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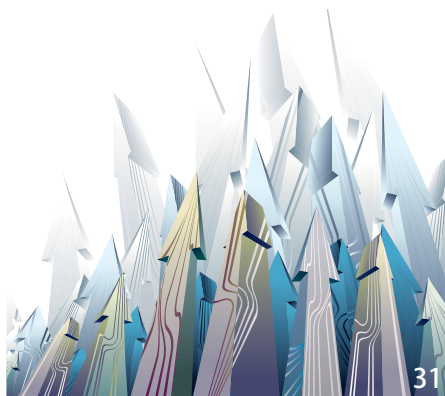
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editor's welcome

This month sees the introduction of the Care Quality Commission's new quality ratings for social care. I'm sure you're all familiar with the new approach to inspection and Ofsted style ratings. Inspectors now ask the following five questions: is the service safe, effective, caring, responsive to people's needs and well-led? This feeds into the new ratings of: 'Outstanding', 'Good', 'Requires improvement' and 'Inadequate'. Stuart Marchant looks into the new inspection regime and quality ratings on page 18 and explores the impact that ratings may have on services.

Also inside, Des Kelly brings his unique insight into the findings of the Demos Commission on Residential Care. Des was part of the year-long Commission that studied the future of the housing with care sector. The report makes a number of recommendations that Des has covered in his article on page 31. They make for very interesting reading and could open up some opportunities for providers.

Our Straight Talk this month is by Paul Simic, he's shared his opinions on how we need to care for the sector; how it needs to be nurtured. He argues that by using 'hit squads' and 'special measures' it's creating a culture of fear. Paul's opinion piece looks at the need for partnerships between providers, the regulator and commissioners in order to find common purpose.

Finally, I'd like to take this opportunity to thank all of the organisations that entered our 3rd Sector Care Awards. The winners will be announced by Esther Rantzen at the Awards ceremony on 3rd December. Tickets are available to buy at www.3rdsectorcareawards.co.uk. I look forward to seeing you there.

Emma Morriss
Editor



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Is it just me...?



Editor in Chief, Robert Chamberlain explores research into public opinion of care funding in the context of the Care Act's funding reforms.

The Government's message to the general public is that the Care Act's funding reforms will cap an individual's spend on care fees making the system much fairer and affordable. However, a number of recent surveys have highlighted mixed confidence amongst the population regarding the prospect of paying for care in the future.

LACK OF CONFIDENCE

A YouGov survey commissioned by the Care and Support Alliance, a coalition of 75 leading charities, is one of the largest to examine public attitudes to social care. With over 4,500 people in England surveyed, the findings show a lack of confidence in the prospect of receiving sufficient care packages of a good quality. There is also a strong belief that the Government needs to do more to improve the social care system.

The statistics will send a strong message to the Care Services Minister, Norman Lamb MP who should be alarmed by their implications. Only 40 per cent of people showed confidence in receiving sufficient care in the future and just 30 per cent believed that this care would be of good quality. 70 per cent felt that they would be unable to afford the care that they will need, this figure rises to 77 per cent amongst the over 60s.

There is strong and clear public demand for these critical issues to be addressed. Two-thirds of the over 60s surveyed felt that the Government should be prioritising social care over and above other areas and expenditure should be increased. To emphasise the extent

of the impact of the issues on the population, the findings show that one in three in England either rely on social care themselves or have a close family member that does.

FURTHER CONCERNS

A separate report produced by specialist insurer Partnership highlights further concerns among the general public. Over the period 2012 to 2014, 4,740 over 45s and almost 200 advisers were interviewed as to their thoughts on social care. The findings

'Lack of public confidence coupled with the questionable affordability of the funding reforms poses a real headache for the Government.'

revealed that, whilst only 21 per cent of those surveyed did not believe that the new care cap would limit an individual's spend on care fees to £72,000, 56 per cent admitted that they didn't understand the financial implications. 73 per cent of people believed that they would still have to sell their homes to pay for care fees and 17 per cent simply did not know. 39 per cent accepted that if the State paid for their care they would have no real choice of provider although 26 per cent felt this was not the case.

The headline discovery from the report

is that the number of people who would deliberately deplete their assets to a level beneath the threshold for State-assisted care fees has almost doubled in the past year. According to the study, 40 per cent of individuals would now manage their finances to ensure that their council foots their cost of care. Partnership estimates that with 150,000 people entering care each year, the implications of these findings could result in a financial burden of £1.58 billion on local authorities in England.

TIME TO LISTEN

It is encouraging to find that the public has not blindly accepted the Care Act as a solution to the care crisis. Lack of public confidence coupled with the questionable affordability of the funding reforms poses a real headache for the Government. Even if it is implemented successfully, the majority of people believe that the care system will still creak under the pressure. There has been unanimous recognition that the current funding system is not fit for purpose. To replace it with an improved but still inadequate system is where we appear to be heading.

This really is the time to listen to the public and take heed of the alternative and radical solutions that have been suggested by the Commission on the Future of Health and Social Care in England. See page 8 for the In Focus of this report.

If you would like to comment please email robert.chamberlain@caremanagementmatters.co.uk

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NEWS

• Planning • Local authority • Corporate
News editor - Des Kelly

A step closer to integrated commissioning

NHS England, the Local Government Association (LGA), Think Local Act Personal (TLAP) and the Association of Directors of Adult Social Services (ADASS) have invited health and social care leaders to help build a new integrated and personalised commissioning approach for people with complex needs.

Integrated Personal Commissioning is a new voluntary approach to joining up health and social care for people with complex needs. This proposal makes a triple offer to service users, local commissioners and the

voluntary sector to bring health and social care spend together at the level of the individual. Service users will be offered power and improved support to shape care that is meaningful to them. Local authorities, NHS commissioners and providers will be offered dedicated technical support, coupled with regulatory and financial flexibilities to enable integration. The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change.

NHS England, LGA, TLAP

and ADASS have published a joint prospectus inviting expressions of interest. It is supported by a guide on developments in making care more personalised and integrated.

Personal health budgets were introduced nationally in 2009 and have continued to grow. The budgets are already available for people who are eligible for NHS Continuing Healthcare. These patients have had a 'right to ask' for a personal health budget since April 2014 and this becomes a 'right to have' from October 2014. NHS care will continue to be free for patients at the point of use.

Sell NHS land to build care homes

A Demos' Commission on Residential Care recommends that NHS Trusts should sell surplus land next to hospitals to build enough care homes and supported living apartments to meet increasing demand. This is one of the recommendations of the year-long Commission that brought together academics, industry experts and providers to explore the future of the housing with care sector.

Less than 40% of land held by NHS Trusts is currently being used for hospitals and medical buildings, leaving over 5,000 hectares potentially available for other purposes such as care accommodation. This would also ease the strain on the NHS, where around 30% of acute hospital beds are filled with people who could be looked after in a care setting.

The Demos Commission's final report calls for incentives, such

as expedited planning permission and reduced purchase prices, to sell surplus land to providers who are willing to reserve a percentage of space for state-funded care, or contribute to local authority services. The idea mirrors Section 106 laws currently used to ensure property developers build affordable housing. For a full round up of the report and what it means for the sector, read Des Kelly's article on page 31.

Pension automatic enrolment warning

Act now and get to grips with automatic enrolment - is the warning from The Pensions Regulator. The regulator has stressed that preparations to automatically enrol staff into a workplace pension scheme should not be left to the last minute. Health care organisations in particular have been urged to leave

plenty of time to decide which workers must be enrolled.

Employers must assess workers to see who is eligible. This can be complex if employing lots of part-time staff, shift workers, agency staff and staff who work varying hours. Leaving this task to the last minute means employers could risk failing to meet their deadline.

This risks non-compliance which can come at a cost.

The regulator recommends that taking time to ensure they have up to date and accurate information about their staff will help providers when assessing workers. The regulator also encourages employers to automate their processes.

APPOINTMENTS

CIC APPOINTS CHAIRPERSON

Community Integrated Care (CIC) has appointed Dame Joan Stringer as the Chair of its Board of Trustees. Dame Joan Stringer is one of Britain's leading public sector figures. She retired as the Principal and Vice-Chancellor of Edinburgh Napier University in 2013, after more than 10 years. Dame Joan replaces Simon Attwell, the former Director of Finance at the University of Salford, who has stepped down as the Chair of the organisation after five years.

MHA WELCOMES CHAIR

Graham Smith has joined national charity Methodist Homes as Chair. He takes over from Keith Salsbury who has completed his six-year term in the role. Mr Salsbury has been an active and popular Board Member since 2001.

Mr Smith is a Board Member of MHA and for over 30 years has held senior positions at Board level in the health and social care sector, both in the UK and in Europe. He founded Goldsborough Healthcare plc, which was acquired by BUPA in 1997, and was Managing Director of BUPA Care Services until 2001.

BETHPHAGE APPOINTS CEO

Following a selection process involving service users, staff and board members, Shropshire-based Bethphage has appointed Andrew Strong as Chief Executive. He will take up the position on the 10th November. He replaces outgoing Chief Executive Rob Tovey who, having held the role for ten years, is joining the Care Quality Commission (CQC).

OSJCT STRATEGIC DIRECTOR

The Orders of St John Care Trust (OSJCT), has appointed Sara Livadeas as its new Strategy Director. With 20 years' experience, Sara has most recently worked as a Commissioner with Oxfordshire County Council, leading on the commissioning of services for adults of all ages and for children.

ARK HOME HEALTHCARE'S CHIEF FINANCIAL OFFICER

Sheffield-based Ark Home Healthcare has appointed Umar Khan to join its team as Chief Financial Officer. Umar is a chartered accountant with a Law degree.

DoL applications rise

The number of completed Deprivation of Liberty (DoL) applications have risen for the fourth year, according to new figures from the Health and Social Care Information Centre. During 2013/14 there were 13,000 DoL applications completed by councils with adult social services responsibilities in England, a 10% increase on 2012/13. An individual can have more than one DoL application made for them during the period this report relates to.

These completed applications relate to 9,400 individuals, 73% had only one application made for them during the period. 18% of individuals had two applications made and the remaining 9% had three or more. Of the 13,000 applications completed

in 2013/14, 59% were granted which is the highest percentage since the DoLS legislation came into force in 2009. 5,400 applications were not granted in 2013/14 as they failed one or more of the six DoL assessment criteria. Older people are more likely to have a DoL application made for them, within the 85 and above age group the rate stood at 212 individuals per 100,000 population, whereas the rate per 100,000 population for the 18-64 age group stood at seven individuals.

During 2013/14 a total of 8,500 authorisations were active and 5,800 ended during the period, of which 70% were in place for three months or less. 22% were in place for three to six months.

Councils' £1.58bn burden

The amount of people who would be happy to reduce their assets below the £23,250 threshold in order to ensure the state pays for the majority of their long-term care has almost doubled over the last year from 23% (2013) to 40% (2014). With an estimated 150,000 entering care each year, specialist insurer, Partnership

suggests that this could see councils shouldering up to an additional £1.58 billion burden in England alone if all of those who say they intend to spend their wealth do so. Councils in the South East (£330 million) and North West (£240 million) are likely to be most impacted due to the relatively high number of care homes in these regions.

NCF workforce survey

The NCF's 2014 personnel survey report findings cover a total of 64,805 staff, making this one of the sector's largest workforce surveys. It provides a snapshot of staff turnover, vacancy rates, age, qualifications, sickness absence, reasons for leaving, agency spend, zero hour contracts and overseas recruitment.

Turnover rates average around 20% with some improvement. However the most worrying finding is the 'churn' rate, which is up for the third consecutive year, with 38.8% of staff leaving within one year of appointment and 65.5% within two years. In homecare services, the figures are even higher with 47.4% leaving within one year and 73.5%

within two years. Only in daycare services (where the numbers are less) do the churn rates fall to a reasonable level.

Information on where staff go and why remains elusive to employers and there are very few clues as to the reasons for leaving. The report observes that there is not one thing that makes the difference but rather the cumulative effects that create a feeling of not being valued.

If the care sector is to be in the best shape to cope with the reforming intent of the Care Act 2014 and be fit for the future it is imperative that providers address these challenges and build on the positive improvements seen in qualification rates.

IN FOCUS

Independent Commission on the Future of H&SC

WHAT'S THE STORY?

The final report from the independent Commission on the Future of Health and Social Care in England discusses the need for a new settlement for health and social care to provide a simpler pathway through the current maze of entitlements. The Commission, chaired by Kate Barker, was established by The King's Fund. It proposes a new approach that redesigns care around individual needs regardless of diagnosis, with a graduated increase in support as needs rise, particularly towards the end of life. The Commission concluded that this vision for a health and care system fit for the 21st Century is affordable and sustainable if a phased approach is taken and hard choices are made about taxation.

