, and with the wider population of potential future service users, in order to redesign services so as to be more reflective of what people want.

However, the first annual report to Parliament of the CSCI noted that while there was plenty of evidence of consultation being undertaken there was little evidence to suggest that this had affected the way services are organised and provided (CSCI, 2005).

Research findings

The English Community Care Association (ECCA) working in

partnership with P&G Professional conducted a small piece of research into consumer views (P&G, 2006) to complement another more strategic study into the organisation and aspiration of care home operators (P&G, 2004).

The principal findings from this recent work were that staff are pivotal to how residents conduct their lives and appreciate the chance to build relationships and invest trust in someone with whom they become familiar; they also want to be treated with respect and to be enabled to be as independent as possible for as long as possible.

They view food and mealtimes as being an important contributor to the overall quality of life they experience and, just as practically, are concerned about the quality of laundry services, enabling them to keep up their personal standard of dress and presentation.

Key performance indicators

These provide an in-depth analysis of the care sector. They are based on actual data to support valuations, generated by Colliers CRE. They are compiled from approximately 1,100 records across a spectrum of providers from corporates to single home units. All figures are calculated from data collected at time of valuation.

Occupancy rates

During the second half of 2005 (2005 H2) the average occupancy rate in nursing homes increased by 0.9% over the first half of 2005 (2005 H1), whereas the Personal Care (PC) homes'

occupancy rate fell by 0.6% (see table 1). Nursing homes now have a marginally higher overall occupancy rate. This suggests that occupancy levels in both types of home may be reaching a maximum and that any future rises may be small.

The demand for specialist homes, however, has grown, and since these types of homes tend to be small, the occupancy rate in the 0-10 bed range has increased from 92.1% to 94.5% between 2004 H2 and 2005 H2.

Average weekly fees

These are increasing. Nursing home fees have increased by 7% over the past year, whilst PC fees have increased by a more significant 27.2%. Nursing homes still achieve a higher absolute average weekly fee at £539, whereas in PC homes it averages £494. However, the gap is narrowing.

The highest average weekly fee in 2005 H2 is amongst the 0-10 bed range, at £1,296. The high fee is because small homes often offer care for mentally disabled young people. Accordingly, they provide a greater standard of care and maintain a higher staff to patient ratio relative to larger homes. Average weekly fees have risen significantly in the 0-10 bed category over the past 12 months (see graph 1).

For the UK as a whole, average weekly fees for all homes grew by 8.2% over the past 12 months. The East has achieved the fastest rate of growth (up 25.6% to £676), whilst the South East grew by 19.2% to £613.

In contrast, average fees in London rose only marginally over the same period (3.6% to £672).

Payroll costs

Both PC and nursing homes reduced their total costs as a proportion of total revenue during 2005 H2 due to decreases in both payroll and non-payroll costs. Payroll costs as a proportion of revenue decreased by 4.5% in PC homes and 1.9% in nursing homes in 2005 H2. Payroll costs have continued to fall as a result of the increased level of recruitment of overseas staff. This has allowed operators to reduce their reliance on agency staff.

Graph 2 shows payroll costs as a percentage of total revenue by size of home. The 0-10 bed range has the lowest proportion of payroll costs (just 44%) compared to larger homes with over 21 bedrooms. This is because small homes achieve higher revenues through the provision of high priced specialised care, for example, for individuals with learning disabilities.

Non-payroll costs

Non-payroll costs as a proportion of revenue have remained relatively stable over the past 12 months. Nursing home non-payroll costs have dropped by only 0.5% since 2005 H1, whilst PC home costs have fallen by just 1.7% (see graph 3).

Heat and light costs in homes have been rising since 2003 H1, due to general increases in gas and domestic electricity prices. It is expected that average heat and light costs in homes will increase by around 7% to £15,000 per home by 2006 H2.



However, these costs have been offset by higher revenues and as a percentage of revenue have in fact fallen for all types of home over the past 12 months.

Profit margins

Profits margins are moving ahead for both types of home. Nursing homes increased profits by 0.8% during 2005 H2, whilst PC homes profits grew by 2.3%.

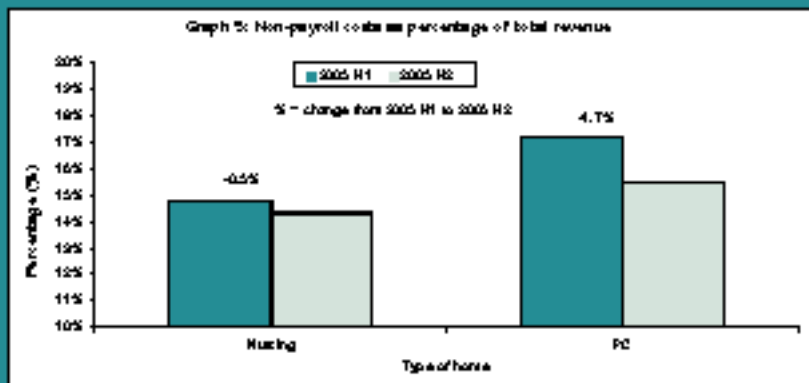
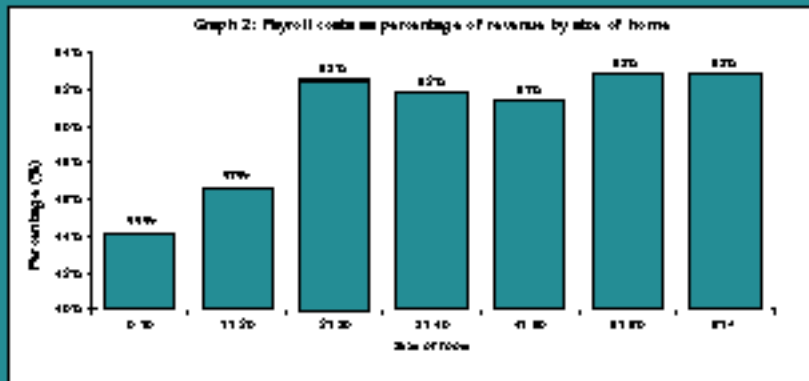
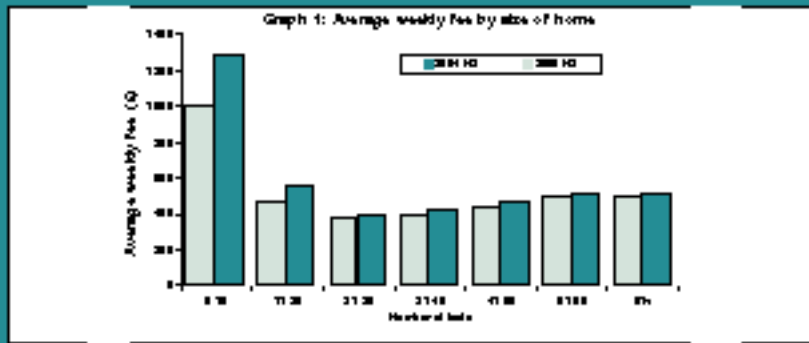
PC homes return the highest level of profit as a percentage of revenue (34.7%) and have shown the largest percentage growth over the past year (15.2%).

Average revenue per bed has been increasing steadily for both types of home since 2004, although the trend lines are converging over time.

Increases in revenue have been successfully translated into profit for both PC and nursing homes, since net profit margins have also been growing over the same time period.

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Year	Occupancy rate	
	Nursing (%)	PC (%)
2005 H2	93.4	92.4
2005 H1	92.5	93.0
2004 H2	93.2	92.9

The future of CARE

Entrepreneurs will continue to prosper by providing flexible and responsive services. John Burton, independent social care consultant, summarises current Government policy that will shape the future of social care and explains potential barriers.

In twenty years time the number of people over 85 in the UK will increase by two-thirds. This may sound like good news but these figures are often more a cause for concern than for celebration.

While we may hope to live to a great age and stay healthy and happy, as we get older we need various degrees of support and care, and the older we get the more help we are likely to need.

These improvements in health and longevity will bring about an expansion in services for older people and those who are disabled or dependent, so this advance in our society poses unprecedented challenges – for the individuals, organisations and enterprises who will provide these services.

Increasing numbers and needs

By 2026 there will be almost 2.1 million people aged 85 and over in the UK. (Government Actuary's 2002-based principal national projections.)

Figures show that around four in ten over 85-year olds can't go outside, while a quarter of them can't get up and down stairs. More than six in ten can't manage some aspect of their personal care and over two-thirds can't carry out common household tasks.

(1998, Office for National Statistics, General Household Survey.)

