Care Home Managers: A scoping review of evidence

Katharine Orellana

The School for Social Care Research

The School for Social Care Research was set up by the National Institute for Health Research (NIHR) to develop and improve the evidence base for adult social care practice in England in 2009. It conducts and commissions high-quality research.

About the authors

Katharine Orellana is a research intern at the Social Care Workforce Research Unit, King's College London and is has just embarked on PhD studies investigating day services for older people. She is a gerontologist and has worked in the ageing sector for fifteen years. Her topics of interest include personal budgets, support planning, day services and preventive services.

CONTENTS

ABSTRACT

Very little is known about the practice, experiences and skills of care home managers and the challenges they face. Yet they are responsible for everything that happens in their homes, overseeing all activities within the home. They make sure the quality of the service and care provided meets the required standards. They carry out their role with care homes regularly in the public eye, often as a result of scandals and inquiries. This scoping review has tried to remedy the absence of material about care home managers for adults in England by drawing together a range of primary research studies, secondary analysis of published data, policy documents and other evidence. It identifies and summarises the evidence available since 2000 to explore who care home managers are; their practice, experiences and skills, and the supervision and support they receive from their own managers or home owners; challenges they face in practice; and gaps in the evidence base.

The evidence found mainly related to care homes for older people which may, in part, be a reflection of the level of provision for this group. This review suggests that there remain many unanswered questions about care home managers. They are an often overlooked group when it comes to research, although many are involved in research about other aspects of life or work in care homes, including studies with a focus on care home residents or members of care home staff. The manager of the home is often a hidden or 'shadowy' figure, although there is frequent allusion to their impact on the culture of care.

KEYWORDS

ACKNOWLEDGEMENTS

INTRODUCTION

Care home managers are responsible for everything that happens in their homes, overseeing all activities within the home and making sure the quality of the service and care provided meets the required standards (HM Government 2010a, National Careers Service 2013). The needs of care home residents are increasingly complex (Lievesley *et al.* 2011). It is well-documented that much care work offers poor pay, poor conditions and limited career prospects and that recruitment and retention are difficult for employers (National Care Homes Research and Development Forum 2007, Cavendish 2013). The work of a care home manager is further complicated by the economic climate, changes in policy, amendments and additions to legislation, regulatory and inspection regimes, and being buffeted by fragmented systems and multiple imperatives. Over recent years, the status of the adult social care workforce has emerged as a matter of public policy concern. Care homes are regularly in the public eye, often as a result of scandals and inquiries, some of which result in Serious Case Reviews (SCR).

Research with care homes tend to focus on the residents or frontline care workers, on external relationships, with primary and secondary care NHS services, for example, or on specific practices within them, such as medication management or mealtime experiences. The importance of the organisational culture has frequently been cited (Luff *et al.* 2011) as, it has been argued, this impacts on organisational systems and processes and the responsiveness or flexibility of the home and, thereby, on staff and residents (Dewing 2009). It has been suggested that the running of care homes depends crucially on the skills and leadership attributes of their managers (Chambers and Tyrer 2002, National Care Homes Research and Development Forum 2007).

Although a broader range of demographic data on the social care workforce is becoming available, most attention has been paid to frontline care workers or the care home workforce as a whole. Thus, very little is known about the practice, experiences and skills of care home managers and the challenges they face.

This scoping review has tried to remedy the absence of material about care home managers for adults in England by drawing together a range of primary research studies, secondary analysis of published data, policy documents and other evidence about them. It identifies and summarises the evidence available since 2000, addressing the following questions:

- ■ 'Who' are care home managers?

- ■ What is the evidence about their practice, experiences and skills, and the supervision and support they receive from their own managers or home owners?

- ■ What challenges do care home managers face in practice and what do they perceive as key issues?

- ■ What gaps, if any, require further research?

As well as identifying areas for further research, this review aimed to provide evidence for care home providers, managers and practitioners, commissioners, policymakers, researchers and for people using care home services and their families.

The review is structured as follows:

- contextual background about care homes;

- description of methodology used and outline of type of evidence found;

- legal status of care home managers, information about their numbers, turnover, vacancy rates, pay and demographic data;

- research and other evidence about what motivates managers, how they are perceived to be motivated and what personal qualities are needed for the role;

- outline of the roles of a care home manager and the level of responsibility that the role entails;

- findings about the skills they need to fulfil their multiple roles, their background, the qualifications they possess, why they leave their jobs and where they move to;

- what is known about the care home manager's professional profile within social care, the potential scope for improvement and current initiatives that support this;

- consideration of why leadership is so important, the influences good and poor leadership may have, what is known about the types of management and leadership that are most effective in care homes;

- the role of and expectations relating to supervision and support for the care home manager and the impact that a supportive culture may have;

- challenges faced by care home managers as identified by reviews, through research studies and from inspections;

- key messages, a discussion of the findings, identification of research gaps and recommendations for further research.