THE KEY FINDINGS

The Commission recommends a single, ring-fenced budget for the NHS and social care, with a single commissioner for local services. A new care and support allowance would offer choice and control to people with low to moderate needs while at the highest levels of need the battle lines between who pays for care, the NHS or the local authority, would be removed. The Commission also recommends a focus on more equal support for equal need, which in the long-term means making much more social care free at the point of use. The Commission largely rejects new NHS charges and private insurance options in favour of public funding.

THE CURRENT ISSUES

The Commission identified three main problems: **The system is unfair** - Most healthcare (major and minor) is free at the point of use. Social care is heavily rationed and means-tested. **The funding is separate** - The NHS budget is ring-fenced, comes

mostly from national taxation and must be spent on health. Publicly-funded social care is paid for by local authorities through a mixture of central government grant, council tax and user charges. **The system is not co-ordinated** - The organisations that commission health and social care - 211 clinical commissioning groups for hospital, emergency, community care and mental health; 152 local authorities for social care; and NHS England for primary and specialist care - are not aligned.

THE SOLUTIONS

Commission health and social care together - Remove the barrier between health and social care. Have a single, ring-fenced budget and commission both together. **Create simpler pathways with more personal control** - Design simpler pathways through the current system that respond to changing levels of need. **Increase provision of 'free' social care** - Make all social care for those with 'critical' needs free at the point of use. Extend this to 'substantial' needs as the economy improves. By 2025, provide support for 'moderate' needs as well.

PAYING FOR IT

The Commission concludes that these changes should not be paid for by new NHS charges, nor funded privately or through insurance. Instead, they should be paid for by public finance, and much of the cost should be borne by those who can most afford it (wealthier people) and those who will benefit from it the most (older people). The report shows how this would work and calls for a public debate ahead of the General Election. It will continue to be debated with the sector but needs to be extended to the wider public. It remains to be seen whether this will happen.

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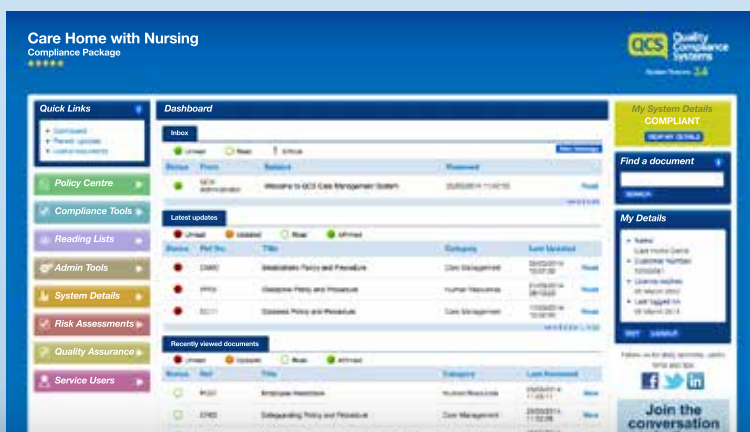
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Carterwood aids Ocean Community Services

Specialist healthcare agents Carterwood has successfully completed an acquisition on behalf of residential services provider, Ocean Community Services. Carterwood were asked to investigate and identify suitable acquisition opportunities for Ocean Community Services, who were looking to extend their service provision in England and were seeking opportunities to complement their existing home in Bristol.

Carterwood conducted

a property search based on knowledge of the local market in the South-West, and undertook a detailed desktop search of existing and former care homes in Bristol and identified a number of opportunities. Tom Harrison, Associate at Carterwood, commented on the acquisition at Ludlow Street, 'Our understanding of OCS's existing services and requirements enabled us to focus our search and source a suitable care home that matched their requirements.'

Arcadia opens second home in South Wales

The husband and wife partnership behind Pontcanna House care home in Cardiff have opened the doors on their second home in South Wales. Dr Shirwan Al-Mufti and his wife, Nasik, have opened a 28-bed care home in Newport after acquiring and renovating the former Newport Lodge Hotel. The couple acquired the property last year and have spent the past 12 months renovating the building at a cost of £600,000.

Arcadia Care Homes

specialises in providing care for elderly people with dementia. It has run Pontcanna House in Cardiff for over 20 years. In addition to 28 rooms, 20 of which are already occupied, the new care home in Newport boasts a cinema room and ancillary room.

HSBC's Cardiff and South East Wales Commercial team provided a finance package to support the acquisition and renovation in a deal managed by Senior International Commercial Manager Andrew Coles.

Wales' first specialist brain injury centre

Castleoak has handed over Wales' first specialist brain injury assessment and rehabilitation centre for leading UK brain injury rehabilitation charity, the Brain Injury Rehabilitation Trust (BIRT). The T'Aberdafen centre in Llanelli comprises 18 high dependency en-suite bedrooms and six extra care apartments so residents can begin

the transition to independent living.

Facilities at the centre include activity and treatment rooms, a training kitchen, IT suite and vocational training area, two dining rooms, various lounge/sitting areas and a family room. Outdoor facilities include secure courtyards and gardens as well as activity areas.

Choice opens new properties

Choice Care Group has been busy opening new homes in southern England, and more are to follow. Red Roofs in Tadley is located next door to Fairview, another Choice property. The new home is able to support a total of eight adults aged 16 or older with learning disabilities, autism and complex behavioural needs.

The property is made up of a spacious six-bedroom main house and two self-contained annexes – each of which provides accommodation for one person – which provide a flexible option for service users who enjoy the opportunity to socialise with others but can find it difficult to live with them.

Red Roofs has been developed as part of Choice's ongoing development of its person-centred support and care for young people as they move from children's services, and for people moving into

residential settings from hospital services. It provides a supportive setting in which residents can develop skills that enable them to progress positively along a care pathway, maximise independence and achieve their goals.

In addition, Beech Tree House in Holmer Green marks Choice's first care home in Buckinghamshire. Beech Tree House supports adults aged from the age of 16 with learning disabilities, autism and complex needs who are leaving residential school or moving out of home for the first time.

Finally, Holmhurst in Salisbury is due to open in October. This home will support people with a mental health disorder and complex needs and enable individuals to continue in their on-going recovery. There will be eight en-suite rooms in the main house and a separate self-contained annexe.

Baylham Care Centre opens despite setbacks

An award-winning care home which employs around 90 people was nearly never built when bank lenders suddenly pulled out, the owners have revealed. Building was almost brought to a halt on the Baylham Care Centre, whose replica 1950s village high street made headlines earlier this year, when the recession hit and capital funding dried up.

Adrian Fairburn and his mother, Prema Fairburn-Dorai, who had put £150,000 of their life savings into the project, were left devastated. Adrian explained, 'We had a number of interested lenders before the recession, but the collapse of Wall Street bank Lehman Brothers changed

everything - they all pulled away, saying the existing plans wouldn't be profitable enough.'

Thankfully, Kerseys solicitors, where Adrian works as part of the business development team, worked on meeting lender Natwest's needs by changing the original plans. Ten extra bedrooms were added to the development - so it would be seen as a more sustainable venture. The law firm then put forward a case for the family to reapply and ultimately succeed in securing a loan.

Cardinal Healthcare Group, owned by Adrian and Prema has residential and nursing care homes in Baylham and Barham in Suffolk.



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Target Healthcare REIT

In April 2014, Target Healthcare REIT Limited, a specialist investor in quality UK care homes, announced it had exchanged contracts to acquire a modern, purpose-built care home in York. The care home was under construction and was due to be completed in summer 2014. Having now reached practical completion, the company has confirmed that it has acquired the property for a total consideration of approximately £5.1m including acquisition costs. As part of the transaction, the company had provided a short-term loan facility to Ideal Carehomes Group to fund the completion of the property and this has been repaid from the consideration proceeds of the sale. The care home is leased to operator Ideal Carehomes.

Target Healthcare REIT has also announced that it has exchanged contracts to acquire a new purpose-built, 80-bed care home in Hastings, East Sussex.

The home will be acquired for approximately £8m including acquisition costs in November 2014, when it is due to be completed, registered and opened. This transaction is in accordance with the Company's investment policy.

The transaction will represent a sale and leaseback of the property from Hastings Court Limited. The lease will be for a period of 35 years, and the transaction represents an initial yield of in excess of 7%. The rent payable under the lease is subject to an annual RPI-linked uplift subject to a cap and collar. Acquisition of this property is conditional upon Target Healthcare REIT successfully completing the raising of additional equity. It has to date invested in excess of £116m, (including acquisition costs), through a combination of equity raised and the use of term loan and revolving credit facilities provided by the Royal Bank of Scotland plc.

MHA 'most trusted charity'

Methodist Homes (MHA) has been named the most trusted charity in the UK in 2014 by Third Sector's Charity Brand Index. According to the findings, MHA scored 85% among respondents when questioned for trustworthiness – the highest out of all 150 charities in the index.

Anna Marshall-Day, Director of People Development, said, 'Since our inception over 70 years ago, we have always sought to

provide the best possible care and support for older people, nurturing spiritual and physical well-being.

'Trust is an absolutely crucial element of caring for vulnerable older people and their loved ones. It reflects the values of MHA. To be deemed the most trusted charity in the UK is a great honour, and testament to the dedication and hard work of our 7,000 staff members and 4,000 volunteers.'

Voyage Care acquired

A consortium of Partners Group, the global private markets investment manager, Duke Street, the European mid-market buy-out sector specialist, and Tikehau, the multi-asset class investment manager have acquired Voyage Care from HgCapital, the European private equity investor, in a £375m transaction.

Voyage Care provides a diverse range of care solutions to people with complex needs including

learning disabilities, physical disabilities and acquired brain injuries. The business supplies registered accommodation, supported living, day care and domiciliary care for more than 3,000 people across the UK. It has a capacity of over 2,500 places across approximately 400 registered and supported living services. Mansfield Advisors provided commercial due diligence to support the acquisition.

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Sunrise and Gracewell

Sunrise Senior Living has acquired the management company of Gracewell Healthcare, a residential care home company owned by Health Care REIT, Inc. (HCN). Sunrise will operate the 11 care homes comprised of 767 units in southern England under the Gracewell brand.

Sunrise has also entered into an agreement with HCN and Gracewell's founders, Tim Street and Daniel Kay, who will continue to be financed by Patron Capital. The agreement includes the redevelopment of one community, the development of 11 additional properties, which are expected to be opening in 2016, as well as the management of a pipeline of future projects of approximately five new properties per year.

Phillip Smith, Senior Director

of Operations at Sunrise Senior Living told CMM, 'This is the first acquisition for Sunrise in the UK. We're delighted to have found a partner who aligns so closely with our core values. Both Sunrise and Gracewell strongly believe in encouraging independence and providing choice to our residents and we are very much looking forward to sharing best practice between the two teams. Whilst we are technically becoming the management company of another provider, Gracewell homes will continue to run as Gracewell homes; this is the joining together of two providers who are very closely aligned.'

Sunrise will continue to operate its current portfolio of 27 communities throughout the UK under the Sunrise brand.

Eden Futures and Select Living Options merged

Eden Futures and the Select Living Options group including Inclusion Care, Assisted Living South West and Assisted Living Solutions merged on 1st September 2014. Both organisations are backed by 'Buy and Build' specialist Sovereign Capital.

The companies both offer personalised care and support for individuals in their own homes and in the community. Eden provides services across the care pathway, which range from supported living through to a small independent hospital. Select provides similar care and support services, with the addition of domiciliary care, registered care homes and

specialist provision for service users with life changing and acquired brain injuries.

Both organisations share an approach, of delivering the highest quality person-centred solutions that enable individuals to live as independently as possible. The combined group will have a national footprint ranging from North Yorkshire to the border of Cornwall. The regional infrastructure will remain in place but all head office functions across the group will be consolidated to the Newark Head Office. Together the organisation will provide care and support to over 700 service users and employ over 1600 people.

LNT Group care home sale to Britto Healthcare

Freeths' specialist care team have advised LNT Group on the sale of Ward Green Lodge, a newly-built

64-bed care home in Barnsley, to Britto Healthcare for £4.8m. Built by LNT Construction, Ward Green

Lodge is a high quality, purpose-built home located in Ward Green in close proximity to Worsbrough

and Worsbrough Mill Country Park. It features dementia care facilities coupled with energy-efficient design.



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The Fremantle Trust opens care home in Chesham

The Fremantle Trust, in partnership with Buckinghamshire County Council and Housing Solutions, has developed a £4.5m nursing and dementia care home in Chesham.

The new nursing home, Chesham Leys, will provide exceptional care and support for 62 people who require nursing or nursing dementia care. The three-storey purpose-built home, features spacious rooms all with en-suite facilities, separate lounge and dining areas, onsite hair salon and landscaped gardens.