The Government's plans

'Our health, our care, our say: a new direction for community services', the White Paper published in January 2006, sets out the Government's plans to meet these needs in England. As yet there have been no equivalent plans in Scotland and Wales, but both countries may follow a similar path. It is ambitious but practical. It requires directors of adult social services and public health to plan services for the next 10-15 years to meet assessed strategic needs and it emphasises the need for locally run and locally responsive services.

There will be vastly improved preventative services, maintaining people's general wellbeing and forestalling admissions to acute hospitals. Choice and control will be promoted through more direct payments and individual budgets making it possible to choose from a range of support options.

Numbers of carers are likely to rise in proportion to the numbers of dependent people and the White Paper recognises that increased support for carers is vital to the feasibility of the new system. Carers will be given more and better information from

a unified system; there will be an increase in respite and emergency care services; and improved access to training.

People with long-term conditions will have their own case manager to co-ordinate the services they need. Primary care trusts (PCTs) and local authorities must establish joint care teams to provide an integrated service. Health and social care must work together to commission community based preventative services and ensure that people's wellbeing is seen as a whole objective rather than chopping up care into separated packages that are costly and unco-ordinated.

As the largest and most significant players in the sector, care home providers are well placed to respond to the increased need and customer base that the White Paper and the demography predict.

Pull to open

Government, both local and central, is traditionally and temperamentally unused to creating flexible, diversified services to meet people's needs. However in the White Paper, the Government appears determined to set up services that are 'pulled' by 'customers' rather than driven by commissioners or providers. The ethos on which the White

Paper is based is to respond to and meet individuals' needs. And this is a fundamental principle of good social care, that will entail a major change of culture for everyone.

Expanding and diversifying

In order to take up the wide range of opportunities and challenges of the future, more care homes need to move from being simply good care homes to being local resource centres. A good care home may well be known locally by its name or just as 'the home' and yet alongside care and employment it probably offers other informal support. This can include advice and a base for carers, activities and social functions, connections with the church, temple, synagogue or mosque, a place where people 'volunteer' but actually gain a lot of support for themselves. Some homes are providing (officially and unofficially) day care and a meals service.

In recent years some care homes for older people have specialised, caring for people with dementia, for example. The general trend towards specialisation has been partly stimulated by the higher fees available, but there is no clear



evidence that someone with Alzheimer's is better off in a specialist home, than in a good generalist home. With a move towards localising services and responding to individual need, there may be a relative reduction in demand for specialist homes and increase in demand for homes that specialise in meeting diverse and individual needs, creating new services in response to people's special situations.

Once a home is established in the community, it can become an essential element of a supportive neighbourhood. In the future this flexible and responsive community function can become more recognised as a 'community care' service and just as important – funded. So, existing and future care home providers should look for opportunities to expand and diversify.

Various forms of 'shared care' in which the staff and facilities of the home are used on a part-time basis. This may be someone who comes for lunch and stays for a couple of hours and is collected by the family carer when they pick up children from school. Or the older person who stays every other weekend to give their family a break. Or the more recognisable 'respite care' when a carer has a longer break, but the temporary resident and carer(s) know the home and its staff because they visit frequently as neighbours and volunteers.

Similarly there may be equipment, facilities and events in the home that are used and attended by non-residents – such as access to a special bath, hairdressing, or a clinic, a social, educational, or therapeutic activity group, tea dances and art classes.

Naturally such activity and involvement will be of great interest and benefit to the longer-term residents of the home.

'Intermediate care' to prevent hospital admission or to prepare patients for a move home exists and has been important in freeing hospital places. In future it needs development and expansion and it attracts a relatively high fee level because it is effective in reducing the even higher costs of hospitalisation.

Support and information for carers could be provided by a support group and a network of carers know or use the home and its services.

'Extra-care' housing is a major development. Instead of expanding the home several additional housing units can be built or converted for lease. A high level of service comes with

the units including care, cleaning, meals and maintenance all of which can be tailored to meet the tenants' needs. Remember that a feature of extra-care should be that the tenants – or their own advisers – take the decisions as to who is going to provide the 'extra' care.

Care homes can develop their staff teams to provide 'home-care', taking care out of the home to the neighbourhood. For example, a home that is situated close to existing sheltered housing could provide a responsive and precise care and emergency call service to people who see the home as their neighbourhood resource centre. These are some of the ways care homes will develop in the future to become a key part of the community health and care services that are envisaged in the

POSSIBILITIES FOR THE SECTOR

Local authorities and the NHS (the 'public sector') in the UK continue to do less to provide residential care services and this trend will continue.

Currently there are fewer than 70,000 people cared for in the public sector. Independent organisations, whether profit – or non-profit-making, now provide the vast majority of places (more than 400,000) and although the large 'corporates' provide around four out of ten of the available places, the 'small' independent providers are still the backbone of the industry. So, without any expansion in overall numbers, there will be a steady demand for new placements for residents (and patients) of public sector homes (and hospitals) as local authorities and health services outsource their own provision.

An even greater expansion in services in the independent sector will come from a combination of larger numbers of people needing existing forms of residential care in homes (with and without nursing) and from the opportunities for diversification and

flexible, local responses to meeting the more complex needs envisaged in the White Paper. The independent care home sector was created in response to demand. It is an ideal business for entrepreneurs. Most of the corporate providers started out as one-home businesses, rapidly expanding by buying another home, running it successfully and borrowing more money to expand. But there are thousands of small providers who pride themselves on running good quality local homes, rooted in their neighbourhoods, with excellent reputations for good care. In spite of a bureaucratic and sometimes irrelevant system of regulation and inspection, and the downward pressure on income (residents' fees) since 1993 when local authorities took over the funding, good care homes have survived and prospered. Many care homes (single, group and

corporate) are expanding their services. As they see a need that can be met (and paid for), they adapt their service. There are three major current constraints on innovation that must be broken or loosened in order that the intentions of the White Paper can be realised in full (see page 11).



White Paper. However, there are three significant – but removable – barriers to be tackled before this vision can become a reality: fees, staffing and regulation. As with the implementation of the White Paper itself, removing these barriers to development will require a joint and determined effort from the Governments and providers.

The three (removable) barriers to the future of the care sector

Fees

Generally fees for state-funded residents are inadequate for the proper care of residents and for development of the service.

This is a long-standing problem. 'Free', non-means tested, personal care in Scotland hasn't solved the funding issue with only the wealthy residents able to top up the low state level of funding to pay a reasonable fee.

In England and Wales, local authorities that have paid realistic fees and worked in partnership with providers have found an improvement in the standard of care. The better the care, the less other expensive services have to be employed (such as hospitalisation).

While there are still very good homes receiving low fees, surviving through the commitment of proprietors, managers and staff, this is not a sound basis for the development of the sector.

On one level, the argument for providing free care and expecting service users to pay for all their own living costs, seems clear and would fit with the philosophy of the White Paper. As with health care, 'social care' is something a welfare state should pay for, but each individual should take

responsibility for providing (or paying for) their housing, food, maintenance etc. If people have the means to buy a luxurious lifestyle and accommodation, let them, but everyone, rich or poor, is entitled to be well cared for.

In his report for the King's Fund, Sir Derek Wanless proposed practical and fundable solutions, the most likely is what he calls a 'partnership model'. This would provide a minimum guaranteed amount of care, two thirds of the total care package, free at the point of delivery. Thereafter, individuals could make contributions matched by the state up to a defined level, beyond that the state would no longer contribute. People on low incomes would have their contribution paid in benefits.

The Wanless proposals make an influential contribution to the debate, however, the Government response is of 'interest' rather than acceptance and it's unlikely that the proposals will be implemented exactly as set out.

Staffing

Without sufficient, competent and committed staff a care service cannot function. This is the most costly and important resource of a home and all the other services that homes may provide in the future. The fact that so many excellent homes have survived, in spite of the inadequate fees for state-funded residents, is due mostly to

their dedicated proprietors, managers and staff. While minimum wage legislation has increased pay across the board, most staff are still underpaid and many are overworked.

Caring is a demanding and skilful job and should command commensurate pay. Rather than being on a par with supermarket staff, care workers' pay should recognise the complexity and skills of the job. As with the NHS, the Government will find that additional funding to implement the White Paper will at first be absorbed by the backlog in pay. They must prepare for this and be realistic about the inbuilt cost of holding back residents' fees and the low pay for staff, for so many years.

Training for staff is generally poor. Although 50 per cent of staff are meant to be qualified (to a minimum of NVQ 2) by the end of 2006, the cumbersome process of training can be wasteful and poorly targeted.

Regulation

The tide of regulation and inspection has turned but only just. Under financial cutbacks and in the run-up to its merger with The Healthcare Commission in 2008, the Commission for Social Care Inspection (in England) has been attempting to take a more sensible line on inspection. They acknowledge that what counts is the 'outcome' for the user. So all three inspectorates (in England,

Scotland and Wales) are now trying to change their approach.