CARE HOME BACKGROUND

After considerable expansion in the 1980s in England, care home provision peaked in the mid-1990s, after which numbers started to decline again. Many care homes closed as a result of policy changes, such as the transfer of national funding to local authorities, the introduction of minimum standards (such as the Care Standards Act 2000) and a move towards community care. Supporting people to remain in their own homes has been a consistent thread in different Governments' policy for some time, appearing in *Our Health, Our Care, Our Say: A New Direction for Community Services* (HM Government 2006), *A Vision for Adult Social Care: Capable Communities and Active Citizens* (HM Government 2010b) and reiterated in *Caring for Our Future: Reforming Care and Support* (HM Government 2012). It also underpins the Care Act 2014 and its emphasis on wellbeing.

Care homes have been perpetually stigmatised and were seen as a 'last resort' in 1985 when the Independent Review of Residential Care was set up. Reporting on this, the Wagner Review (1988) articulated that moving into a care home should instead be a positive choice. However, almost 25 years later, the My Home Life programme found that care homes were often still perceived as a 'last resort' (Owen *et al.* 2012b). The already poor reputation of care homes has further suffered following several recent high profile failings of care such as abuse at Ash Court in Camden (BBC 2011), and neglectful care which led to deaths at Orchid View in West Sussex (Samuel 2013). As a consequence, quality and safety in care homes are becoming an increasingly important concern for the adult social care sector and for other stakeholders such as policymakers, the media, family carers and the general public.

Paul Burstow MP, former Care Services Minister, is (at the time of writing, Spring 2014) chairing a year-long (2013-14) Commission on Residential Care[1] supported by the think tank, Demos. The Commission aims to develop a 'new vision' for residential care that is 'fit' for the 21st century. Challenging misperceptions and dispelling the notion that living in a care home is the 'last resort' are the stated aims behind setting up the Commission, members of which include representatives from the private and voluntary sector care providers, academia and local and national policymakers.

Definitions

The regulatory body for health and social care in England, the Care Quality Commission (CQC), defines a care home as:

> a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it (CQC 2010, p.26).

---

1 See www.demos.co.uk/projects/corc

Care Home Managers: a scoping review of evidence

Residential, rest and convalescent homes, respite care, mental health crisis houses and therapeutic communities are all included under the single umbrella category of 'care home'. A care home with nursing is defined as one providing qualified nursing care, to ensure that the full needs of the person using the service are met (CQC 2010). Care homes:

> range in size from very small homes with few beds to large-scale facilities; offer care and support throughout the day and night and staff help with washing, dressing, at meal times and with using the toilet (CQC 2014a).

Regulatory requirements

Care homes must comply with a series of regulatory requirements. The CQC is in the process of introducing a new system for regulating, inspecting and monitoring care services. Proposals at the time of writing included a formal consultation on provider guidance from April to June 2014, piloting of the new system in two waves between April and September 2014 and for the new regulations to be in force for residential social care in October 2014 (subject to Parliamentary approval). Proposals have included replacing the existing 16 essential standards of quality and safety with five key domains, one of which is 'well-led' which is deemed to be important for positive outcomes in the remaining four: safe, effective, caring and responsive (CQC 2013b, 2013c).

Following the abuse that was exposed at Winterbourne View private hospital for people with learning disabilities, the CQC is making registration criteria more stringent for services for people with learning disabilities. It has started to change how it assesses leadership of and corporate responsibility in providers of services for people with learning disabilities. The first step has been to change the way providers are registered (CQC 2013e). New providers now have to demonstrate that they have quality assurance systems in place and must name individuals who will be responsible for meeting quality and safety standards. The CQC expects stronger tests for all providers to this group of residents to be in place by 2014 via the new regulations.

Size and structure of care homes

The residential care sector in England is large and varied. In an analysis of the size and structure of the adult social care sector and workforce in England in 2013, Skills for Care (the sector skills body) reported that around 566,000 people work in care homes. Of those, 289,000 people work in CQC registered care only homes, 276,000 work in care homes with nursing and 1,000 work in 'other' regulated residential services (Skills for Care 2013a).