Chesham Leys is the last of eight care homes to be built under the 'Project Care' partnership agreement. Project Care has been successful as well as ambitious, designed to significantly improve the quality of accommodation for older people and people with learning disabilities across Buckinghamshire.

Patricia Birchley, cabinet member for Health and

Wellbeing at Buckinghamshire County Council, said, 'I'm delighted to see the completion of Project Care. Having visited all the care homes in the project, I've seen first-hand how working in partnership with Fremantle and Housing Solutions has given our residents such wonderful homes and facilities as well as a first-class service to very vulnerable people.'

The opening of Chesham Leys, which will employ around 80 staff, is positive news for job creation in the area. Vacancies will include management, nursing, care, housekeeping, kitchen, activity coordination and administration roles. Commenting on the completion of the new home, Sue Green, director of operations at the Trust, said, 'This is a very exciting time for Fremantle, with the opportunity to add to our existing network of care homes across the region, to provide care for more people and to complete the Project Care agreement.'

CQC action to cancel registration

CQC has taken urgent legal action to stop a care home owner from being able to run a Nottinghamshire residential home. CQC successfully applied to the court for a cancellation of the registration of Redlands Care Home, on Rock Hill, Mansfield, Nottinghamshire, with immediate effect. This means that the registered provider, Redlandscare Limited can no longer provide a care service from its premises.

CQC took this action on the basis of information received from Nottinghamshire County Council (NCC) in relation to a commercial dispute between a third party and the registered provider. As a result of this, CQC decided urgent action was needed to ensure that people using services were protected from the impact of that dispute.

NCC has assessed the needs of the residents to ensure that suitable alternative accommodation has been found. CQC has been working closely with NCC whilst taking action to ensure the welfare

and well-being of residents at Redlands Care Home. CQC also made attempts to work with the registered provider to gain a better understanding of their position, prior to taking this decision.

Adrian Hughes, Deputy Chief Inspector at CQC, said, 'CQC applied to the Nottingham Magistrates Court to cancel the registration of this home, because of serious concerns in relation to the welfare and well-being of its residents.'

'Taking action leading to the closure of any service is not something that we take lightly, but in this case we had no choice but to take urgent action to protect people living at the home. This sends a strong public message that we will not hesitate to use our powers to take tough action if we have significant concerns about the care and welfare of people who use services. We continue to work closely with the local authority who will ensure that people are moved to suitable alternative accommodation.'

Barchester opens in Southport

Barchester's Sutton Grange, in Southport, is the first of the national care provider's new builds to open this year and will provide high-quality residential, nursing and dementia care to the local community. The 70-bed care home is another new build in partnership with Cinnamon, which has been designed by Condry Lofthouse Architects and constructed by builder and developer Seddon.

The home offers a warm and homely environment with a spacious garden, comfortable lounges, sunlit communal balconies and a beauty salon. Solar panels and a charge point for electric cars help ensure Sutton Grange is an environmentally friendly addition to the area. Braeburn Lodge care home, in Deeping St James, will be the next Barchester care home to open this year.

GB Building Solutions' £36m retirement village contract

GB Building Solutions has won a £36m contract to build a luxury retirement village in Great Alne, near Stratford-Upon-Avon for joint venture partners Renaissance Villages and Helical Bar. The 80-acre brownfield site, formerly the Maudslay Motor Company vehicle production works, is being remodelled and reprofiled to create a village setting for the development comprising a mix of one, two and three-bedroom apartments and cottages. Country club style facilities including a restaurant, library, indoor swimming pool and a state-of-the-art gym will be located in a sympathetic recreation of Great Alne Hall.

Work has started with the earthworks profiling, road infrastructure and the construction of the first seven cottages, with prices starting at £485,000. The remainder of

Phase One, including the club house and one apartment block is expected in early 2016, with Phase Two completing in April 2017.

Due to the rural nature of the site, GB Building Solutions is working with ecologists to relocate newts living in the area to other parts of the meadow land and constructing two new ponds especially designed to enhance their habitat.

Maudslay Park is the fourth development from Renaissance Villages. All the properties in the village have been designed to be energy efficient, sustainable, luxurious homes featuring excellent insulation and double glazing as well as an air source heat pump system that provides underfloor heating and hot water, thereby reducing environmental impact, and also minimising energy costs.

Sheffcare's Sheffield contract

Sheffcare has been awarded a major new Sheffield City Council contract. The Sheffcare Home Care Service provides a full range of services to clients in their own homes. The service also provides dedicated dementia care, matching the levels of dementia support provided at Sheffcare's residential homes.

Now, as part of Sheffield Council's Framework for Supported Living Services, the authority will be able to purchase flexible services from Sheffcare, promoting independence and encouraging self-reliance where appropriate and possible. The service will be available to a wide range of people with different needs.



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THE LATEST PHASE IN CQC'S COMING OF AGE:

QUALITY RATINGS AND THEIR IMPACT
ON YOUR BUSINESS



HOW WILL THE CARE QUALITY COMMISSION (CQC) DETERMINE ITS NEW RATINGS, WHICH WILL START BEING PUBLISHED FROM OCTOBER 2014? WHAT IS THE LIKELY IMPACT ON PROVIDERS? STUART MARCHANT CONSIDERS THE NEW SYSTEM.

NEW INSPECTIONS AND STANDARDS

By now providers will be getting more familiar with the five key questions that CQC inspectors will be assessing services against, namely is the service:

1. Safe? People should be protected from abuse and avoidable harm.
2. Effective? People's care, treatment and support should achieve good outcomes, promote a good quality of life and be evidence-based where possible.
3. Caring? Staff should involve and treat people with compassion, kindness, dignity and respect.
4. Responsive? Services should be organised so that they meet people's needs.
5. Well-led? The leadership, management and governance of the provider organisation should assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture.

The CQC outlined in the recent consultation on its Provider Handbooks its new system for inspecting and rating services and noted at the outset that it will, 'identify, highlight

and celebrate good practice,' continuing, 'we want to inspire providers to strive to be outstanding and continuously improve the care they provide. Our inspectors will work closely with registered providers, nominated individuals and registered managers to build open, two-way relationships where inspectors and providers feel able to contact each other to discuss matters as they arise.'

This all sounds positive, of course. Andrea Sutcliffe, the Chief Inspector for Social Care, taking a slightly starker tone, has been quoted as saying that the new system will be aimed to make it 'blindingly clear' to care home owners what standards they were expected to meet.

There's currently a 139-page consultation document out which will focus the minds around 13 regulations contained within the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*. These are:

- Person-centred care;
- Dignity and respect;
- Need for consent;
- Safe care and treatment;
- Safeguarding service users from abuse and improper treatment;
- Meeting nutritional and hydration needs;

- Premises and equipment;
- Receiving and acting on complaints;
- Good governance;
- Staffing;
- Fit and proper persons employed;
- Duty of candour; and
- Fit and proper directors.

We can see from what's happening in the NHS and from pilot inspections across all sectors that there will be a significant shake-up of how inspections are planned and managed. The essential elements for care providers will include the following stages:

- Intelligent monitoring – a tool will combine and analyse (a) people's experience of care, (b) staff feedback about their experiences of aspects such as management, staffing, training and qualification, and (c) a range of information from statutory returns about deaths, injury or abuse, untoward incidents and previous CQC findings/action.
- Provider Information Returns – web-based forms which require providers to say what is in place within an establishment to satisfy in some detail the five key questions, as set out above.
- Inspections – with detailed

approaches to inspection planning, site visits, judgements based upon the new Key Lines of Enquiry (KLOE) and reporting, including a final rating for each service.

RATINGS

From October 2014, the CQC will start publishing ratings from its pilot inspections under its new approach, although the inspections are currently applying the 'old' (ie present) standards rather than the new regulations.

There are to be four ratings which will indicate to the public, commissioner and other stakeholders whether a service is: 'Outstanding'; 'Good'; 'Requires improvement'; or 'Inadequate'.

The CQC has published its proposed rating scale which details how these will be determined (see table).

The starting point will be: is the service good? This is a qualitative shift from the current starting point which focuses merely on whether a service is compliant. For a service to be rated as 'Outstanding', the provider will have to demonstrate that it satisfies the elements associated with outstanding – currently as set out opposite. It is not clear →

CQC'S RATING SCALE

Outstanding	'Outstanding' services are innovative, creative, constantly striving to improve, open and transparent.
Good	'Good' services consistently provide the level of service that people have a right to receive, and robust arrangements when things go wrong.
Requires improvement	Services that 'require improvement' may have elements of 'good', but are inconsistent and there are potential or actual risks to people. They are inconsistent in their response when things go wrong.
Inadequate	Significant harm has or is likely to occur, there are shortfalls in practice, and ineffective or no action is taken to put things right or improve.

→ how much the provider will have to contribute to getting a rating above 'Good', but every opportunity should be taken to maximise these qualities (for example within the Provider Information Return).

RATINGS: MAKING THE JUDGEMENT

The CQC will apply a weighting system so that the aggregated scores for the five key questions will have a direct bearing. These, 'ratings principles', are:

1. If two or more of the key questions are rated 'Inadequate', then the overall aggregated rating will normally be 'Inadequate'.
2. If one of the key questions is rated 'Inadequate', then the overall rating will normally be 'Requires improvement'.
3. If two or more of the key questions are rated 'Requires Improvement', then the overall rating will normally be 'Requires improvement'.
4. At least two of the five key questions would normally need to be rated 'Outstanding' before an aggregated rating of 'Outstanding' can be awarded.

Furthermore, a service may not be capable of being rated as more than 'Requires improvement' in cases where a home lacks a registered manager and CQC is not satisfied with the steps taken to recruit one; where another condition of registration is not being met or where there has been a failure to submit statutory notifications.

RATINGS IMPACT

The type of rating achieved by a service will have a significant impact upon the business of each service and for the provider.

Ratings will be linked to frequency of inspections

From October 2014, the frequency of inspections will be linked to ratings so that:

'Inadequate' means a service will be inspected within six months of the last inspection.

'Requires improvement' means it will be inspected within 12 months.

'Good' means it will be inspected within 18 months.

'Outstanding' means it will be inspected within 24 months.

Outside this timetable, there will be a proportion of random checks regardless of the home's rating.

Ratings will be used for and against providers

The CQC's interim regulatory impact assessment on these changes recognises the fact that ratings will be used to distinguish services from each other. Local authorities may apply a benchmark to which services will receive business. We saw this happen under the old star rating system, with some authorities also applying different funding bands to different ratings. Self-funders will also discern between services based upon rating.

There will be direct and indirect costs

Inspections will be longer and will impose additional resource burdens on providers due to the need to supply increasing information and facilitate staff and service user involvement. Providers with lower ratings will have a higher frequency of inspection and commensurate additional resource burden. If the CQC is to offer a re-inspection service (which is being contemplated) so that services can seek to demonstrate compliance to a higher standard, it is likely to charge for this.

SPECIAL MEASURES AND A TOUGHER APPROACH

From April 2015, failing homes

rated as 'Inadequate' could be put into 'special measures', a system that has been used in schools over the years and more recently applied to several NHS hospitals. The CQC has said it anticipates about 100 care providers a year would be likely to go into special measures under the regime, giving them a fixed time to make improvements or close.

In an interview for the *Telegraph* newspaper in August 2014, David Prior, the CQC Chair said the regulator's new inspection regime would take a tougher approach - even if that increased the risk that it could lose some cases in the courts to legal challenge. He is quoted as saying, 'There is a distinction between what is legally right sometimes and what is best for the people in the home.'

'What we are saying is we are on the side of the people in the home. And if that means sometimes bringing a case which is not legally watertight but we feel that it's in the interests of the people living in the home then we will always do the latter.'

Having been battered by scandal in recent years, this is a clear sign that the CQC will not necessarily heed the law and is prepared to face the consequences in the interests of being seen to protect vulnerable members of the public. However, we have seen that misjudgements made by inspectors can have a catastrophic financial impact upon a care business from which it may never recover.

RATINGS REVIEWS AND CHALLENGES

Crucial to any ratings system is the means by which providers can fairly challenge inspection findings and judgements. Without an effective review system, the commercial interests of providers could be seriously damaged.

Inspection findings will continue to be subject to the right to challenge, based

on factual accuracy or the robustness of evidence of any potential breach of regulation. However, the proposed ratings review system will only allow a provider to request a review if they feel that the inspector did not properly follow the process for awarding the ratings. This will be dependent upon the quality and clarity of policies and procedures which describe how inspectors decide upon a rating. A provider will not be able to frame an appeal around a mere disagreement with the inspector's judgement on compliance.