The inspectorates have had great difficulties with staffing and training their workforce. The turnover of inspectors is high; many have little knowledge of what they are inspecting and their workload is demanding. At the top of the national inspectorates, the commissioners and most senior managers are attempting to redesign the organisations to be more effective and waste less time and resources in homes that could be redirected into providing better care.

The innovations and opportunities for development set out above, will be driven by the need for new services and the responsiveness of entrepreneurial providers. However, the regulators will also have to respond to these new needs and initiatives by being more flexible and imaginative in how they register and inspect services.

The Government's attempts to stimulate the provision of additional services must be matched by corresponding directions to their regulators to concentrate on 'outcomes' for service users.

There are encouraging signs from some forward thinking managers in the inspectorates; these have to be consolidated into a consistent movement towards 'timely, targeted and proportionate' inspection practice.

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- Government Actuary's 2002-based principal national projections.

Care Business FINANCING

The care sector is a very buoyant market and there are many opportunities for care providers to explore. The financing of expansion, new build development or acquisition is a fundamental consideration and good financial planning can make the difference between a business thriving or struggling, especially in the development phase. There are many lenders to choose from but it is advisable to identify those with long term experience and specialist knowledge of the care sector.

What are lenders looking for?

When a lender is approached by a care business for finance, the amounts they are willing to lend, the interest rate and loan term all depend on a number of factors and are individual to each customer. The lender needs to understand what it is they are being asked to fund and what risk it represents and this determines how and what they will lend.

The National Minimum Standards (NMS) including room size and the ratio of single and en-suite accommodation tend to be a large focus for lenders. Compliant stock will attract funding more easily than a property that could fall foul of future changes or enforcement of the Standards. It is clear that market forces are encouraging providers to move toward compliance and the review of the NMS in 2007 could further impact on care home values if the physical environmental standards become stricter.

When considering a term loan there are a number of key factors a bank will examine:

- asset quality in relation to the environmental standards,

- registration categories,
- inspection reports,
- location and demand for services,
- existing and new competition,
- occupancy levels and ratio of private clients,
- strong cashflows,
- relationship with commissioners and other stakeholders,
- dependency on agency staff,
- management team experience,
- financial controls.

New entrants to the market have no track record in the sector and therefore must be able to demonstrate how they have researched and planned their intended business and how they intend to bridge the experience gap. The lender will look for a strong management team with necessary experience and skills to operate a successful care business.

Existing providers will have their trading performance examined to ascertain the current strength of the business but a strong business plan based on research, planning and vision is required. If the finance sought is particularly complex or difficult the lender may wish to secure this loan on other assets owned

by the organisation seeking the finance.

The purchase of a care home that has been in administration can be seen as a risky venture as it is likely to have suffered from sub-standard inspection reports prior to its sale. A purchaser will have to convince any lender of their capability to improve the standards and overcome any detrimental effects to the reputation of the home with commissioners or local stakeholders that could impact on the performance of the business.

Term loans

Term loans or mortgages are usually spread over a maximum of 15 years though, in certain circumstances it is possible to stretch up to 20-25 years.

Determinants in the length of the term are:

- quality of asset,
- compliance with NMS,
- age of owners.

When considering term loans over 15 years or more, the lender is looking for providers to have the necessary vision and planning to adapt with the market as it will undoubtedly

change over this time period. Care businesses must be flexible and adapt to the changing needs of the market which could involve diversification into other forms of provision such as close care or extra care.

The majority of term loans are linked to base rate rather than fixed rate. There are no guidelines for the typical interest rates charged as each loan application is looked at on an individual basis. Interest rates will obviously fluctuate during the term loan period (unless interest rate hedging is in place) and this is another reason for the need of a margin of safety. Businesses with strong cashflows should be able to withstand increases of a few per cent in the interest rate without running into financial difficulties, provided they have not over-stretched on the Loan to Value (LTV) ratio in the first instance.

LTV of between 70-75% is typical amongst lenders. However, it is possible to obtain a higher LTV. Some lenders will offer higher than average LTV rates but these should be considered carefully to ensure that there is a sufficient margin of safety when taking into account debt servicing costs and director's or owner's

THE ROYAL BANK OF SCOTLAND PROVIDES FINANCIAL SUPPORT FOR CHACOMBE PARK LTD

The healthcare team at The Royal Bank of Scotland (RBS) has provided support to Chacombe Park Limited a care village developer and operator, in the development of their care village at Chacombe, three miles north east of Banbury. Chacombe Park Limited which is run by Bob Lari, Mehra Meh and Michael Bone purchased the site of Chacombe House which was built in 1880, in 2000. The house, which is set in 15 acres, was first registered in 1985. The company gained planning permission in January 2001 for a new 45-bed purpose built residential and nursing home together with the conversion of the existing homes into luxury sheltered homes. This phase of the development was completed in October 2002 and officially opened by the Earl of Wessex. In December 2004, planning permission was granted for the extension of the nursing home to develop another 32 additional beds within a three-storey addition and this was completed in January 2006 and provides the company with a total registration of 77 places.

Both of these developments have been funded by RBS, through Kenny Nelson, Senior Manager, Healthcare. The company has acquired two further sites for development, both of which have been funded by the Bank, which will be looking to provide development finance for both of these projects. Kenny Nelson commented: 'Chacombe Park is a model example of a well thought out and carefully planned care village. By working closely with the management team throughout the development of the project we have been able to structure accordingly the correct facilities at the right time to enable the business and development to grow.'



‘The Bank has provided us with support throughout the development of the project. They were with us at the beginning and have always provided support and advice at the milestone moments of our expansion.’

**Bob Lari, Managing Director,
Chacombe Park Limited.**

remuneration requirements. It is important to maintain the right debt and equity balance. Don't make the mistake of looking solely at the LTV when choosing a lender.

Lenders should use a break-even model to ascertain the appropriate LTV rate without over-stretching the business. They should also take account of the business' serviceability, cashflow and management ability in their calculations. A break-even at around 75-80% occupancy is considered healthy.

If you require a higher than average LTV, it is sometimes possible for a lender to accelerate payments in the first few years to bring the LTV down to more typical levels. This way the risk is in the shorter term and both lender and provider enjoy more acceptable margins of safety for the mid to longer term.

Development funding

Development funding can be acquired for extensions, refurbishments, new builds etc. Interest rates tend to be higher than those of term loans to represent the higher risks involved in this form of investment.

There are a number of factors that have to be taken into account for the development of new build and extensions to existing care homes. The location of a development is a key factor. Demand for the new service and the ability to recruit the appropriate numbers and calibre of staff to develop the business will determine the viability of the business. Lenders will want to check that there is no other planning permission for care provision in the local area that could affect the potential success of the business.

Are any major providers looking to move to the area to fill the same market opportunity? If there is the possibility of other providers or provision being developed in the area the lenders will need to be satisfied that the business plan has taken this into account and the business can sustain the competition.

Lenders will also want to be involved with the project management of any new build to ensure that projects are delivered on time and to budget.

In the case of building an extension or developing land in the grounds of an existing care

home there are other factors to take into consideration. There could be disruption to the existing business during construction. Residents may have to be moved around or rooms kept empty to allow building to take place. In these circumstances a building project can be slowed down due to consideration of existing residents in an adjacent or adjoining care facility and this must be accounted for in the project management, build period and existing cash flow requirements.

New builds can take a period of between 12-18 months to achieve 90% occupancy and careful financial planning is required to ensure a loan is serviceable during this initial period. There are a number of ways that lenders can help you to fund developments to accommodate these considerations. There are capital repayment holidays where you only pay interest until the property has been built and occupied to a sufficient level. In certain circumstances it is possible for a roll-up of interest on top of the principle debt over the initial period of development. Sometimes a lender will agree a

trigger-based interest rate. This means the rate reduces once a certain break-even point has been achieved. Lenders with substantial care sector experience and market understanding should be able to structure a financial package that takes account of the factors affecting the development process.

Financing fittings and equipment

Equipping a care home with the appropriate standard of equipment and furnishings requires significant investment. Many providers fund these purchases from cashflows or overdrafts rather than acquiring finance which can tie up their banking facilities. It is sometimes prudent to equip your care home through the lease purchase of equipment where you take title of the goods once the final payment has been made.

Specialist lenders can offer loans specifically for the purchase of everything from bed linen to the latest assistive technology but there is usually a minimum loan



THE ROYAL BANK OF SCOTLAND FUNDS SEDDON GROUP

Established in 1897, Seddon Group is one of the UK's major privately owned construction groups, with a turnover in excess of £180m. Today, the Group is under the direction of the third and fourth generations of the Seddon family and offers the same high standard of personal service on which its reputation was originally founded. The Group serves many sectors, including the residential care sector, and has been involved with numerous care home construction projects. Seddon Group Director Christopher Seddon cites many reasons for choosing to do business with The Royal Bank of Scotland. 'Working with the team at RBS, I was impressed by the time taken to fully understand our business and processes, and by how they introduced us to a number of potential new clients,' he said. 'But the key reason we chose to do business with RBS is its specialist sector expertise – it's great to know that we're dealing with a Bank that has a team of experts who fully understand the market in which we're operating.'