Care homes outnumber care homes with nursing by far, but the total number of beds provided by each type of home is roughly similar, because care homes with nursing (and those that are dually registered) are bigger operations (see Table 1). Most homes were run by social care organisations with only 0.7% (n=121) provided by NHS/healthcare organisations. On 3 February 2014, CQC (2014c) reported that there were 17,350 residential care homes and nursing homes registered in England. Of this number, 4,676 were care homes with nursing and 12,976 were care homes without nursing. Some of

Table 1: Numbers of care homes and beds (CQC 2014c)

	Care homes without nursing	Care homes with nursing	Care homes – dually registered
Number of homes (total 17,350)	12,674	4,374	302
Number of beds (total 463,161)	242,726	205,358	15,077
Average no. of beds	19	47	50
Median no. of beds (middle point)	5	43	50
Mode no. of beds (most frequently occurring number)	6	40	60

Table 2: Numbers of locations care homes are operated from (CQC 2012a)

Type of care home	Number of locations					Total homes
	1	2–5	6–10	11–19	20+	
Residential	4,452	802	39	14	4	13,134
Nursing	1,551	200	9	14	4	4,672
Total						17,806

these homes (302) were dually registered as both care homes and as care homes with nursing. Translated into beds, this amounts to 463,161 care home beds of which just over half were care home beds (n=242,726), just under half were in care homes with nursing (n=220,435 beds) and the remainder were in those dually registered homes (n=15,077).

Table 2 shows that many providers run more than one care home[2] but that around one third of care homes and care homes with nursing are operated from only one location. Homes vary from very small homes run by an owner who is also the manager to large multinational chains.

---

2 Note: The chart takes account of corporate 'brands' which own a number of providers but are not themselves registerable entities.

Table 3: Proportion of all care homes registered for each client group (CQC 2014c)

Older people	Dementia	Learning disability/ autistic spectrum	Physical disability	Mental health	Sensory impairment	Misuse of drugs/ alcohol	Detained under Mental Health Act	With eating disorder
64%	40%	36%	28%	20%	13%	2%	2%	1%

Care homes may specialise in certain client groups, including older people, people with mental health problems or learning disabilities, people who are terminally ill or people with physical disabilities. It is common for a care home to be registered for more than one client group. Table 3 shows the proportion of all care homes that are registered for the various client groups. It is evident that the largest proportion is for older people.

Profile of residents

There is evidence that care home residents are now more disabled with more complex needs than previously (Lievesley *et al.* 2011). This trend has implications in several areas, such as staffing levels and training, medication management, increased need to liaise with local health services and in the management of risk.

In 1996–97, Challis *et al. (*2000) investigated the dependency and health status of 308 older people who had recently moved into a care home. They classified half of this group as having low dependency while 15% were experiencing severe cognitive impairment (dementia). Those who had been diagnosed with dementia entered nursing rather than residential only care homes.

Lievesley *et al.* (2011) concluded from their review of research that:

> care homes are moving away from being an alternative form of housing for frail older people towards a location of last resort for individuals with high support needs towards end of life (p.8).

However, this does not imply that the prime need of residents is for end of life care. Lievesley *et al.* noted that residents with dementia who otherwise are in relatively good health have longer stays in care homes than residents without dementia who are physically frail. According to BUPA's 2012 census of its UK care home residents, the median length of stay to date among all residents was 20 months. Median lengths of stay to date for residents with mental illness (other than dementia) were 32.5 months, 31 months for younger residents with a physical disability, 21 months for people with dementia and 19 months for the frail elderly (Centre for Policy on Ageing 2012). In an Alzheimer's Society's study, of the 1,125 people with dementia who lived in care homes, around half (57%, n=640) had lived there for up to two years, a third (29%, n=327) for between three and six years and 14%(n=158) for more than six years (Quince 2013).

Censuses of BUPA care homes residents carried out in 2003 and 2012, the results of which are outlined below, showed increases in the proportions of residents with dementia and frailty. According to Bowman *et al.* (2004), who reported on the 2003 survey, 'loss of mental capacity, predominantly as a consequence of dementia or stroke, remains the single biggest issue' (p.565) and is expected to rise.

The 2003 census of UK BUPA care home residents (n=15,483 in 244 homes) found very high levels of dependency among residents such that the authors considered that their support needs could not practically be met in the community. Dementia (36% of all residents), frailty (25%) and stroke (22%) were the major reasons for moves to a care home. Overall, only 24% of residents could walk without assistance and only 28% were continent. Half had double incontinence. Those who were defined as 'confused' or 'forgetful' numbered 64%, 20% exhibited challenging behaviour, and 19% were depressed or agitated (Bowman *et al.* 2004).