The system for reviews of ratings also seems hugely cumbersome and unwieldy, to the point where it is unlikely to provide swift and effective justice. The system is as follows: Senior CQC staff, not involved in the inspection, will compile a report and present this to a Rating Review Panel (RRP). The RRP, chaired by an independent reviewer from outside CQC, will consider the case and provide advice to the ultimate decision-maker - none other than CQC's Chief Inspector or Chief Executive. The Chief Inspector or Chief Executive will then consider the recommendation of the RRP and make a final decision.

Once this has been exhausted, the only means of further challenge will be via the Ombudsman or the Courts (through Judicial Review).

COMING OF AGE

The CQC has been through a huge process of review and it now rolling out what it hopes will be a clear ratings system for services. With ratings linked to frequency of inspections and the review system looking cumbersome, the sector will watch and see how the system works in practice from October.

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INSURANCE
IN THE CARE SECTOR:

ARE YOU COVERED?



Care providers have seen some prominent names in the industry's insurance withdraw from the sector. What is happening? What can providers do about their insurance? David Waters shares his personal views on the situation.

In late 2012, Ecclesiastical withdrew from providing insurance for care businesses. In late 2013, Hiscox - who many had seen as Ecclesiastical's natural replacement - also withdrew from the market place. Most care business owners are asking us why; what does care need to do differently; and what will the insurance industry do to help care businesses overcome the issues, whatever they are?

UNDERSTANDING THE SITUATION

Before tackling any of these questions, we need to understand the background to the situation. If any care business was to buy their principal covers separately - material damage/business interruption; employers, public and products liability; malpractice; and legal expenses - the premiums would be substantially higher. We have always argued that the care sector has a far better claims experience than most other business sectors. The combined policies provided by brokers have enabled care businesses to buy insurance at a far cheaper rate than the market generally.

Most businesses with good claims records (few claims at a low cost in comparison to premium paid) expect their insurance to cost circa 0.6 per cent of their turnover, yet care has enjoyed premiums at a rate closer to 0.35 per cent, especially care homes. Unfortunately the risk management within care, weather-related claims and increasing litigation no longer enable care to enjoy this special status. Essentially, for care homes, it's been very good for many years and it just can't stay this way.

I have been asked to address these issues myself, not representing my company and I gladly do so. These are my own personal views following

25 years' experience in the care insurance sector. They are my own views and no-one else's.

WITHDRAWAL FROM THE SECTOR

Why have Ecclesiastical and Hiscox withdrawn from the market? This is relatively straightforward and down to a combination of actual claims histories and actuarial projections (mathematical formulae that account for various scenarios to predict future losses (or profits)).

In Ecclesiastical's case it has had to pay out more and more claims over the last five or more years than it had been receiving in premiums. Furthermore, in both Hiscox's and Ecclesiastical's case, the actuarial projections showed a considerably worsening environment for insurers. They will then have looked at the way care buys insurance and the competition this creates.

THE REALITY OF THE MARKET

Care as a sector chases premiums down, so quality insurers can often feel vulnerable to short-term market conditions. The two major insurers left are New India and Gable. New India is an insurer wholly owned by the Indian Government. As the new Indian Government is likely to privatise this business it poses an important question. Will New India's management and shareholders be able to accept losses being made on an account operated in the UK? Then Gable, based in Lichtenstein, with no experience in the care sector, Will they be able to sustain the losses Ecclesiastical has suffered and Hiscox's actuaries project? History reminds us of Balva, a Latvian insurer, which within months of becoming involved in the



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→ care sector went out of business and also Milburn and ERIC, two other insurers that have exited the sector.

The combination of a large section of care businesses chasing cheap premiums and the competition created by New India and Gable, coupled with losses incurred and projected to be incurred, has caused two of the UK's main insurers to withdraw from the care sector. As a consequence care is experiencing a hardening market, where insurers offering insurance must do so at realistic premiums for the covers and services they provide.

SECTOR PERSPECTIVE

A few questions for all the readers here, if you were an insurer, would you insure your business at the premium you have? If your answer is yes, is this a qualified yes? Are there any issues you would want addressed before insuring the business? If so, what are these? Do you use a zero hours contract? How do you believe this will impact on employers' liability claims?

It is an interesting set of questions to ask yourself, not from a risk and insurance perspective necessarily, but in terms of how you could make your business better. Every claim takes time and resources away from frontline care.

What does care need to do differently? The answer is to manage risk better and this can be done in two ways:

1. Review the risks you face using risk assessments and, I would recommend, an external risk assessment company. Look at all aspects of your business, from the environment through to staff training; from relationships with customers or residents' families through to regulatory compliance. What could you do better?

One area that has caused insurers many painful moments has been the increase in employers' liability insurance claims, with an increasing number of employees having almost trivial incidents. I dealt with a claim for an employee, late for work, who slipped on a gravel driveway and claimed for £600,000 plus costs at

£390,000 (remember lawyer's fees are never cheap). Ultimately this was settled for far less, but for a trivial incident almost, in my opinion, of her own making, the employee cost this particular care home's insurers some £250,000. This compares with an annual premium for all covers of less than £2,000.

Zero hours contracts of employment give rise to insurance claims, as injured employees are not paid when off work through injury. Effectively this working environment encourages employees to claim for minor incidents. If you use a zero hours contract, can you also include pay for periods of time off work due to a work-related injury or illness? If not, insurers have to factor that cost into their premiums.

2. Make sure records, such as those relating to incident dates and policy documents, are readily available and provide them to insurers quickly. If you don't, you leave insurers with the option to refuse to manage or pay for claims. This means you may have to pay yourself.

We have found care businesses that are Investor in People (IiP) accredited make fewer employers' liability claims. The claims they do make are settled at a lower cost than those made by care businesses that are not IiP accredited. Achieving IiP accreditation involves a simple series of steps that helps you think deeper about your organisation, and is built around making the most of your biggest asset – your people. It will make your business better.

The media profile of care is poor right now. However, there are outstanding care providers out there, whose excellent work is overlooked in favour of headline grabbing stories of poor care. When was the last time a positive story about care was given a high profile by the media, or even the Care Quality Commission? All care business need to work hard to rectify this. The opportunity to join care associations, share knowledge and reach higher standards is there and should be taken.

We all know budgets in the care sector are stretched to breaking point, but it is essential to provide the

best staff training and management supervision possible. This will help keep claims to a minimum and improve your risk profile, improving your business and making it more attractive to insurers, not to mention potential customers. It will also help your business to save money in the long term too.

PARTNERSHIP CULTURE

How will insurers help care businesses? Firstly, they will take on the risk at a fair premium. A fair premium is one which enables insurers to achieve a profit and the care business to enjoy the safety of good insurance protection. Then insurers need to survey more customer businesses.

Historically, the idea of insurers knowing and understanding the risks facing care businesses has been viewed by some as an invasion of their privacy, which can seem suspicious to insurers. Insurers have a wealth of experience in making businesses risk averse and understand likely future events. Care businesses and insurers working in partnership will produce a better environment for all.

Care businesses have been let down by insurers withdrawing from the market place and this is a great shame. However, insurers do not make these decisions lightly. It is because they are losing money and project they will continue to lose money.

We need to develop a partnership culture. The care industry is not dealing with media perception, nor accepting the actual risks it continues to face. I urge care businesses to work together through care associations to redress the media, and public, perception of care. It is vital to listen to people who can help make your business better, more caring and therefore less likely to make an insurance claim. Ultimately this will allow more time to concentrate on what you do well, the most important thing of all, caring for vulnerable people.

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David Waters is Managing Director of Care Home Insurance Services and PrimeCare Insurance.
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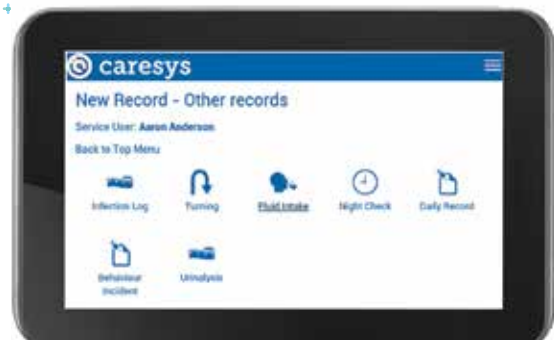
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EXPERTISE HOMECARE – A UNIQUE OFFERING?

Expertise Homecare is a start-up homecare franchise. Based on trust, transparency, quality and support, it's offering bespoke technology, honest reviews and exacting standards.

Expertise Homecare launched on 1st September and is the idea of Natalie Richards and Harriet Smith. Based in Kent, Natalie and Harriet have worked in homecare start-ups, having seen the process from the inside. Taking their experience they felt there was a need to tackle inefficiencies in homecare delivery, streamline processes, safeguard residents and offer a quality service to the private pay and continuing healthcare market. As a result they've spent a year working on and developing their model.

Natalie explained, 'We have extensive experience from working in four homecare start-ups. We have seen the lack of quality in the industry first-hand and want to change this by raising standards. The sector is undeveloped and inherent issues aren't being addressed. We know there are efficiencies that can be made and as we are passionate about providing high-quality care and support, we have developed ways to make them.'

THE OFFERING

Expertise Homecare is offering franchisees a

similar package to other franchise companies but with a number of key unique points.

A franchise is £34,000 plus VAT with an ongoing monthly management fee of 6 per cent. Franchisees are rewarded up to 1 per cent back for performance through customer service and financial turnover.

Beyond that they have actively sought out solutions to common home care problems and spoken to experts within other parts of the process to devise ways of changing procedures. For example, they've developed a bespoke software package based on existing payroll and rostering services. It enables staff to access all necessary care details via a smartphone. The system will contain each individual's roster and interactive care plans, risk assessments and MARs, as well as personal development information.

As each member of staff carries out each visit, the software provides real-time updates to the office, giving management a clear idea of how visits are progressing, what has happened, any issues, errors or potential concerns. Family members can also be automatically updated on aspects of the visit.

INTEGRATING SERVICES

Natalie and Harriet have ambitious plans for the software and see it as their way of integrating services around the individual. They have considered offering log-ins to GPs to reduce any lengthy waits or confusion between care workers, district nurses and GPs; any changes to medication can be seen and accessed on the smartphone. When asked about any data protection issues, Natalie said, 'The software provider is registered as a Data Controller with the Information Commissioners Office and hold personal data in compliance with the *Data Protection Act 1998*. They are also certified against the strict ISO27001 standard, which reassures clients that we take the security of data very seriously. Staff only have access to the information they need for their visits. Phones and the mobile website are password protected and can be locked from the main office to ensure data protection protocols are always maintained. Phones will only be able to call certain numbers such as the office and emergency services.'



Prove your model works before considering franchising

Jane Orr-Campbell
Independent Social Care Consultant

Anything which helps providers of support in people's own homes to deliver better services is to be applauded.

However, Expertise Homecare are making some huge claims about the benefits of their system which on the face of it does not differ from a variety of others already in use in the market. It is not the system which influences the quality of services; it is the way in which it is used. Many providers buy superb technological systems but then they use very little of the functionality effectively. Systems only do what people tell them. The offering from Expertise Homecare seems light on training and staff management support, without this, the system is just a system.

There also seems to be some confusion over Data Protection. It is not enough for the franchisors' software company to be registered with the ICO, each franchisee will also require such registration and a data controller as they are handling

personal data.

Expertise Homecare is offering quality assurance activities through an external organisation but there appears to be no proposal to support franchisees to achieve the highest standard in the new Care Quality Commission (CQC) ratings which are coming into force.

Up to five people per week, keen to start a homecare business, contact me and I direct them to the route which best suits their background and experience, including established franchisors. It is, quite rightly, not easy to get registered with the CQC now and I would be concerned about referring someone, starting out, to a franchise which has no track-record of actual operations.

For the sake of the brand, my advice to Expertise Homecare would be, 'Develop your model and prove it achieves what you want it to before putting it in the hands of those new to running a homecare business.'



Has picked up on the key homecare themes

Colin Angel
Policy Director
United Kingdom Homecare Association

Expertise Homecare has picked up on key themes that all homecare providers face: delivering quality services, openness and transparency with their customers and good use of technology.

Effective use of IT systems for rostering and payroll have become essential for providers, and online records and care plans delivered through smartphones are an attractive proposition for quality monitoring. Prospective franchisees will want assurance that the bespoke system has been adequately tested and that there are robust back-up procedures available, as technology doesn't always work, and staff working remotely often lose connection to the mobile network.

The benefits of using 'electronic call monitoring' to track care workers' visit times has been somewhat tarnished by councils imposing such systems to develop per-minute billing. However, the ability to check on the safety of clients and care workers, and reassurance for families,

are extremely positive.

Subscription to independent third-party review sites is not unique, but is still relatively underused in our sector. Franchisees will be making a commitment to transparency and customer feedback that will be highly beneficial if used as a learning opportunity that leads to continuous improvement. Knowing how to respond positively to feedback is essential. Franchisees should also fully enhance their free provider profiles on the NHS Choices website, as this site will become the aggregator of quality measures.