RBS has a long-term track record of providing financial services for companies operating in the healthcare sector and, by investing in local teams throughout the UK, the Bank provides its customers with sector specialists who are close to the market in which they're operating. One such dedicated business development healthcare team was recently established in Scotland, and is headed up by Ken Brown. Ken and his team arranged a £3m funding deal with Seddon, which is enabling the Group to build a 70-bed nursing home in Dundee, in a pre-arranged sale between Seddon and Southern Cross Healthcare, an independent provider of residential and nursing care services in the UK.

Christopher continued: 'The funding package Ken's team put in place not only supported our current needs but also demonstrated support for our overall business strategy.'

Ken added: 'We are delighted to be working with Christopher and his team at Seddon Group. Our knowledge of the healthcare sector and the structure of our funding package were instrumental in winning this business.'

‘Working with the team at RBS, I was impressed by the time taken to fully understand our business and processes and by how they introduced us to a number of potential new clients.’

Christopher Seddon,
Director, Seddon Group.

amount of £5,000. Loans for care groups can reach up to £200,000 though these amounts are not typical.

Lenders tend to offer secured loans or seek personal guarantees but unsecured loans for smaller amounts can sometimes be arranged. In both cases, the lender will look for strong balance sheets and cashflows to support an application.

Choosing your lender carefully

Borrowing substantial sums of money, whether to buy a home, build an extension or install the latest hi-tech equipment requires careful consideration. Lenders should work with you to understand the best way to structure the finance with a sensible margin of safety. If a lender offers a LTV ratio that is much higher than the competition it is advisable to take advice from a third party before proceeding.

Due to the strong performance of the care sector in recent years there is an

abundance of new lenders keen to offer deals to care providers. There are only a couple of lenders that have been involved with the care sector for the long term and these are the lenders that are most likely to stay with the market if fortunes dip. Over the period of a 20 year term loan the market will go through a number of cycles and it is advisable to work with a bank that understands the dynamics of the sector and will be more sympathetic if the market turns difficult.

The Royal Bank of Scotland are experts in lending to this market. They have extensive commitment and experience and match resources with customer's locations and have a team of experienced managers around the UK. They are currently working with customers on facilities for the elderly, mentally ill and those with learning disabilities. Their specialists deal with a wide range of professionals in the sector, including regulators, accountants, valuers, lawyers, health & safety experts, property developers and planners.

These relationships give The Royal Bank of Scotland an ability to approach deals from 'both sides of the desk', with an understanding of different points of view.

Their services include:

- current account banking and money transmission,
- finance for development,
- acquisition opportunities,
- remortgage opportunities,
- interest rate hedging,
- mentoring on healthcare issues,
- introductions to external expertise: eg capital allowances.

In community care, The Royal Bank of Scotland has the appetite and the capability to help – whatever the scale and complexity.

That's why over a third of UK healthcare providers choose to bank with The Royal Bank of Scotland Group.*

Experts in asset finance

In addition to providing banking and capital finance services, The Royal Bank of Scotland Group includes Lombard, the UK's

leading provider of asset finance.

Lombard offers flexible solutions for a wide range of care home assets, including cards for directors and senior staff, vans and minibuses, VAT funding, lifts and mobility aids, specialist therapeutic and medical equipment.

Leasing allows customers to preserve working capital and gives you most of the benefits of ownership, with increased flexibility. Asset finance also helps solve the problem of how to maintain or update the assets in an ever-changing marketplace.

With specialist knowledge and experience of the care home sector, Lombard is well placed to structure bespoke financial solutions where they are required.

*Source pH Group, December 2005

Valuations and DISPOSALS

Valuing and disposal of care businesses is a very specialised field. It is essential to use a genuine well-resourced experienced firm. Andrew Sidwell, expert property valuer of GVA Grimley shares his knowledge on the key issues.

As in any property or business, market values are ultimately driven by supply and demand.

With the reduction in available beds, set against a continuing demand for long-term care of the elderly, and also the learning disabled and mentally disordered, the demand/supply balance has continued to be stable or rise.

This has led to rising profits during the last four years. This in turn has increased business confidence, more readily available funding, competitive bidding for acquisition opportunities and increasing values. There is no sign of a reversal of this trend although most commentators expect values to level off at a plateau.

Return on investment

Value is ultimately driven by the returns that a purchaser/owner

can achieve or reasonably expect to maintain. This applies equally to an individual home, a small group or large portfolio. Values are generally higher for groups of homes than for individual homes due to economies of scale and a variety of hungry funding sources apply enthusiastic purchasing and appraisal criteria.

The return on an investment, or yield, is the sustainable profit that the purchaser will expect to receive from either the ownership and operation of the business, or the rent, if leased out.

The latter only applies to a handful of transactions where the tenant/operator is of sufficient size and asset backing to offer a strong covenant, eg Four Seasons Health Care, BMI Hospitals or Southern Cross Healthcare.

The return on a purchase (yield) is the inverse of the years purchase (YP)/multiplier of profit that is commonly quoted. Thus a yield of 8% equates to a multiplier of 12.5 times profit and a yield of 10% equates to a multiplier of 10 times profit.

Profits

The sustainable profits are key to the value of any business. Purchasers, valuers and bankers will look at historic, current and projected profits. These may be described as earnings before interest, taxation, depreciation and amortisation (EBITDA), net operating profits (NOP) or adjusted net profit (ANP).

In all cases the analyst strips out non-recurring and personal or financial items from the accounts. Current and projected figures are the most important,

particularly the forecast run rate – eg the realistically sustainable future business profits. Sophisticated cash flows are seldom used, as it is difficult, indeed dangerous, to forecast beyond three or four years, at least without allowing very substantial sensitivities.

It is important to recognise how sensitive profitability is to even slight variations in the key performance indicators (KPIs), with the compounding effects, as illustrated in table 2.

YP/Multiplier

Valuers apply an all-risks multiplier to the sustainable future profits, taking into account the various opportunities and threats to the home's trade.



SUCCESSFUL DISPOSALS

Three key areas for successful disposals are:

- Professional advice from an experienced and reputable specialist agent.
- Preparation – working alongside the agent and doing everything possible to facilitate a successful sale and maximise the sale price.
- Pricing – ensuring that the price guidelines achieve the maximum price without aiming too high and killing the market, or at least losing credibility.

WHAT IS THE MARKET LOOKING FOR?

First time buyers and small operators consider good quality conversions. Small groups consider the same, or the acquisition of smaller groups and are particularly keen on homes with extension potential. Specialist operators are very keen to expand their fields and increasingly, elderly care groups are looking to diversify. Groups, developers and others are keen on sites as the viability of care businesses has been restored and new developments are becoming attractive again despite high land costs.

Care villages, extra care facilities etc are seen by many as the future. They require massive investment and long-term commitment. Various models exist and it is yet to become clear whether selling or letting accommodation or the hybrid of the two will become the most successful. It largely depends on the target market eg self-pay or local authority assisted. The growth of this element care provision is also hampered by land shortage.



For individual care homes of reasonable quality and performance, YP/multipliers have increased significantly during the last three or four years with many transactions now at multipliers of seven or eight where they used to be at five or six.

For particularly attractive propositions, or properties with potential or successful groups, multipliers can be significantly higher.

Compliance

The quality of care home stock in the UK has improved steadily. Newly built units are now much more highly specified and operators are wisely building homes above the National Minimum Standards (NMS) although with concomitant build costs of over £40,000 per bed and maybe even £60,000 per bed or more for the highest quality. These exclude land costs.

Deficiencies within a care home measured against NMS compliance will have a significant effect upon value, particularly if correction is difficult, costly or impossible.

Non-compliance often lies

within staffing, a backlog of capital expenditure or repairs and room configuration.

Acceptability

Purchasers, banks and valuers today are more relaxed regarding compliance, as are many of the inspectors, due simply to the supply shortage. However, value will be hugely influenced by the practicality or otherwise of reconfiguring or extending accommodation to enhance both its functionality and presentation.

Failures to comply on management, staffing or other policy or procedural issues will also affect value, particularly if persistent understaffing has been the pattern.

Geography

Wide variations in valuation occur across geographical areas but also within areas. Values are broadly similar in East Anglia, South West and the North West, but within regions or even towns there will be significant local variations, largely according to local supply and demand. Local supply may change rapidly and

dramatically with just one home's opening or closure.