The 2012 census of UK BUPA care home residents (n=12,901) reported that most people (94.3%) moved to their care homes for long-term care and that 93% of their residents were aged 65 and over. Many (87%) had high support needs, defined as having one or more of the following: dementia (45.6%), confusion (64%), challenging behaviour (24%), dual incontinence (56%), severe hearing or visual impairment, or total dependence in mobility. Less than a quarter were mobile without assistance. Fifty seven per cent of residents had a neurological or mental disorder, with the most common being dementia (46%), stroke (16%), depression (6.5%), Parkinson's disease (5%) and epilepsy (3.7%). Non-neurological conditions included heart disease (9%), lung/chest illness (4%), sight (6%) and hearing (3%) problems, diabetes (10%) and cancer (5%). The 'frail elderly'[3] category accounted for 51% of residents. Almost a quarter of residents were reported to display challenging behaviour (24%), with the top four conditions associated with this being Huntington's disease, schizophrenia, bi-polar disorder and dementia (Centre for Policy on Ageing 2012).

The Alzheimer's Society has reported that recent studies suggest that no less than 80% of people in care homes have dementia or significant memory problems (Quince 2013).

Future demands for care homes

Estimates related to the needs of future populations suggest that there will not be a decrease in need for care home places. However, these assume that a constant proportion of people with high support needs will move to care homes, which may not be the case given that current policy focuses on supporting people to remain in their own homes.

Jagger *et al.*'s (2011) study of 841 people who were born in 1921 and living at home or in care homes in Newcastle upon Tyne and North Tyneside aimed to project future demands for care. Despite finding that a high proportion of the 85 year-olds were independent[4],

---

3 Frailty, a state of vulnerability resulting from declining health and functioning, is a much debated concept. See Clegg *et al.* (2013) for a full discussion or Woodhouse and O'Mahony (1997) for an overview.

Care Home Managers: a scoping review of evidence

Jagger *et al.* observed that there was still a significant proportion that needed full-time care at home or in care homes. The study included people with cognitive impairments. Study participants were representative of the same age group across England and Wales with respect to gender, residency in care homes and living alone, and the authors highlighted that narrow age-band cohort studies are more reflective of the reality of populations. Their projections suggested that there will be an increase in numbers of people aged 80 and over who are dependent (by 82% for the critical-interval dependent group) with a related demand of 630,000 care home places by 2030 (in England and Wales) unless alternative options are presented.

Emerson's (2010) scoping review of the estimates of young people (aged 14–16) with physical or learning disabilities in England suggested that there will be a rise in need for social care services among young adults with disabilities over 2012–30. Projections were calculated using different scenarios based on whether social care services are available to people with moderate, substantial or critical needs. Annual growth rates for those with physical disabilities are projected to be 1.8–6.5% – an additional 6,000 to 46,000 young adults over the next ten years. Annual growth rates for those with learning disabilities are projected to be 2–2.7%, which equates to an additional 37,000 to 52,000 young adults over the next ten years.

The current Commission on Residential Care has proposed that care homes do not always meet the needs of younger disabled people, such as those who have been injured in the armed forces and the increasing numbers of people with profound or complex learning disabilities. The Chief Executive of Demos said:

> When people think of care homes they think of old age, but medical advances means there will be more and more younger disabled people in the UK. Some need a lot of support and often only care homes can deliver this. But too few are geared to helping young people – we need a rethink about what care is on offer and where, as our society changes (National Care Forum 2014).

Similarly, in relation to the specific needs of people with learning disabilities, concern has been expressed that a lack of training could result in their particular needs not being met. Increasing numbers are reported to be living in care homes for older people, despite not necessarily being over 65 (Thompson 2001).

In contrast to the above, recent data suggest that the predicted rise in dementia may be less than anticipated (Matthews *et al.* 2013). This research assessed 7,635 people aged 65 years or older and found that younger cohorts have a lower risk of dementia than had previously been predicted.

---

4 Approximate proportions were: 40% independent, 40% long-interval dependent (i.e. requiring help less often than daily), 10% short-interval dependent (i.e. requiring help at regular times of the day) and under 10% critical interval dependent (i.e. requiring 24-care by formal and informal carers).

SCOPE AND METHOD OF THIS REVIEW

This review identifies and summarises a variety of evidence on managers of care homes for adults in England since 2000. The review was desk-based and used online literature search engines, website searches and a targeted call for evidence to identify and gather evidence available from a variety of sources. Box 1 provides details of the inclusion and exclusion criteria and Box 2 details of the search strategy and method used for selection.