A commitment to pay staff a living wage is extremely positive, reducing turnover and recruitment costs. Franchisees should be aware that this will price them out of many local authority contracts. Their target audience are self-funders, who carry a higher overhead in business development. Franchisees will need to price accordingly and be sure their local market can sustain the prices needed in sufficient volume.

They hope the technology/smartphone process will help to raise efficiencies in the sector but Natalie and Harriet have also spoken with many other professionals in the sector to try to streamline homecare. Natalie continued, 'In developing the software and our package we've turned over everything. We've looked at how to solve common problems in the system, inefficiencies that affect our sector, but also issues that have something to do with others in the sector such as GPs or specialists. Care providers often end up at the centre of coordinating care at home, booking appointments from district nurses, GPs and OTs. We understand the difficulties of coordinating this effectively and believe that access to our system will be the first step towards multiagency working to ensure quality homecare. It would provide the perfect platform for information sharing and communication that is quick, efficient and helps to streamline services.'

HONEST REVIEWS

They hope that these efficiencies will enable them to offer quality care and raise industry standards. Natalie feels that valuing staff, paying them a living wage and supporting them will reduce staffing issues. She feels passionately that the use of unregulated staffing agencies to bridge sickness or

absence of staff impacts on the quality of the service and the trust she hopes people will have in the brand they are building.

To ensure that high standards are being upheld throughout the network and customers and their families have trust in the service, Expertise Homecare has signed up to Reevo, the independent reviewing company. Natalie explained, 'Each franchisee will purchase a Reevo account which will be attached to their section of our website. Once a week they will send the details of all consenting customers and relatives to Reevo who will send them an email inviting them to rate the service. They can complete this immediately or at a later date but they have the link and ability to do so. They are able to say what they want and negative reviews cannot be removed, Reevo has complete control over the reviewing process. This feedback then creates a star rating which will appear on Google searches. This transparency will provide people with trust in our service and showcase the excellent work our network will be doing.'

Natalie is confident that any poor reviews will be addressed by franchisees. However, if there are any ongoing problems then, as franchisors, they are able to step in to ensure that the high standards of the brand are maintained. Franchisees will be expected to attain a specified level of customer

satisfaction and will be provided with rebates on franchisee fees for achieving a certain level. They are building an 'ethical' brand and have very high standards that they expect franchisees to embrace and meet. Natalie and Harriet are able to step in to help deal with any issues and support their franchisees, flag any concerns and provide guidance. In extreme cases they are able to expel poor performing franchises from the franchise. Natalie said, 'We want a level of service that is consistent across the brand and our franchisees will know this from the start and what is expected of them to ensure the highest level of quality.'

Natalie and Harriet have ambitious plans for the brand and before launch have already had interest in two territories, of which one is now reserved and going through contracts.

CMM

Over to the experts...

Expertise Homecare is building a brand on trust, transparency, quality and support. With innovative technology, processes and systems to streamline the process and ensure quality care. Is the offering new? Is there space for a new franchise in the market? Will it help to integrate services around the individual? Will the reviewing process help to increase transparency and quality? What do the experts think?



Selection process should be thorough

Trevor Brocklebank
Chief Executive
Home Instead

With our ageing population and demand for privately-purchased care increasing significantly year-on-year, there is a growing opportunity across the sector for strong companies to make a real difference and build a successful business at the same time.

What's more, buying a franchise can be a fantastic method of purchasing a business. However, over the last five years a significant number of care providers have tried to expand through franchising and many have failed. As a result, the individuals who purchased the franchise may have lost their life savings. It is, therefore, critical that the selection process used to select a franchise is thorough and considered.

Not knowing the specifics about Expertise Healthcare I thought it useful to highlight key selection criteria for potential franchisees when considering any franchise opportunity. The British Franchise Association has selection criteria

that assess if the business is viable, franchisable and ethical. It's important to speak to as many existing franchisees as possible to find out what it is really like. People should understand the level of risk they are happy with. If people need to be conservative with their investment, stick to a proven business where they can validate cash flow requirements, profitability and the opportunity. Ensure the management team have franchising as well as care experience, supporting a franchise network is very different to running regional offices. Make sure franchisors understand what is involved. Above all else look for cultural fit as franchisees and franchisors will hopefully have a very close relationship for a long time. Make sure everyone gets on personally and have aligned values and objectives. Finally, regardless of how compelling it seems don't buy from the first franchisor you meet, find the best fit.

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60 SECONDS WITH...

RAINA SUMMERSON



Raina Summerson is Group Chief Executive of independent care provider, Agincare.

WHAT IS YOUR BACKGROUND?

I started in social care at 19 in social and health care roles. I joined Dorset County Council Adult Social Services in 1993, where I completed my social work qualification, then my MA in Mental Health. I was then with the regulator for five years. My roles covered most service user groups, focusing on older people, palliative care, dementia and mental health.

In 2004, I joined Agincare when it was a much smaller company and a handful of us covered pretty much every role. In 2013, I became a Non-Executive Director of United Kingdom Homecare Association having worked closely with the Executive Team and other significant provider representatives to tackle the challenges facing the sector.

HOW HAS THE MARKET CHANGED FOR AGINCARE'S BROAD RANGE OF SERVICES?

The diversification and expansion of service types has been part of Agincare's growth plan for years. This has enabled us to adapt well to significant market changes, consolidating and protecting in one area whilst achieving growth in others. It has also enabled us to offer a better pathway of care and to retain staff who can develop skills across services. Coming into the independent sector, I was struck by how services worked in isolation. Until recently provider services worked at odds with one another with little crossover. It is now more commonplace to see organisations diversifying, particularly into specialist services and live-in care.

Legislation and independent reports are again giving real focus to the importance of integrated working. At a recent long-term care conference, William Laing referred to 'independent integrators' and I think Agincare can truly say we have been one for many years; though we can do more. Enabling operational staff

to share services, skills and signpost remains a challenge.

WHAT ARE THE BIGGEST BUSINESS AND SECTOR CHALLENGES?

On some days this feels like everything! Workforce, funding and commissioning remain key with a multitude of issues beneath each. Probably the single biggest challenge is getting all of the right people (and budgets) in the right place at the same time to facilitate the fundamental changes which the system needs to cope with future demands. When everyone is facing individual daily challenges and priorities, finding the co-ordinated effort and energy to change an established system, which is not fit-for-purpose, remains difficult. For this to happen, we need better expectation management, risk-sharing and honest, open relationships across the public and private sector and with the public.

WHAT'S THE BEST CAREER ADVICE YOU'VE RECEIVED?

To challenge and not be afraid to stand against the norm or majority view, combined with 'what's the worst that could happen and how would that look to an objective bystander'. Also the advice from the managers who persuaded and supported me to get my social work qualification via secondment, as it's been fundamental to my career. The advice that has most impacted my career, has come from my personal networks who have always supported me to be who I am and to not believe that a job or salary defines you. This has helped through difficult choices and career decisions. I'd advise people to start with their own ability, natural strengths and personality, consider what roles suit this and you're more likely to be happy and successful. Don't be afraid to take risks. **CMM**

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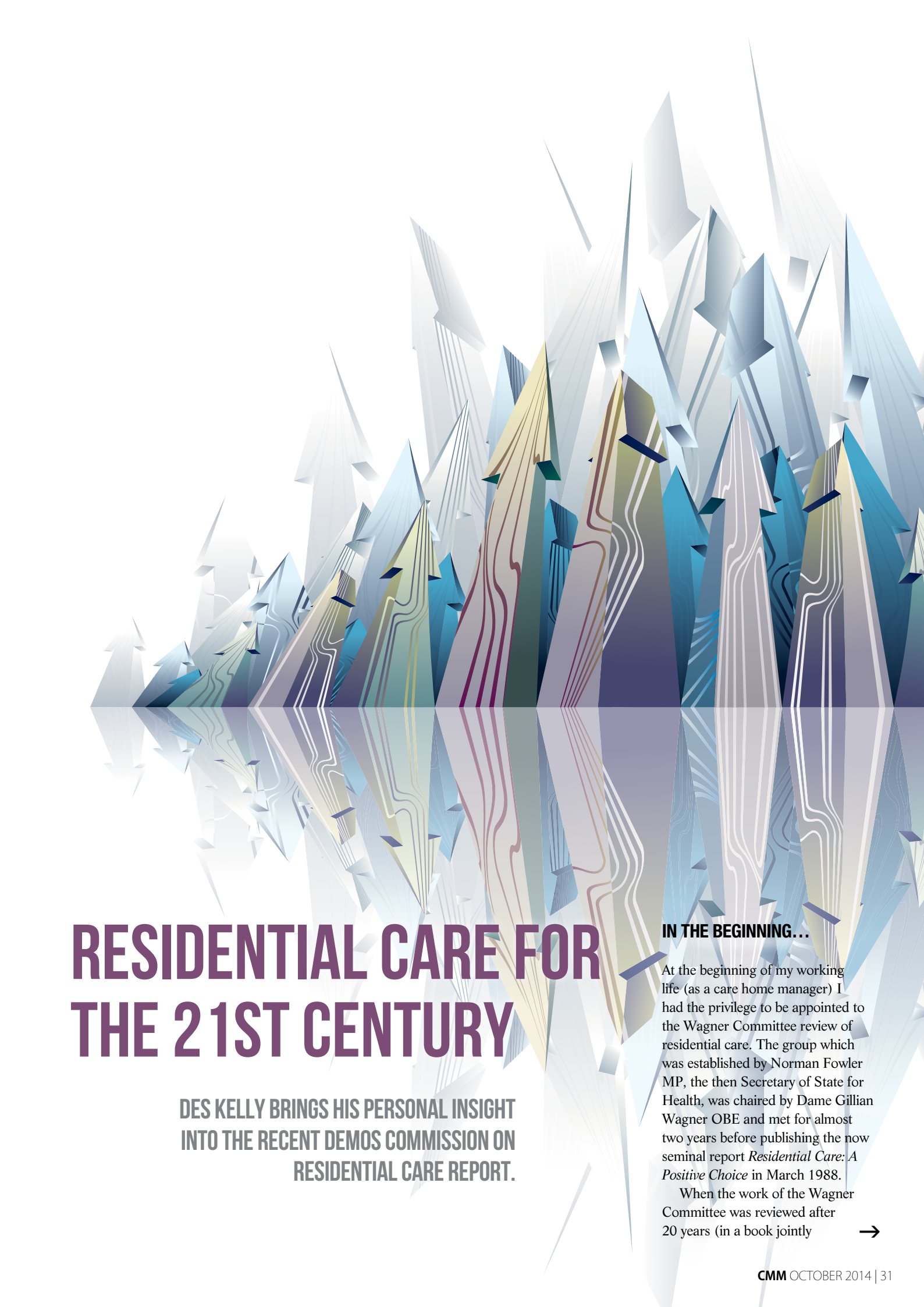
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RESIDENTIAL CARE FOR THE 21ST CENTURY

DES KELLY BRINGS HIS PERSONAL INSIGHT
INTO THE RECENT DEMOS COMMISSION ON
RESIDENTIAL CARE REPORT.

IN THE BEGINNING...

At the beginning of my working life (as a care home manager) I had the privilege to be appointed to the Wagner Committee review of residential care. The group which was established by Norman Fowler MP, the then Secretary of State for Health, was chaired by Dame Gillian Wagner OBE and met for almost two years before publishing the now seminal report *Residential Care: A Positive Choice* in March 1988.

When the work of the Wagner Committee was reviewed after 20 years (in a book jointly



→ published by Care Management Matters and the Residential Forum – *Residential Care: A Positive Future* all the recommendations of the original report were revisited to determine the progress that had been made. The level of success in implementing the report recommendations was surprisingly high. I make these comments as part of my introduction not to draw attention to how long I have been around but simply as a reminder that really big change takes time.

REVISITING THE POSITIVE CONTRIBUTION OF RESIDENTIAL CARE

The Demos Commission on Residential Care was formed with the aim of developing a vision of residential care that is fit for the 21st Century. Chaired by Paul Burstow

MP, it had its first meeting in July 2013 and published its final report in September 2014. Between the meetings of Commissioners there was a literature review, a call for evidence, polling, interviews with experts and a series of visits by the chairman. There is a link between these two major reports *Residential Care: A Positive Future* and the Commission's report as they both have at their heart the intention to improve the quality of care and support services in residential care settings.

The Demos report *The Commission on Residential Care* is substantial, running to some 271 pages. I can't, therefore, do justice to all the recommendations made in the report which are grouped under the following headings:

- Leading from the front;
- Working in housing with care;
- Commissioning and assessment;
- Providing housing with care;
- Building housing with care;
- Regulation, registration, inspection;
- Funding.