Prices

Thus prices paid vary enormously across a range of care home businesses with a huge variety of factors to be taken into consideration. Competitive bidding by purchasers with strong support from banks has been driving up prices. As well as the great advantages in working with an experienced and knowledgeable bank, purchasers/owners, brokers and banks should continue to use one of the genuine well-resourced experienced specialist firms of valuers.

Disposals

The disposal of a care home may be the largest financial transaction an individual will make. Therefore, it is vital to ensure that everything is handled properly from start to finish. It is important to use a specialist care sector agent who understands the market, is well established and who will have been continually updating a substantial list of purchasers. Avoid using an agent who

changes from selling one type of business to another. You should also take into account confidentiality.

Appropriate pricing

This is of fundamental importance. Over-price and you will kill your market. Even with a subsequent price reduction, interest levels will be lower than if an appropriate price had been quoted initially.

A reputable, professional agent will take time to explain the advised pricing strategy and how the business records will support it. With appropriate pricing a sale is less likely to collapse through the purchaser's bank or valuer down-valuing from the agreed price.

Preparation

This cannot be stressed too highly. The home should be presented as attractively as possible. Allow time to refurbish tired areas, perhaps obtain planning permissions that may be feasible and ensure that accounts and all records of trade (including records of service users, wage rates, staff contracts, suppliers

contracts etc) are clear, concise and up to date. It is also important that all information is plausible and anything that might raise concerns can be explained.

Sale material and media

The expert agent will prepare clear and concise sales particulars, laid out so as not to disclose the identity of the home. The material must be accurate and sellers must work closely with their agents to ensure this.

It is generally unnecessary to advertise and inadvisable to do so, except possibly with development sites. The care press and agents' own websites provide an outlet for advertising care homes for sale, but they are usually not necessary in the current market.

A reputable agent will already have a substantial pool of buyers. Your agent's mailing list should be discussed with you and edited to manageable

proportions. This is part of the filtering process of handling daily enquiries from the many hundreds of purchasers seeking the relatively small number of businesses available.

Viewings

These should be arranged through your agent by agreement with you at a convenient date and time. A cover or excuse can be agreed if the home's staff are not aware of the sale. The agent should follow up viewings to discover what attributes and shortcomings were perceived by the potential buyers.

Negotiation

Even in a strong seller's market the practice of 'gazundering' continues, where a buyer attempts to reduce the price without reasonable justification. Sellers must stand firm on this point, unless there is a genuine reason that has been uncovered. Again, the successful agent should have

multiple buyers and keep the seller 'in the driver's seat' during the process.

Other professionals

The seller will need accountants and lawyers who are familiar with the business and property and have sufficient experience of commercial transactions in the care sector.

The level of expertise and resources needed rises if a company sale is involved through the due diligence process. Sorting this information should start before the property goes onto the market.

Warranties

This can often be challenging as purchasers will want warranties and guarantees for everything and sellers will generally be reluctant to provide them. There has to be some flexibility and common sense in this respect and any issues that are likely to be contentious need to be

considered carefully by the seller beforehand. The advice of an experienced agent, lawyer and accountant will prove invaluable.

Disputes

Disputes between different parties on the seller's side can obstruct the sale. It is imperative that any difficulties are resolved so that a clear strategy, decision-making and reporting process are in place.

Trust

Trust between all parties can be of enormous benefit in solving any small problems before an intractable position is reached.

Finally, when it comes to informing staff of a sale. In many cases it is far better to be open with staff reasonably early in the process.

Most staff simply wish to do their jobs to the best of their abilities and receive their wages regardless of who owns the business.

TABLE 2

Hypothetical 50-bed provincial care home currently trading as in column B.

	A	B	C	Comments
Capacity	50	50	50	
Occupancy	49	48	47	
Av. Fee	£402	£400	£398	
Revenue	£1,024,296	£998,400	£972,712	
Staff Costs	£626,000	£624,000	£622,000	Slight savings in short term
Percentage	61.10%	62.50%	63.90%	
Non-Staff Costs	£145,000	£144,000	£143,000	Slight savings with occupancy
EBITDA	£253,296	£230,400	£207,712	
Percentage	24.70%	23.10%	21.40%	
Loan interest on £2 million	£110,000	£120,000	£130,000	Assume 6% ± 1/2 %
EBITDA after loan interest	£143,296	£110,400	£77,712	

Note how fractional movements in KPIs and interest rates produce a substantial variation on the bottom line.

Staffing ISSUES

Attracting and retaining a skilled workforce is difficult for all care providers and a reliance on overseas staff brings a new set of challenges. Increased regulation aims to professionalise the caring profession to improve standards and raise the profile of the sector.

In 2001, new bodies were created to regulate the social care workforce in England, Scotland and Wales. Each has a duty to develop Codes of Practice.

The Code of Practice for Employers sets out the responsibilities of employers in the regulation of social care workers in a list of statements that describe the standards of professional conduct and practice required of them at work. It requires that employers adhere to the standards set out, support social care workers in meeting the Code and take appropriate action when workers do not meet expected standards of conduct. The regulation of the social care workforce in each country is now underway as detailed below.

Workforce registration England

All social care workers in England should register with the General Social Care Council and abide by their Code of Practice for Social Care Workers that demands they are trained and fit to be members of the workforce. At present the register is only open to social workers but in the near future it will be opened up to other groups, from care workers to directors of social services. In view of the size of the social care

workforce, registration will begin incrementally and will take some years to complete.

Qualifications, health and good character are checked as part of the process. Registration can be done online at www.gsc.org.uk where paper copies of the form can be ordered.

Scotland

Staff wishing to work in the sector will need to register with the Scottish Social Services Council (SSSC). Managers can register now and care supervisors will be able to register from September 2007. Practitioners and support workers in adult residential services will only be able to register in 2009 but care providers are being asked to demonstrate their plans to meet the SSSC registration to meet inspection requirements. The necessary qualifications are set out on the SSSC's website at www.sssc.uk.com. Applicants who are not fully qualified may, if they meet all the other eligibility criteria for registration, be granted registration subject to achieving qualifications within a specified period.

Wales

The Care Council for Wales (Cyngor Gofal Cymru) has been responsible for the registration of the country's care workforce since

2001. The Register is currently open to all social care managers and workers as described in the Care Standards Act 2000. The CCW is responsible for agreeing Codes of Practice that apply to social care workers and employers across the sector. Signing up to the Codes of Practice is a condition of acceptance on to the social care register. Help and advice can be sought from the CCW helpline on 0845 0700 399.

Criminal record checks England and Wales

• Criminal Records Bureau (CRB)

The CRB's aim is to help organisations in the public, private and voluntary sectors by identifying candidates who may be unsuitable to work with children or other vulnerable members of society through detailed background checks. In relevant cases, information held by the Department of Health and the Department for Education and Skills can also be accessed.

An enhanced CRB check is a condition of employment and must take place before a position is offered.

• Protection of Vulnerable Adults register (PoVA)

The PoVA scheme aims to ensure that individuals with a track

record of poor practice, or who are intent on harming vulnerable adults, cannot be part of the care workforce. A PoVA check must be undertaken on any new member of staff. Current legislation means a PoVA check can only be obtained at the same time as a CRB Disclosure.

PoVAFirst is available to employers who are entitled to check the PoVA list and who have requested a PoVA check on the Disclosure application form. It allows sight of the result of the PoVA check as soon as possible and before the full Disclosure is received. However domiciliary care staff in Wales cannot start working following a PoVAFirst check as CRB checks are still being processed so at present there is no point in Welsh providers requesting a PoVAFirst check.

Scotland

• Disclosure Scotland

Disclosure Scotland is part of the Scottish Criminal Record Office which is an executive agency of the Scottish Executive. Disclosure Scotland is designed to enhance public safety by providing potential employers and organisations within the voluntary sector with criminal history information on individuals applying for posts. Disclosure Scotland issues certificates – known as

A MULTICULTURAL WORKFORCE

During the past decade the numbers of overseas staff working in this sector has grown immensely. Managers need the skills to manage a multicultural workforce and overcome the associated challenges.



A multicultural workforce has applications to organisations of all sizes and implications for human resource management policies. It is important that integration and training reflects an understanding of the issues of multicultural diversity. Companies that fail to be aware of diversity at every level risk alienating their employees and an atmosphere of bitterness developing.

Diversity has the enabling ability to address the changing demography of the client groups, assisting to address individualised care for clients and provide a service tailored to person-centred care.

Members of multicultural teams are to a greater extent exposed to the risk of hostility, if there is no clear direction or

supportive mechanisms in place, and with increasing work pressure and stress, the propensity for harmful stereotyping increases. Some of the strategic options in multicultural team working include:

- Basic skills training, reading, writing, numeracy, speaking and understanding the English language. These courses can be carried out in-house or through Learn Direct and can often be available free.
- Terms and conditions and family-friendly policies like flexible working and equal opportunities that work in practice for all employees.

Prospective employers of overseas staff need to accommodate the challenges staff

may face in order to assimilate into a new working environment. These include setting up bank accounts, accommodating different dietary needs and finding suitable accommodation that can enhance a sense of belonging.

The principle objectives of managing a multicultural workforce include awareness, education and positive respect of differences among people.

It has become increasingly evident that appropriate management of a multicultural workforce is critical for organisations that seek to improve and maintain their competitive advantage, reflect the diversity of the communities they serve and maintain individualised care provision.

'Disclosures' – which give details of an individual's criminal convictions (and in the case of Enhanced Disclosures, where appropriate, non-conviction information) or state that they have none. Disclosure Scotland does not currently have access to the PoVA list maintained in England and Wales but it hopes to in the future.

Recruitment and retention of staff

The recruitment and retention of staff is the main problem affecting this sector. Care staff earning little more than the minimum wage can find alternative employment in much less taxing occupations and often do. However, higher wages isn't necessarily the answer. Most recruiters accept that salaries alone are unlikely to influence someone to work in a care home. There has to be something else. It is often easy to forget that this sector offers challenging and satisfying work.

Qualifications and training differentiate this sector from many similarly paid jobs. Most people value learning and development opportunities. Training must commence as soon as an employee joins an organisation and should never finish. Induction training and the Care Level 2 S/NVQ are the start, with other qualifications leading up to a management role. Then there are short courses to develop skills and knowledge. Training must also cover the five mandatory units, that are a Commission for Social Care Inspection requirement.

Many candidates are looking for a career structure and most care homes recognise that clear career progression linked to qualifications and experience gives staff the motivation to continue training. This gives a sense of achievement as they move up the organisation with an increasing salary. Most jobseekers need some level of

responsibility and job satisfaction. Care work requires a willingness to accept responsibilities, to share information and to be a committed member of the team. The satisfaction received from making a client happier and more comfortable makes the work worthwhile.

Teamwork fulfils most peoples' need to interact with others. A care environment offers the opportunity to work closely with others, to share routines and responsibilities and to feel the satisfaction that other people are relying on them, just as they are relying on others.

Flexible hours are increasingly popular, particularly for women returning to work with children. The shift system in care homes can accommodate flexible working better than many other industries.

• Set your home apart

These selling points should be common to all care homes so

how do you distinguish yours from your competitors'?

A good brand identity is an answer. Some think that this only applies to larger groups and that smaller homes can't devote time or resources to brand development. But it is not the quality of the marketing materials or the profile of the company in the media. It's more about your reputation in the marketplace and your staff culture including the service you offer clients, the way you treat your staff, how well you develop staff potential and the remunerative rewards they can gain.

These apply to any business, regardless of size. It is important to understand your local competition and benchmark your business in the marketplace.

By recognising the benefits of working in your care home versus others in the locality you can sell these points to a potential recruit.

Training and FUNDING

Training of the social care workforce is high on the agenda across the UK and has been subject to National Minimum Standards (NMS) for a number of years. The standards vary from country to country as does the available funding.

England Induction Standards

Skills for Care has developed new Common Induction Standards (CIS) which they expect to become the NMS requirement from September 2006 replacing the 2001 Induction and Foundation Standards.

The CIS are designed for people entering social care as well as those changing roles or employers and will form the basis of registration of all social care staff. They are directly linked with the Health and Social Care National Occupational Standards and the GSCC Code of Practice for Social Care Workers. The new programme should be completed within 12 weeks of the start of employment instead of six weeks as previously required. Some individuals may not need the full 12 weeks to complete it.

NVQ training requirements

The NMS state a target of 50% of all care staff to have achieved an NVQ 2 and all managers to hold an NVQ 4 and a Registered Managers Award by the end of 2005. There has been no announcement of an extension to this deadline but the Standards are currently being reviewed by the Department of Health. The Commission for

Social Care Inspection is taking a flexible approach with well run homes but a harder line with those that are not.

Knowledge and Skill Sets

Designed to fit alongside the CIS and NVQs, the Knowledge and Skills Sets are there to ensure that employers understand what trainees should know in key areas of work. They provide a list of minimum learning outcomes for specific aspects of care delivery. Care providers will be able to commission the correct training by using the learning outcomes as a checklist of requirements or alternatively, they can be used as a framework to develop in-house training programmes.

Four Sets have been launched so far with 32 planned in total. The first four are Dementia, Medication Handling, Infection Control and Prevention and Workers Not Involved in Direct Care. The Sets aren't mandatory, however those who aim to provide a high quality service will view them as a welcome opportunity to develop the knowledge and care practice of their staff.

Scotland Training and qualifications

The original deadline for SVQs as stated in the National Care

Standards has now been superseded. Revisions have been made in light of the on-going registration of the social care workforce with the Scottish Social Services Council (SSSC) which requires the achievement of recognised qualifications.

Care home managers can register now and care supervisors will be able to register from September 2007. Practitioners and support workers in adult residential services will only be able to register in 2009 but care providers are being asked to demonstrate their plans to meet the SSSC registration to meet the requirements at inspection. The list of SSSC recognised qualifications can be found at www.sssc.uk.com.

Care Scotland is the Scottish Qualification Authority's (SQA) one stop shop for advice on care sector qualifications in Scotland. Visit their website at www.sqa.org.uk.

Wales Induction

The Care Council for Wales (CCW) has issued a Social Care Induction Framework that provides recommendations for the way that the induction process should be carried out. The Framework is not intended to replace any induction

procedures that employers have in place and is designed to specify outcomes for induction and can compliment existing induction programmes. Visit their website at www.ccwales.org.uk.

The Framework is designed to commence on the first day of a care worker's employment and will be assessed by the end of the twelfth week of the employee's engagement. Even experienced/qualified workers must be given a full induction on the new employer's organisational policies and procedures. The Induction Framework is currently being reviewed by the CCW but the timescale of the review has not been made available.

NVQ training requirements

Under CCW's Qualifications Framework the requirement to train care staff is mandatory and applies to all workers providing or managing care. The NMS stated that, by April 2005, all managers should hold an NVQ level 4 in care or equivalent and 50% of care staff be at least NVQ level 2.

This deadline has passed and has not yet been revised but the CCW are currently reviewing the Qualifications Framework, the timing of which has not been announced.

FUNDING FOR TRAINING

ENGLAND

There is no single source of funding support for social care employers for workforce development, education, training or assessment. Therefore it is necessary to consider a number of sources.

• *Skills for Care (SfC)*

Every area has an employer partnership. You can claim money for every completed unit of NVQ and for Induction, subject to partnership funds being available. As a guide this will be approximately £70 for each unit but there is local variation. Through local employer networks SfC will have access to the Enabling Fund. Bids to this fund will need to have some match funding from another source, for example, from your local authority. It is not something individuals can bid for and there are criteria for applying.

• *Business Link*

Currently brokering a range of offers for employers with two to 250 staff. The main one is the Employer Skills Offer. This can be £500 of match funding to support skills, management development and NVQs. There is also a £1,000 grant for Proprietors, Managing Directors and Chief Executives of eligible organisations to fund management development following a short session to identify development needs.

• *European Social Fund (ESF)*

ESF training and development projects will vary throughout the country. To access ESF funding you have to be an eligible company with less than 250 employees and direct beneficiaries must be EU residents or have lived in the UK for three years.

• *Learning Resource Networks*

A source of funding for innovative development projects like the Enabling Fund.

• *Department of Health (DH)*

DH's National Training Strategy Grant and Human Resource Development Grant to Local Authorities is allocated to local authorities to support workforce development across the whole care sector – statutory, independent and voluntary. 2005/06 saw big increases from DH and confirmation of a further three years funding. Some authorities allocate money via care associations, partnerships, directly to care providers or through SfC. But be aware that you cannot double claim from this source and SfC for the same training.

• *Local authorities*

Some local authorities join forces with health and provide opportunities in local areas for joint training. Try their training and development team or approach your contracts manager who may be able to find out what is available.

SCOTLAND

In Scotland, various bodies disburse the money for training.

• *Modern Apprenticeships (MAs)*

Funding for MAs comes from Local Enterprise Companies (LECs) of Scottish Enterprise and Highlands and Islands Enterprise.

• *Voluntary Sector Development Fund (VSDF)*

Approximately £1 million is disbursed by the Scottish Executive's Social Work Policy Department to voluntary sector providers of social care to assist them with the costs of training staff to meet the Scottish Social Services Council's registration qualifications.