Any one of these themes would quite easily provide material for an article in the space available here. However, the headings give something of an indication of the comprehensiveness of the recommendations and the inter-related nature of them. They are best seen, I think, as a package of measures. Without adequate funding, for example, the ambitious recommendations on the rewards for the workforce and the investment in qualifications and training will not happen. Without changing the relationship between commissioning and providers we won't develop a shared vision for residential care for the future. Without changes in the approach to regulation and inspection the recommendations on continually improving quality of services will be undermined.

EMBEDDING GOOD PRACTICE

There are a total of 32 recommendations addressed to Government, policymakers and planners, local authorities and commissioners, the Care Quality Commission as the regulator, and to

“

THE REAL TEST OF THE SUCCESS OF A REPORT IS IN ITS ABILITY TO CREATE ENOUGH INFLUENCE TO STIMULATE CHANGE.

”

providers of residential care services.

The report argues that there is a strong case for rebranding residential care services as 'housing with care' because there are such negative associations, particularly in the media, with the term 'residential care'. This is not about semantics; not intended to be simply an exercise in creating a new label. 'Housing with care' is a better description of the way in which care and support services have developed. It enables the blurring of the boundaries of care with the emergence of 'extra care' to be included in the definition. More importantly it makes it possible to reconsider the separation of the accommodation from care and from services. By separating accommodation from care and from services each can be more clearly defined, costed and funded. It will make it easier for the public to understand why this separation is important.

A SHARED VISION AND MEASURES FOR CHANGE

The Commission recommends that providers and people using their services, local commissioners, regulators and Government work together to develop a shared vision for housing and care services. This recommendation is underpinned by calls for:

- Promoting a shared evidence-based vision of what works;
- The care sector to be a living-wage sector;
- Minimum levels of training and the introduction of a license to practice;
- Integrated commissioning models;
- Sponsoring innovative redesign and enabling technology;
- Exploring a tenancy framework for care home settings;
- Greater use of planning incentives and measures to relax change of use measures to develop care facilities more easily;
- CQC to conduct an annual survey of people using housing with care services and a workforce survey;
- Extending CQC's role to inspection of local authority commissioning practices;
- Open book accounting and a fair funding formula.

Taken together these recommendations offer a step-change in thinking about the future of housing and care provision for adults and older people.

The report acknowledges other work to improve care settings and is a positive account of the potential of housing with care to be truly transformative. Case studies are used to illustrate the best practice ideas in the UK and abroad. Demos has reviewed a wide range of literature and interviewed a number of experts, including Dame Gillian Wagner, to build a better understanding of what good care and support actually looks like.

Recognition is given to the *My Home Life* (MHL) initiative within the report. MHL has developed into a significant UK-wide movement (in partnership with City University, Age UK and national care provider bodies), highlighting the importance of relationship-centred working underpinning best practice. The report reaffirms the value that MHL has brought to the housing with care sector and its contribution to promoting service improvement and supporting registered managers.

The Commission also makes a strong case for the care sector facing a very significant dilemma.

The report says, 'In some ways, the future of social care is balancing on an axis. On the one hand, the *Care Act 2014* promises to be revolutionary – bringing in a new duty of wellbeing, carers' rights and commitment to preventative action – measures which have been long-awaited and much-welcomed by practitioners and representatives of disabled and older people's groups alike. On the other hand the funding crisis looms large.'

Clearly the future of all care and support services, including housing with care, will be determined by our ability to resolve the problems associated with the persistent underfunding. The report makes clear that adequate funding is vital, 'It is the foundation stone on which the wider vision...must be built.'

FROM ASSETS TO ACTION

Housing with care must be seen as an asset which has a future as an

essential part of the health and care system. The report argues for a new vision and new offerings of housing with care to deliver the outcomes people both want and value with four steps. Firstly by building on the community potential of services to support rehabilitation, re-ablement and outreach; secondly, stimulating greater choice, flexibility and diversity in market provision; thirdly, separating care from services and accommodation (for commissioning and regulating) in order to alter attitudes and the mindset typically associated with housing with care; and finally, the fourth step is to decide how we fund care and avoid the emergence of a two-tier system.

The Demos Commission report concludes, 'Much has been said and written, but much less has been done...we want to create a powerful action plan for change...'

Here is the rub – any report can only ever be the starting point for action. The real test of the success of a report is in its ability to create enough influence to stimulate change. This will only be achieved through joint efforts that gain the active engagement of all those identified earlier – a partnership between commissioners, care providers and those receiving services and their families (in other words, the public). The purpose of housing with care, the way it is funded and delivered, its potential to support people and improve their quality of life needs to be debated with the public and not just with professionals.

The Demos Commission was struck by the seemingly unrelenting nature of negative public perceptions of residential care. Despite the positive experiences of people reflected in reports by the regulators, the public tend to see such settings as places of illness and frailty – the proverbial 'last resort'. The demographic changes alone will mean that more and more people will come into contact with care and support services. People need to be involved in the debate about a shared vision for 21st Century housing and care. After all, all our futures are at stake.

CMM

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ALLERGEN LEGISLATION

Are you prepared for the change?

**NEW ALLERGEN
LEGISLATION IS COMING
INTO FORCE IN DECEMBER
2014, BUT CARE PROVIDERS
ARE NOT PREPARED, WITH
MORE THAN 50 PER CENT
UNAWARE OF THE NEW
LAW. CMM EXPLORES THE
LEGISLATION CHANGES AND
WHAT PROVIDERS NEED
TO KNOW.**

THE NEW LEGISLATION

The current labelling rules cover pre-packed food and guarantee that all food labels have a comprehensive ingredient listing making it easier for consumers with food allergies to identify which products to avoid. However, from 13th December 2014, these allergen labelling rules will be changing.

The new regulation was published in October 2011 and built on the current labelling provisions. However, it also introduces a requirement for allergen information to be provided for foods that are sold which are non-packed or prepacked for direct sale. There has been a three year transition period to allow businesses to change their labelling processes and ensure they comply →

→ with the legislation. This transition period is almost up.

CARE PROVIDERS ARE UNPREPARED

According to research conducted for Unilever Food Solutions, with less than three months to go until the introduction of new allergen legislation, it has been found that over half of care providers (53 per cent) are unaware of the new law.

Almost 60 per cent were unable to identify allergens although more than three quarters stated they were asked for information by residents and their families, occasionally or frequently.

Nearly 40 per cent of operators said they had read about the legislation in the media and a third have obtained information from the Food Standards Agency. Despite this not even 10 per cent said they felt prepared for the changes. A significant 92 per cent of respondents felt that the changes have not been well communicated by the Government.

WHAT DO PROVIDERS NEED TO KNOW?

Under the new rules introduced by the *EU 1169/2011 Food Information for Consumers Regulation (EU FIC)* providers will need to be able to answer any queries by those they support, or family members, on 14 specific allergens in the food they serve. The 14 allergens are eggs, milk, crustaceans (shellfish), molluscs, fish, peanuts, sesame, soya, sulphur dioxide, nuts, cereals containing gluten, celery, mustard and lupin.

Organisations that provide non-prepacked food, a category which includes care homes, must provide information on allergenic ingredients, either in writing and/or orally, for example, staff asking if allergen information is needed when taking an order.

The new allergen labelling rules will not control how businesses choose to provide this information, just that it should be provided.

Allergen information should be easily accessible, visible and legible, regardless of whether the consumer has a food allergy. If writing allergen information on menus, this can be presented in different ways. The allergen(s) can be written on the menu with the ingredient and allergen category eg Chicken Korma [contains Cream (Milk)] or just stating the allergen in the dish eg Chicken Korma (contains Milk).

If certain allergen information is not provided on the menu, there must be clear signs in place to indicate where information can be found. For example, something similar to, 'Food Allergies and Intolerances: Before you order your food and drinks please speak to staff if you want to know about the ingredients.' would suffice. However, this only covers information about major allergens used as ingredients, and doesn't cover accidental contact with an allergen.

As providers have a duty of care to those they support, a process should be put in place to safeguard individuals, particularly those who cannot communicate their dietary requirements. Allergen information will need to be recorded and reported in accordance with the *EU FIC* regulation, and the requirements of mental capacity legislation must also be considered. Therefore, where someone does not have the capacity to make their menu choice, care staff, for example, would have to make a safe dietary choice on behalf of the person.

To ensure staff members are fully aware of the situation, consider using a system where at least one staff member on shift is aware of the ingredients and allergens in the food offered, so other members of the team can ask for guidance. Alternative by having ingredients on an information sheet staff will be able to confirm allergen information when speaking with service users. Also, ensure that 'free from' lists are always current. For example, as menus and recipes change, always ensure that the ingredients are checked and added to the 'free from' list.

ENFORCEMENT ACTION

The regulations are clear that when an

organisation has not acted in accordance with the provisions, it is a criminal offence, due to failure on public health. Therefore, it is vital that care providers understand and abide by the new food allergen legislation, in order to avoid prosecution. The maximum fine for non-compliance is £5,000 with the potential that this will change to an unlimited fine. If a client has an allergic reaction or that reaction is fatal as a result of non-compliance with the legislation, the ramifications are likely to be even greater. Enforcement of the legislation will lie with the local authority's enforcement officers.

BE PREPARED

From December, care providers will have a duty to provide information on the 14 allergens listed in law to all residents. They will also need to ensure that those who lack capacity to choose their meals are supported and any allergen information is properly recorded and communicated amongst staff. It is essential providers are fully up-to-date with changes and responsibilities. Ensure chefs and kitchen staff are aware of the changes and if training is required, locate a properly accredited trainer to deliver it.

CMM

With thanks to Wendy Duncan, Research and Development Manager at Unilever Food Solutions.
UFS@williammurray.co.uk

ADDITIONAL INFORMATION

The Unilever Food Solutions tools
www.ufs.com/allergens

The Food Standards Agency's interactive food allergy training tool
food.gov.uk/allergy-training

A Think Allergy poster: <http://multimedia.food.gov.uk/multimedia/pdfs/publication/thinkallergy.pdf>

EU Food Information for Consumers Regulations http://ec.europa.eu/food/food/labellingnutrition/foodlabelling/proposed_legislation_en.htm

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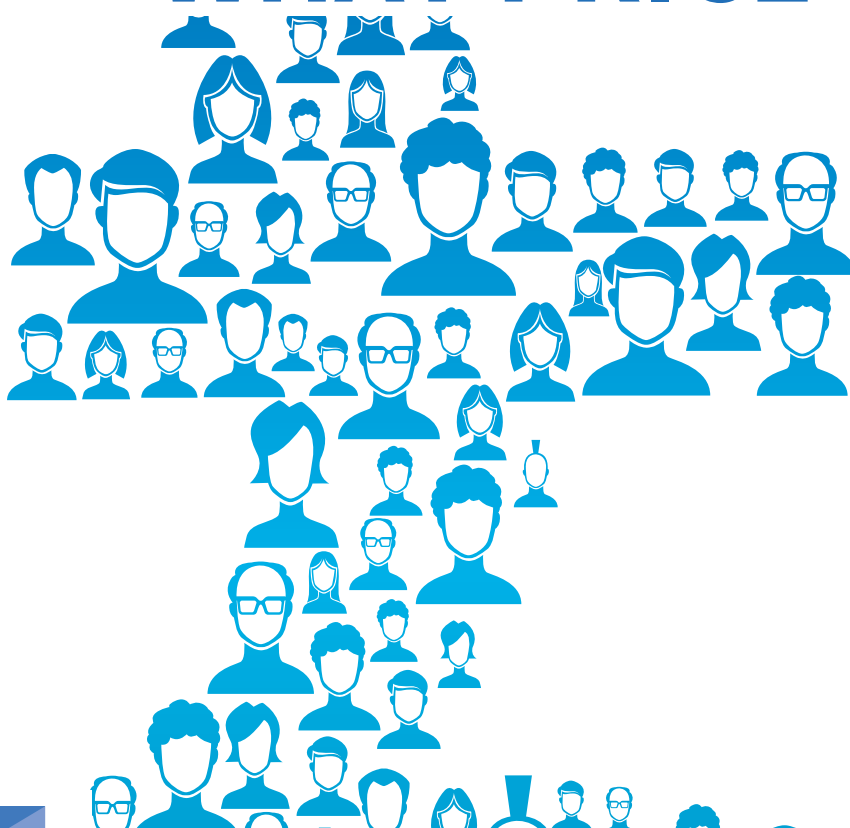


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WHAT PRICE CARE?



• NMW, LW and a fair price for care •

Martin Hopkins looks at the current situation around the National Minimum Wage, the Living Wage and sustainable funding of social care.