• *Section 9 Funding*

This is another funding stream disbursed by the Scottish Executive, in this case to large voluntary organisations delivering social services in Scotland.

WALES

Seeking funding for training in Wales can be complex and varies by area and time of year. Funding can be accessed through several channels such as Education and Learning Wales, the Welsh Development Agency, Business Connect and through further education colleges, training providers and universities. The support offered may be through grants, subsidies, loans or consultancy.

• *Modern Apprentice Frameworks*

Any members of staff who are willing and able to achieve technical certificates and key skills as well as their NVQ are able to access a comprehensive, funded training programme.

• *European Social Fund (ESF)*

There are opportunities for employers in Objective 1 or 3 areas to use the ESF to access NVQ for little initial financial outlay.

• *Social Care Workforce Development Programme (SCDWP)*

Designed to support national training targets across the whole of the social care workforce, local authorities need to apply for the grant on behalf of their SCDWP.



Health and SAFETY

Health and safety is integral to any business, especially the running of a care home where staff, residents and the general public are at risk if it's not properly followed. Chris Hawkings of Ecclesiastical Insurance explains the risks of ignoring it and discusses best practice.

Health and safety has been much maligned over the years. If a school playground is forced to close due to unsafe swings, health and safety is blamed. If a corner shop closes for business because food is out of date, health and safety shoulders responsibility. And if a care home faces a claim from a member of staff tripping, health and safety has to answer to criticism.

Let's make no bones about it; lack of consideration for health and safety can have serious consequences. Every year accidents in care homes do occur and in many cases a better consideration of health and safety could have prevented them happening. Slips and trips are the most common source of accidents closely followed by incorrect lifting of residents. These accidents result in claims that, although they should be covered by insurance, still have a big effect on your care home.

Dispelling myths

But health and safety isn't to blame – quite the opposite. We've got a lot to thank health and safety for. Its reputation has been tarnished by accidents caused by a total disregard for its guidance.

Accidents cause pain and suffering to those who are injured, but they also place additional strains on your

business. You may need to employ temporary staff, place additional workloads on existing staff, provide sick pay and face additional administrative work.

As well as the possibility that the injured person may make a claim against you for damages in a civil action, criminal prosecutions may be brought against individuals as well as the business under health and safety law. Penalties can be as high as a £20,000 fine and two years imprisonment.

But health and safety is not a barrier to running your care home, it should actually help you to run it better.

Going through the motions

All too often businesses and individuals are heard to utter 'we can't do x because of health and safety'. In many cases 'x' can't be done because it isn't safe in the first place, not because health and safety doesn't want to let it go ahead. In actual fact health and safety should be a tool to help you make it happen.

Health and safety should be part and parcel of the daily running of your care home. It should be part of the way you work. If your care home is well run and efficiently organised it's likely health and safety is naturally a concern for you anyway. If you follow health and safety guidance closely and

sensibly, it can help you to minimise the risk of your staff, employees or the general public encountering an accident on your premises.

Health and safety guidance must be put into the context of your own home. Every care home is different in the way they work and the residents they care for. So health and safety guidance must be looked at in terms of your own particular circumstances. Your care home

needs a health and safety policy tailored to its needs and this is where your expertise and understanding of your care home comes in.

You know your care home better than anyone else so you're in the best position to do a thorough check of health and safety and keep an eye on potential risks. After all, if you do neglect to do it properly, it is you who will be held responsible.

TAKE IT SERIOUSLY

Just because you've considered health and safety, it doesn't mean you can then forget all about it.

You may have a Health & Safety Law poster on the wall and you may have completed a risk assessment but this doesn't mean you don't need to think about health and safety ever again.

Once you've carried out an initial assessment you need to ensure you monitor procedures to take account of changes in the way you work or changes in new risks. Health and safety deserves a

better reputation. I think it's time we all gave it a little more credit.

For more information visit www.hsebooks.com where you can obtain the following resources, Five Steps to Risk Assessment – HSE Free leaflet INDG163 (also available in Welsh), Health and Safety in Care Homes – HSE 220 and An Introduction to Health and Safety – HSE INDG259 (also available in Welsh).



HYGIENE

Hygiene and infection control is the subject of National Minimum Standards in the UK. Within this article the standards are explored and Dr Harley Farmer of NewGenn offers advice on dealing with outbreaks.

England

Care homes for older people and care homes for adults

The outcome of the standards on Hygiene and Infection Control is that the home is clean, pleasant and hygienic.

This should be achieved by ensuring that the premises are kept clean, hygienic and free from offensive odours and that systems are in place to prevent the spread of infection in accordance with legislation. Laundry facilities must be appropriately sited so soiled articles do not come into contact with food or residents and sluicing facilities should be available. Laundry must be cleaned at appropriate temperatures and washing machines must have specified programming ability to meet disinfection standards. Services should also comply with the Water Supply Regulations 1999.

Laundry floor finishes must be impermeable and readily cleanable. Hand washing facilities must be prominently located where infected materials or clinical waste are handled. Policies and procedures must include the safe handling and disposal of clinical waste, dealing with spillages, provision of protective clothing and hand washing.

Wales

Care homes for older people

The standards are the same as for England except all care

homes where commodes or bedpans are used need sufficient provision of these items to minimise the risk of cross infection.

They should also have a suitably located sluicing disinfectant or other appropriate disinfection procedures. This only applies to homes with more than three residents.

Care homes for adults

These standards are the same as for care homes for older people with the addition that laundry facilities must have direct access to an external area.

Scotland

Care homes for adults

These require that there are accountability arrangements and clearly defined responsibility for infection control.

Policies, procedure and guidelines must be up to date, implemented, audited and reported. An infection control key worker must be responsible for the day to day implementation.

Systems are required to ensure expert infection control advice is sought and staff receive relevant training.

An annual infection control programme must be produced with clearly defined objectives and priorities.

All systems must be monitored and reviewed to make improvements and a clear hand hygiene policy must be implemented.

DEALING WITH OUTBREAKS

Outbreaks are inevitable in a care environment. Infectious diseases adversely affect the ability to deliver good care, especially when outbreaks of Noro Virus (Winter Vomiting Disease) occur.

Outbreaks strike patients and staff and can affect the quality of care on offer. A home still has to be run properly regardless of an outbreak and managers must choose to have staff working but at risk of spreading infections or at home being paid to recover from an illness caught at work.

Prevention

Prevention is better than cure and leads to superior care. By moving the perspective from virus to illness, it allows everyone to see something they can manage. Infectious illnesses start at one focus and spread. The best way to handle them is to have a fully integrated systems approach and prevent it happening.

When it comes to other microbes including MRSA, Clostridium difficile, Salmonella or influenza a logical, cost effective and simple prevention procedure will control them all. Trying to contain them after an outbreak will only lead to them finding a way through. The microbes that cause infections are always present and only need to spread for another outbreak to occur. Fortunately it

is very easy to prevent disease outbreaks if good advice is taken from those with a history of success. A prevention philosophy to outbreaks leads to better care. By introducing prevention procedures and products before outbreaks occur money will be saved long before the new outbreak strikes.

Products

It is necessary to understand that the myriad of various viruses is confusing and how important it is to instigate a full systems approach that encompasses them all. As Noro Virus is so obvious and spreads so quickly, take it as the benchmark and only purchase hygiene products that control it. Once that is defeated all the others like MRSA, C. difficile, Salmonella and influenza will be controlled.

Every opportunity should be taken to reduce the number of microbes in a care home. Specific cleaning and hand hygiene products should be chosen that are antimicrobial, using Noro as the benchmark. By doing so money can be saved as many products are replaced with a few.

Nutritional NEEDS

The importance of proper nutrition within a healthy diet cannot be overstated. Malnutrition is one of the commonest problems among elderly people and one of the least diagnosed. One in seven people over 65 are thought to suffer from or be at high risk of malnutrition and that figure rises for those in institutional settings. It is estimated that between 20 and 40% of residents in care fall into this category.

The reasons for these statistics are complex and can range from a lack of understanding of the importance of nutrition or a failure to identify the warning signs to the fact that residents may be malnourished before they come to the home.

The National Minimum Standards require that residents receive a varied, appealing, wholesome and nutritious diet, which should be suitable to the assessed needs of the individual. Religious and dietary needs and special or therapeutic diets must also be catered for. The Standards stipulate requirements for the conduct of meals and mealtimes, these are important as both a social function of a home and because malnutrition may arise as a result of

a person not being helped or encouraged to eat. The consequences of failure are undeniable. Malnutrition significantly increases the risk of infection, delays recovery and ultimately, of course, endangers life.