The National Minimum Wage (NMW) and the Living Wage (LW) have drawn headlines for some years now. The NMW was introduced in 1999 and the LW campaign can trace its history back to 2001. However, recent negative publicity has brought both of these rates into sharp focus within the care industry.

The question being posed by many is whether the NMW, LW and a fair price for care can exist together and if so, how? In addition, many are querying whether

rates paid to care providers are sufficient to allow them to provide the level of care required at the rates demanded by either the NMW or LW. At the same time as these questions are being posed, employers in the care industry are preparing themselves for proposed reform to the legislation governing zero hours contracts and are considering the implications of that proposed reform.

NATIONAL MINIMUM WAGE

Before proceeding into the detail it is worth reminding ourselves of the relevant rates for the NMW and the Living Wage; shown below are adult rates:

CURRENT RATES	2013/14	2014/2015
NMW	£6.31	£6.50
Living Wage	£7.65 (£8.80 London rate)	To be announced on 3/11/14

In terms of the NMW, the implications of not paying should, in my opinion, be well-known to all employers, but particularly those operating in the care industry. After 15 years I find that nearly all the employers I deal with are aware of the NMW and are paying it. There is a very small percentage who are not, through ignorance of the existence of the NMW. A slightly higher percentage are failing to pay at the correct rate because they do not have a proper understanding of which payments and which hours can be taken into account when calculating the NMW. The intricacies of those calculations are too detailed for me to consider in this article but the risks for employers should be clear. The Government is now naming and shaming employers who they find have failed to pay the NMW. There are also significant financial penalties in terms of back pay and fines for such employers. Finally, and arguably most importantly, providers risk their reputation and future contracts by being found to be in breach.

LIVING WAGE

The implications of not paying the LW are less, as there is no statutory force behind the rate. However it is worth visiting the LW website (livingwage.org.uk) to consider the history of the Foundation, the high level support it receives and details of the Social Care Campaign it supports. This campaign has been launched by Citizens UK, which originally created the Living Wage Foundation (icareaboutcare.org.uk) and sets out four main aims: Dignity in Work, Enough Time, Better Relationships and Proper Training. Whilst there are elements in the Enough Time aim that relate to this article (homecare workers to be paid for travelling time between visits and care homes to be sufficiently staffed), it is the first of the aims which has most relevance to our context. The campaign calls for care workers to be paid the LW, and to be offered access to an occupational sick pay scheme and a clear pathway for career progression. Laudable aims, but how are they to be funded?

The campaign cites the example of Islington Council,

which introduced contracts in June 2014 with its homecare contractors under which the 800 care workers who provide care in the borough are paid the LW. At the same time, Islington is to pay increased Personal Budgets in order that individuals are able to pay their care staff the LW.

As set out in the table opposite, the LW for the coming 12 months will be announced on 3rd November 2014, during Living Wage Week. Expect to see increased coverage of the LW and the Social Care campaign around that time.

SUSTAINABLE FUNDING OF SOCIAL CARE

It is clear that there is a groundswell of support for the LW and that the publicity around the NMW is changing some attitudes. However, a negative view of the level of pay within the care industry is supported by reports released at the end of last year. The *Guardian* reported on 25th November 2013 that Her Majesty's Revenue and Customs (HMRC) had identified £338,835 in back-pay owed to 2,443 workers in the care sector through failure to pay the NMW. This followed a two-year investigation of the sector by HMRC. Worryingly, of the 183 investigations completed, 48 per cent of employers had paid workers less than the NMW. The reasons for this are clear, according to Katie Hall, Chair of the Local Government Association's Community Wellbeing Board, who told the *Guardian* in October 2013, 'Until something is done to put council finance on a sustainable footing social care will remain significantly underfunded and services will suffer as a result. The bottom line is that the standard of care will not be substantially lifted until more money is put into the system.'

CONTINUED DEBATE

Whichever view you support, what is clear is that there will continue to be significant debate over the care sector and the levels of pay within it. What is also very clear is that employers in all sectors must pay the NMW. The implications of not doing so are serious and can be very costly.

For balance, I thought I should consider another industry and how it is doing with levels of pay. Being a lawyer, I immediately thought of the legal sector. I was pleased to see reported in the Law Society Gazette last week that the number of legal employers signed up to the LW had increased by 50 per cent in one year. I was less pleased to note that this significant increase only results in a total of 33 law firms, barristers' chambers and related organisations being signed up. To put that into context, there were 10,726 practising law firms in England and Wales in September 2013.

So next time you are challenged about levels of pay in the care sector you might like to refer to what lawyers are doing to provide you with some context.

Martin Hopkins is a Partner at Birkett Long LLP.
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£750,000 - £3,368/month	£1,800,000 - £8,082/month	£11,500,000 - £51,635/month
£985,000 - £4,423/month	£2,600,000 - £11,674/month	£15,000,000 - £67,350/month
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Who's who...

FINANCE AND FINANCIAL SERVICES

A hand is shown pointing upwards, with several circular and linear data visualizations overlaid on it. The background is a light blue and white pattern of dots and lines. The hand is positioned in the center-left of the frame, with the index finger pointing towards the top right. Overlaid on the hand and background are several data elements: a circular gauge on the index finger showing 81%, another circular gauge on the middle finger showing 56%, a circular gauge on the thumb showing 55%, and a circular gauge on the ring finger showing 30%. A white line graph with a sharp upward curve is also visible, passing through the hand. The overall aesthetic is clean and modern, with a focus on financial data and growth.

The sector has seen a real change in financing since 2008. Some lenders have exited, new ones are coming in from overseas and the market is starting to evolve. Care sector-specific financiers and financial services know the sector well and are able to advise you on key issues and offer solutions to meet your needs. Whether you are looking for funding to grow, refinancing, due diligence, advice or other financial services, the following organisations should be able to help.

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BARCLAYS



Paul Birley is Head of Healthcare at Barclays and manages a team of relationship directors based across the UK and Ireland. Paul has worked for Barclays for 33 years and has been involved in the healthcare sector for the last 16 years. Barclays is committed to 'giving people in care a better experience' by supporting the healthcare industry and building relationships with a range of providers and organisations that operate within it. Sector specialist propositions covered include care providers both large and small, the NHS and the third sector, including the following sub-sectors: high street healthcare, healthcare services, asset-backed healthcare and life sciences. Barclays also supports the sector by facilitating networking events and industry sponsorships and has won HealthInvestor's Bank/Lender of the year for five times in the last six years, the last of which was in 2014.

PAUL BIRLEY *Head of Healthcare*

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CHANDLER & CO



John Read is a senior partner at Chandler & Co and has been working in the healthcare finance market for over 30 years. Over this time he has built up many close relationships with a wide range of lenders and professional contacts in the industry.

He and Jerry Webb set up Chandler & Co in 1995 and together with their partners have completed loans in excess of £2 billion nationwide. His first-hand experience in operating care businesses has proved invaluable when advising other investors.

He says, 'With our 20th anniversary next year, we are still going strong, continuing to deliver our independent service to our clients providing a tailor made package incorporating not just finance, but expert assistance with the entire process.'

JOHN READ
Senior Partner

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CLYDESDALE AND
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Derek Breingan has more than 25 years' banking experience, ten of which working directly with a wide variety of healthcare businesses: care home operators, dentists, nurseries, pharmacists and general practitioners.

His role as Head of Healthcare at Clydesdale and Yorkshire Banks is to support healthcare businesses to identify and execute strategic growth opportunities, whilst coordinating the Bank's national approach to the sector.

Derek is a panel member of Developing Strathclyde, a charitable organisation which provides business loans to the third sector and SMEs which may not qualify for traditional bank support. He also lectures business studies to final year dentistry students at the University of Dundee on behalf of NHS Education Scotland.

DEREK BREINGAN
Head of Healthcare

In 2014, the Bank was nominated for the HealthInvestor Healthcare Lender of the Year.

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DELOITTE



David leads the dedicated Deloitte Healthcare and Life Sciences Corporate Finance practice. For over a decade, he has advised on mergers and acquisitions in the sector including buy-side and sell-side transactions, joint ventures and public sector partnerships. Clients praise his hands on approach – 'expertise with a human face' and 'deals delivered with unyielding commitment and professionalism'. He has been at the forefront of high profile and innovative deals, working with clients including BUPA, United Drug plc and various financial investors.

At the 2013 and 2014 HealthInvestor Awards, the team was recognised as Corporate Financier of the Year. With a strong track record of success driven by deep industry knowledge, David's team works with corporates, management teams, founder shareholders and private equity houses across a range of sub-industries, from healthcare services to pharmaceuticals, while Deloitte's network of healthcare and life science professionals allows the team to operate on a global scale.

DAVID JONES
Partner

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Jonathan joined GI Partners in 2010 and is responsible for the sourcing of new investment opportunities. He also oversees GI's investment in the Cambian Group of which he was a board director until its IPO at an EV of c.£530 million in April 2014. In addition to Cambian, Jonathan was previously a board director of Care Aspirations and was involved in the sourcing and build-up of Advanced Childcare, the UK's largest provider of residential children's homes. Prior to GI Partners, Jonathan worked within healthcare at The Carlyle Group and he began his career in investment banking at Rothschild.

GI Partners is a leading private equity and real estate investor. In healthcare, GI's focus is on backing businesses with entrepreneurial management teams with a view to creating best-in-class market leaders via expansion through acquisition, organic growth and investment in business infrastructure.

JONATHAN MILLET *Director*

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MARK WIDDOWS
Senior Partner

Mark Widdows founded Global Business Finance in 1989. He originally trained as an accountant and was later headhunted to run a financial services firm, before leaving this position to establish Global Business Finance. He and his team assist clients throughout the UK who specialise in the healthcare sector to achieve their objectives in refinancing, purchasing further businesses or developing new care homes.

Mark can offer, not just a finance broker's or accountant's approach to the task, but also that of a care home operator. For the past 11 years, Mark has operated care homes specialising in dementia care of the elderly, which brings a wealth of additional knowledge and an insight that most brokers cannot offer their clients.

Telephone: 01242 227172 • Email: enquiries@globalbusinessfinance.com • www.globalbusinessfinance.com

Global Business Finance only works with clients in the care sector and has completed over £1.5 billion in loan facilities for customers to achieve their goals. They have extensive banking contacts and a reputation and 'buying power' that allows them to source highly-competitive funding facilities, with not just exceptional interest rates but excellent overall borrowing terms and repayment periods of five to 25 years and even interest only periods where the transaction justifies this facility, such as refurbishment, new build, extension or the taking over of a failing care business.

Credit facilities commence at a few hundred thousand but run into multi-millions for some clients and all manner of projects are handled by the firm. Recent successful loan placements have included a new 64-bed dementia home, a Georgian

renovation, an eco-build extension, a refinance of over 200 beds to release funds for an unrelated business and the purchase of a further care home via an off-shore company.

However, everyday facilities have also included a new buyer seeking to purchase two care homes, a family investing in the next generation through a parental 'gifting' scheme as the children had no deposit funds plus a 'deferred-payment scheme' to help a buyer with limited funds buy a home that required immediate capital investment along with many other upgrading and extension funding transactions.



DANIEL SMITH
*UK Head of
Private Healthcare
and Partner*

Daniel Smith is Grant Thornton UK LLP's UK Head of Private Healthcare and a Partner in the Advisory department. He is well-known in the sector with 20 years' private care sector experience.

Daniel's team provide a range of advisory services to the elderly and specialist healthcare sectors including fundraising, mergers and acquisitions, exit planning and restructurings with 25 recently completed mergers and acquisitions deals in the sector. High profile disclosable cases that Daniel has recently headed include Southern Cross and Castlebeck.

With a transaction size of £5 million to £250 million this makes Grant Thornton the preferred supplier in mid-market care transactions with an extensive network of contacts within the corporate and finance environments. Grant Thornton has won many Corporate Finance awards in recent years, reflecting our passion, capability and experience.

Recently, Daniel was invited onto the technical committee chaired by the Department of Health's Director General of Social Care, advising on the future regulation of private sector care.

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ANDREW BROOKES FCA CF
Partner and Head of Health and Care

Andrew has a wealth of experience gained over 20 years of advising in the social care sector providing proactive accounting, tax, business and corporate finance advice to many care operators.

Andrew is nationally-recognised for his knowledge of the sector, having qualified as a chartered accountant in 1989 and then specialising in corporate finance in the early 1990s.

Andrew has a wide range of experience on mid-market transactions, which he shares with his many clients.

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Hazlewoods is a long established accounting firm based in Gloucestershire, ranked 34th by size in the UK (the Corporate Finance team is ranked in the top 20). We are specialists in the healthcare sector, operating throughout the whole of the UK, and have long established reputation for innovation and service.

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PHIL HALL
Chairman, Healthcare

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The UK healthcare business is chaired by Phil Hall in London with regional representatives operating in Bristol, Leeds and Edinburgh. Phil has been at the forefront of the industry for many years, providing healthcare advice to operators, investors and lending institutions across many cycles in the market.

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MARK ELLIS
Head of Property and Social Care Banking

Mark Ellis is Head of Property and Social Care Banking for Lloyds Bank Commercial – which provides tailored banking services to care home businesses with a turnover up to £25 million.

He joined Lloyds TSB Group in June 2007 with a brief to develop a social care proposition to operate alongside the bank's established primary care offering.

Mark has also held key positions in a number of high street and merchant banks working in both commercial and corporate banking and has extensive experience of the healthcare market, having been involved in the care sector for many years.

The bank has made significant investment in building a specialist team that understands the specific challenges firms face and can develop appropriate tailored banking solutions.

The Social Healthcare Banking team is targeting further lending increases in the sector during 2014 and is focused on growing its customer base in England, Wales and Scotland.

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STUART DEAN
Head of Healthcare and Pharmaceuticals

Stuart Dean is Head of Healthcare and Pharmaceuticals for Royal Bank of Scotland's Corporate and Institutional Bank. In this role he leads a national team of sector focused relationship directors who support all types of healthcare businesses from both the independent and third sectors.

The team are focused on supporting new and existing clients that have a strong, person-centred care ethos.

Prior to this role, Stuart spent eight years working alongside private equity on a variety of transactions that included Advent International's purchase of Priory Group and Bridgepoint Capital's take private of Care UK.

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ASSESSMENTS AND DEMONSTRATIONS

THE CARE SHOW BIRMINGHAM AND DEMENTIA CARE SHOW

4/5 November,
Birmingham



Care Show
4-5 NOVEMBER 2014
NEC BIRMINGHAM



Dementia Care Show
4-5 NOVEMBER 2014 • NEC BIRMINGHAM
Part of Care Show Birmingham



The Care Show takes place on 4th and 5th November in Birmingham and is the biggest trade event in the UK for the care sector. The UK care home market is currently estimated to be worth in excess of £10 billion, and the Care Show will be a vital platform for industry (and Government) to deliberate on the issues that face the UK's long-term care market.

In a recent industry survey by the Care Show, concerns over staffing, sourcing, reduced local authority funding and delivering integrated care, were broached by 22,000 care home owners and managers, home care agencies, NHS staff and other industry contributors. The Care Show will be the 'broadest event of its kind in the UK, welcoming established suppliers to the market, new innovators and importantly a key platform for debate on the immediate as well as long-term issues affecting the industry, including the impending Care Act.'

Last year, the Care Show attracted over 2,900 visitors and 250 exhibitors. This year, as well as a promising number of organisations exhibiting, there will be a range of other activities and seminars including:

- The **Wellbeing and Activity Zone**, where visitors can enjoy a coffee, a massage and a manicure. Activities like this are meaningful and can make a huge difference to a care home and the wellbeing of the people it supports.

There will also be a comprehensive conference programme, where public and private sector speakers share best practice and answer burning questions from delegates.

The Care Show will house over 250 exhibitors, who will offer practical support, advice and products for those operating in the long-term care sector.

The Care Show Birmingham will also incorporate the Dementia Care Show.

The **Dementia Care Seminar Theatre** will feature discussions and presentations on thought-provoking topics such as dementia care in the community and inspirational dementia care projects. This is a new and innovative part of the Care Show.

If you've ever wondered how outdoor spaces can benefit people with Alzheimer's, what colours work well for people with cognitive impairments or anything else about making your care home dementia-friendly you can come and see how it all works first hand with a full exhibition stand showcasing a range of meaningful activity spaces and outdoor spaces – all built in the exhibition at the Dementia Care Show.

The **Dementia Design Academy** in association with **DSDC University of Stirling** will include a range of meaningful activity spaces including a Tearoom, Social Club and outdoor spaces – all built in the exhibition at the Dementia Care Show. DSDC University of Stirling will be on hand to answer any questions you may have on how to make the care environment dementia-friendly.

Exhibitors at the Care Show Birmingham include Advanced Health and Care, Biodose, Clydesdale and Yorkshire Banks and Skills for Care.

The Care Show is working with Stirling University's Dementia Services Development Centre (DSDC), UK Active, the Care Quality Commission (CQC) and the National Care Association.

To register to attend and find out more visit
www.careshow.co.uk/birmingham



WHAT'S ON?

Selection of Homes Currently for Sale

 Residential Care Home 11 beds Adapted, Purpose Built £2,300,000	 23 Single Bedrooms 19 En-Suite Plus Apartment and Guest Room £4,475,000	 Residential Home 28 beds Fully Managed £965,000	 Profile of £20,000 24 beds Plus Four Bed Flat £1,090,000	 LIP Home 20 beds Main House Plus 3 Flats £1,300,000
 Residential Home Apartment Fully Managed £115,000	 Guest Profile 37 beds Purpose Built Extension £1,095,000	 Residential Dementia Home 20 beds All Single All En-Suite £1,400,000	 Residential Home 20 beds Single Manor House £2,250,000	COMING SOON Devon Residential Home 28 beds Profile of £20,000
 Residential Home, 40 beds Plus 2 Bed Flat Plus 2 Bed Bungalow £2,300,000	 1 D Home 42 beds Plus Flat £950,000 Profile £480,000	 High Profile 21 beds Beautifully Decorated £3,000,000	 Vero, Spacious 14 beds 2 Large Flats £660,000	SELL YOUR HOME WITH US!

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An Inspector Calls

coming ready or not!
The challenges of delivering social care in the new world

ICG Conference & Exhibition
7 October 2014, York Racecourse



Media Partners of ICG

BOOK TODAY!

7 October 2014 at York Race Course

Topics will include:

- The changes you need to know about rated inspections – October 2014 and beyond
- Delivering social care in North Yorkshire and the City of York
- Dementia – THE SPECIAL METHOD and three golden rules of contented dementia care
- Infection control – unannounced visits!
- Homecare – making it work
- The burden of paperwork in social care
- Customer care and treating people with respect
- Social care's national position

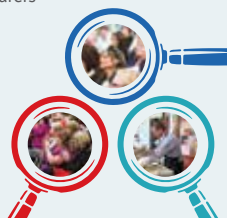
Speakers will include:

- Andrea Sutcliffe, Chief Inspector of Adult Social Care, Care Quality Commission
- Chair for the day Harry Gratton, BBC Look North
- Richard Webb, DHASS, North Yorkshire
- Paul Edmondson-Jones, Deputy CE and DHASS, City of York
- Penny Garner, Contended Dementia Trust
- John Kennedy, Director, Joseph Rowntree Foundation
- David Pearson, President ADASS
- Ian Donaghy, Director of Training, Training for Carers

BOOK NOW!

Call Jacki Brailey on 01293 851869, or visit www.mcculloughmoore.co.uk/icg

If you are interested in exhibiting at the ICG exhibition, please call Jacki Brailey on 01293 851869



Event: REHACARE INTERNATIONAL 2014
Date/Location: 24th – 27th September, Dusseldorf
Contact: Messe Düsseldorf, www.rehacare.de

Event: National Association of Care Catering Training and Development Forum 2014
Date/Location: 1st – 3rd October, Nottingham
Contact: McCullough Moore, Web: www.mcculloughmoore.co.uk/nacc

Event: ICG Conference and Exhibition 2014
Date/Location: 7th October, York
Contact: McCullough Moore, Tel: 01293 851869

Event: Care Show Birmingham
Date/Location: 4th – 5th November, Birmingham
Contact: Care Show, www.careshow.co.uk/birmingham

Event: Care England Conference: The Road to Integration
Date/Location: 13th November, London
Contact: Care England, Tel: 020 7492 4846

Event: Improving outcomes in dementia care: integration, personalisation and the Dementia Challenge
Date/Location: 25th November, Central London
Contact: Westminster Health Forum, Tel: 01344 864796

Event: Next steps for palliative and end of life care: funding, resources and One Chance to Get it Right
Date/Location: 13th January 2015, Central London
Contact: Westminster Health Forum, Tel: 01344 864796

Event: The future for social care in England - funding, integration and next steps for policy
Date/Location: 22nd January 2015, Central London
Contact: Westminster Social Policy Forum, Tel: 01344 864796

CMM EVENTS

Event: Berkshire Care Conference 2014
Date/Location: 16th October, Reading
Contact: McCullough Moore, Tel: 01293 854401

Event: CMM Insight: Learning Disability Services: Current Developments and Future Opportunities
Date/Location: 26th February 2015, Manchester
Contact: Care Choices, Tel: 01223 207770

Please mention CMM when booking your place.



straight talk

Paul Simic discusses 'Finding Common Purpose'.
We need to care for care, don't Paxman it.



PAUL SIMIC

CHIEF EXECUTIVE

LANCASHIRE CARE ASSOCIATION

The Care Quality Commission (CQC) is to extend special measures 'hit squads' to solve the problems in care homes and homecare. We need less 'hitting' and more nurturing in our stance on care. We need to care for the sector in tackling fundamental and longstanding structural challenges. Change needs to come from within and be allowed to grow. The end of the 20th century saw the nurturing parent as the paradigm replacing the Victorian parent yet in relation to parenting our care services we retain that authoritarian model.

A recent Association of Directors of Adult Social Services report referred to *Finding Common Purpose* between providers and commissioners. Although the report was about learning disability services the principles are general to the relationship between commissioners and providers. In recent years, both in Lancashire and Greater Manchester where I have worked (through the Social Care Partnership with Lancashire County Council and the Care Sector Council with the Greater Manchester Chamber of Commerce and Association of Greater Manchester Authorities) we have tried to work with providers and commissioners, employing the notion that providers need help rather than just punishment when things go wrong.

No-one can knock quality into the system and the relationship between regulation and care quality is ambiguous. A senior local authority manager colleague noted recently that there are 21 organisations who have some overseeing role. How many does it take to change that light bulb? And, when will the light come on that the solutions are imminent as much as transcendent? Some argue that we should have a national health and social care service because the problem is the private sector, as if the mere fact that a service was in the public or third sector meant it was good; just because it wasn't private. The economics and politics of it aside, those who make that argument make a giant leap in their presumptions about ethics, motivation and quality in relation to the different sectors.

There needs to be recognition that to make the system work well (and care is delivered through a system) we need the right environment. Regulation is just part of that but it sets the emotional tone. Nurturing should be a bigger part however touchy-feely that statement may sound. Why do we use 'hit squad' and 'special measures' terminology and thinking? What role is 'fear' meant to play? All we (the system 'players') should want is to look after people who need care and support well and look after those who look after them well, too. A culture of fear paralyses rather than mobilises through serving the wrong masters.

Commissioners need to be subject to critique, too, and - *quis custodiet ipsos custodes* - so do those who regulate and monitor care through quality and contract monitoring and through safeguarding. I've seen some terrible examples of poor regulation and monitoring but this avoids the limelight. All parts of the system - care delivery, commissioning, monitoring and regulation - should be subject to proper regulation, the most important feature of which is the means to have critical analysis feed shared learning. This will help protect against system 'skew' so we focus on care not on secondary functions of inter-organisational and inter-sectoral politics and back-watching.

Roy Lilley made the point well recently; there is a need for there to be resources in place that actually address problems before they occur not wait until afterwards when it's too late. This requires more from within rather than more from without to correct. The sector is a fund of expertise and knowledge, why isn't this tapped into? Why is the assumption that the Department of Health, CQC, local authority or CCG commissioners are the experts on care? Provider/clinical expertise can't be left outside. Providers can setup joint working processes and structures to find effective 'common purpose' with commissioners and it isn't costly.

Registered Managers (RM) are now, finally, being recognised as having the key leadership role the sector requires but we don't have enough, they aren't supported well and are overloaded. We're developing our own Lancashire RM support network in recognition of this. As well as RMs, the upskilling and upsizing of the frontline care workforce is a vast challenge as we move towards needing some 2.5 million care workers over the next decade. They need to feel and be valued. This is a system task. Poor care happens and needs to be challenged and corrected but the public discourse uses selective sampling techniques: it selects only from failures never from successes. It's as if everyone in the care sector has our own Jeremy Paxman avatar who follows us around all day. We wake to criticism and scorn, it shadows us waiting for the slightest failure and then keeps us awake hectoring us with what we failed to do well today and what mistakes we will make tomorrow until we fall into a fitful sleep hearing a perpetual narrative of failure.

A development culture, driven towards excellence from within, in a partnership between care providers, commissioners (and even regulators), is a more effective means of structural transformation than the 'hit squad' intervention paradigm and the Paxman persona as parent. We need to care for care through finding common purpose. This is much harder.

CMM

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