Bon appétit

Dietary needs should ideally be discussed in a needs assessment before a client moves into the home. Screening tools for malnutrition, looking at unintentional weight loss, body mass index and poor diet can be used on admission and frequently thereafter. New guidelines from the National Institute for Health and Clinical Excellence require all care home residents to be screened

regularly to establish their nutritional status and for all care staff to receive training on the importance of providing adequate nutrition. Once the client is assessed at high, moderate or low risk of malnourishment, strategies can be drawn up regarding their diet. Those at high or moderate risk should be offered a high-calorie, high-protein diet, supplemented with nutritionally-dense snacks.

In a care environment it is important that each member of staff understands their contribution to mealtimes. From the cleaner, responsible for keeping the dining rooms clean and pleasantly-smelling, the staff who lay tables and must understand the needs of

particular residents, to the care staff who must ensure that eating itself is as enjoyable as possible. But if the food that is served is unpleasant or unappetising then all the efforts of the team are wasted.

Chefs must balance the various nutritional requirements of residents with the task of creating meals that look, taste and smell appetising. Creating interesting food for those with soft diets can be difficult and even harder when puréed food is required.

Advances in catering technology have impacted on this problem, benefiting clients with chewing and swallowing difficulties, but the challenge remains.

ASSISTANCE



The National Association of Care Catering are launching a Menu Planning and Special Diets Manual to assist managers to operate an effective and appropriate catering service in care homes. It offers solutions to common menu planning problems, dietary issues and enables managers to serve a balanced diet.

There are also many courses available to train staff to provide interesting, nutritional food. These courses can focus on the nutritional needs of people with specific requirements or those who may need assistance with eating or drinking. The Royal Institute of Public Health offers courses on eating for health in care homes. They are focused on the nutritional content of residents' diets and show how to produce modified

consistency foods that look good but are easy to digest. They also offer ideas for producing strong tasting food for those whose palates are jaded and advice on the importance of fluid intake. Some care providers are also developing their own training courses for staff covering basic food production, preparation, presentation and nutritional needs. Training courses and the recognition of entering chefs for local and national awards have their part to play in motivating catering staff, although it is apparent that training only has a value if something changes as a result. Training and changes need to be implemented in the care home for effective results to be seen. To do this commitment from the top is the key to any improvement.

Improving your BUSINESS

Marketing is integral to every industry. This sector is no exception with its tight profit margins, confused legislation and external forces controlling its fees. These set the sector apart from others where price is the main focus of competition and market forces dictate supply and demand more freely. In this respect, the care sector requires a more tailored approach to marketing.

Marketing is 'a company-wide philosophy where identifying and meeting customer needs both profitably and ahead of competitors is the central focus'. This means that every employee in your business is, in a sense, in marketing. It covers everything you do which has a potential effect on the experience of your customer. With this in mind, the start of any successful marketing plan is to identify customer needs and wants.

It's your opportunity and responsibility to recognise these and to communicate your understanding and empathy to each customer through your service delivery.

First impressions count

The power of first impressions cannot be underestimated. There are several early points of contact when opinions form and develop and to which special attention must be paid:

- receipt of brochure and relevance of content,
- initial contact by telephone,
- the home's outside appearance,
- first contact with staff and manager.

The starting point is to assess your care home as if through the eyes of a potential resident. Telephone manner, the home's external appearance, the atmosphere amongst staff and

residents, cleanliness and staff attitudes all affect perceptions. The next stage is to assess your competition to benchmark your home and then carry out a SWOT analysis (Strengths, Weakness, Opportunities and Threats) to identify what you do well and what could be improved.

Even the most well written business plans can fall short of their objectives if your premises or staff do not promote a positive image to your customers. Many care providers employ the services of a management consultant to help implement a company-wide marketing strategy.

Management consultants

Management consultants are there to improve the home's administration. They may be asked to work on logistics, paperwork, audit trails, staff relations etc. They are not medical consultants and should not be expected to comment on anything to do with healthcare.

When choosing a consultant consider:

- what they know about the industry and running a care home;
- how creatively they tackle problems;
- how they'll work with staff and residents – and make sure you meet consultants, not just a sales team;

- where they're based and who pays for travelling time;
- what relevant technical skills they have;
- how they propose training staff in any new procedures as a result of their work;
- their code of conduct and terms and conditions.

Some consultants have specific skills in certain areas, such as commissioning a new home, taking over an existing home, or developing new services. Most managers are looking for a 'process consultant', ie an expert

who can help define the steps needed to accomplish a particular task or project. They are experts in organising people and methodology.

A consultant's daily rate often works out at about one week's fees for one bed. More experienced consultants often charge a higher rate but can work more quickly to minimise disruption and reduce costs.

Independent operators are probably 20-30% cheaper than small companies and small companies are about 20-30% cheaper than large ones.

QUALITY ASSURANCE

RDB Star Rating is the largest independent accreditation for care home quality standards. Homes are visited annually and assessed against 200 RDB care standards that result in an award of between two and five stars. Visit their website at www.rdbstar-rating.com.

The RDB Star Rating of care homes is linked directly to local authority fee levels with an incremental increase for every extra star. The accreditation is a powerful management tool to assist with business planning, development and marketing. The process identifies what is

done well, what could be improved and how to raise standards. Staff can feel empowered and motivated as they can see a direct benefit to the business from their everyday activities which were previously thought routine.

Many care providers go through the Investors in People programme (www.investorsinpeople.co.uk or www.iipscotland.co.uk) which, although not sector specific, has a benefit to any business in terms of planning and communication within an organisation. Staff benefit from sharing in the business plan and objectives and the employer benefits from an empowered and motivated workforce.

Effective MENTORING

Mentoring and the techniques mentors use to develop an individual's ability to do their job and further their careers are very topical. Patrick Vyvyan-Robinson of People Inspired explains the role of the mentor, why they are important to those working in the care sector and how they improve business effectiveness.

Mentors are role models able to provide a focus for analysis, reflection and action that enables the mentee to achieve success in one or more areas of their life. At one time mentoring was reserved for senior managers and company directors, now there is a growing trend for mentoring to be available to a wider audience as a development tool.

Helping change

This sector is experiencing constant change and mentoring is closely linked with helping people deal with changes in a manner consistent with their personal values and goals and the objectives of the organisation they work for.

Organisations have to adapt to remain competitive and meet the ever-increasing demands of their customers. To keep pace with change means people have to adapt too. They have to learn new skills, change their way of working, operate out of their comfort zones, do more – with less – quicker. Training courses and formal methods of development have their place but pressure on time and budgets, and the realisation that 'one size does not fit all' has led organisations to look more keenly at mentoring as a means to value, develop, enable and support staff. There is a significant increase in the take up of mentoring from middle managers, team leaders and supervisors in the private

sector. In the care sector it is these who are under most pressure and will benefit from this method of support and development.

Develop skills

Many managers in the care sector have no management training but have been appointed because of their technical expertise and qualifications, experience and commitment. Mentoring provides these key people with a role model to help them develop the management and leadership skills required to get the best out of people whilst maintaining standards in an ever changing environment. It is not unusual for managers to feel isolated, under pressure and overwhelmed by the demands on them to lead their teams successfully. Mentoring develops a manager's skills and confidence to delegate effectively, to coach their teams and to spend more time 'on the business' rather than 'in the business'.

Applications

There are numerous, varied applications and benefits of mentoring. It can enhance morale, motivation and productivity by making people feel connected with organisational changes. Giving people time and listening to problems helps the mentee express and legitimise their feelings. It is an effective way of dealing with negative behaviour

making people aware of their actions.

Tailor made

Mentoring is designed to suit a mentee's personal needs and learning styles. It releases potential, fine tunes and develops skills. It can address specific performance problems and can be highly effective when used to support training initiatives to ensure that key skills are transferred. It helps to improve communication and interpersonal skills and makes people more self-reliant and encourages them to explore options and act on their decisions with confidence and vigour.

Mentors can come from within or outside the organisation but they will need the appropriate attributes, skills and

knowledge to be successful. Above all they must be credible and able to earn the respect of their mentee.

As mentoring is becoming more common in this sector it is worth remembering that it has been a part of nurse training for many years. In care, the supervision that has been established to ensure that standards are delivered, development requirements are fulfilled and support is provided is itself a form of mentoring when conducted correctly.

Be wary of thinking that mentoring is the latest management fad – it's been around in one form or another for many years and is here to stay as a means of improving individual performance and organisational profitability.

GOOD MENTORING

A good mentoring programme will motivate and inspire. It will provide a balance between fulfilling organisational goals and objectives whilst taking into account the personal development needs and concerns of individuals. The success of a mentoring programme will depend on the time and resources that need to be committed to the initiative. For the mentee they must:

- work on establishing a long term relationship,
- meet regularly with the mentor,
- agree and set clear objectives,
- review objectives at each meeting,
- be honest,
- rely on the mentor for guidance, not answers,
- not use the mentor as a dumping ground!

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