A scoping methodology was used, which is an increasingly popular way of reviewing evidence (see Arksey and O'Malley 2005, Levac *et al.* 2010), as it provides a rapid way of mapping the current evidence based on systematic searches for relevant material without the need for quality appraisal. Recent examples of scoping reviews in the area of social care are Manthorpe and Moriarty's (2014) examination of day centre provision for older people using the Equality Act 2010 and Gridley *et al.'*s (2013) study of good practice in social care for adults with severe and complex needs.

Following scoping review methodology, a consultation exercise to inform and validate findings was carried out. Draft findings were presented to a Virtual Advisory Group consisting of 13 providers, umbrella organisations, residents of care homes and relatives and a community of practice for care home managers for comment in February 2014 (see Appendix for details of group membership).

Box 1: Inclusion and exclusion criteria

Inclusion criteria:

• Relating to England

• Published since the Care Standards Act 2000

• English language

• Managers of care homes, care homes with nursing and 'other' residential homes for adults of all ages, with or without mental health problems/illness

• Other UK and international literature – where findings are relevant to English regulatory frameworks.

Exclusion criteria:

• Adult placement homes/shared lives, extra care/sheltered housing, supported living services and children's homes.

Care Home Managers: a scoping review of evidence

Box 2: Details of information gathering and organising

Information gathering

Search terms used	'Care home manager', 'residential home manager', 'nursing home manager' 'residential care manager' and 'home manager'. Where there were few results, particularly when searching organisational websites, the terms 'social care', 'workforce' and "home' and 'manager" were also used.
Call for information (early December 2013)	Call for sources of information, including information about research in progress, and assistance by email and social media to networks, relevant organisations and key researchers/academic networks, and published on the Social Care Workforce Research Unit's web pages.

Searches (December 2013)

Nationally available data	Skills for Care, Care Quality Commission, Health and Social Care Information Centre
Structured search of databases	Web of Knowledge (MedLine, Science Citation Index, Social Sciences Citation Index, Conference Proceedings Citation), EBSCO, Applied Social Sciences Index and Abstracts, OvidSP/EMBASE, AgeInfo, National Institute for Health and Clinical Excellence's NHS Evidence, Cochrane Library, Social Care Online
Structured search of publication platforms	IngentaConnect, Wiley Online Library, JSTOR
Hand-searching of journals	Ageing and Society, Health and Social Care in the Community, Journal of Care Services Management, Journal of Nursing Management, Journal of Intellectual Disability Research, Nursing and Residential Care, Working with Older People
Internet searches	Using search engine Google Scholar Websites of organisations concerned with care homes and social care (My Home Life, Personal Social Services Research Unit, National Skills Academy for Social Care, Skills for Care, Age UK, The Tizard Centre, Joseph Rowntree Foundation, National Care Forum).

Method

In the first instance, the title and abstract/summary were read. Materials were saved where they appeared to be relevant to any of the research questions, and those obviously irrelevant based on the content of the title and abstract were discarded. If unclear whether potentially relevant, the full text was retrieved where possible and this was used to make a decision as to whether it should be included as potentially relevant. A record of each item retrieved was stored in EndNote bibliographic software. Following further review, materials were checked for relevant content, themes recorded and irrelevant literature discarded. Further material was accumulated by following up references, responses to the call for information (12) and individual contacts.

Care Home Managers: a scoping review of evidence

The extent and nature of the evidence

A plethora of evidence containing the search terms was identified (see Table 4). Scoping reviews generally encompass a broader range of evidence than systematic reviews (see Table 5 for a breakdown of evidence included in this review).

Table 4: Search results

Source	Total search results	Potentially relevant
Electronic databases and publication platforms	1,316	317
Hand searched journals		114
Websites		75
Total (before de-duplication)		506
Total number of sources identified (including searches, materials gathered from call for information and by following up references and contacts)	657	
Number of resources referred to in review	145 37 background/contextual/illustrative 108 evidence	

Table 5: Types of evidence referred to in review*

Type of material	Number**	Resident type	Number
Peer-reviewed journal	28	Older people/dementia	46
Government/government agencies	21	Learning disability	5
Sector reports	17	Physical disability	2
Professional press	11	Mental health	2
Commissions/reviews/inquiries	7	Not specified	60
Expert opinion	7		
Other	28		

* Some materials may derive from the same study

** Totals are greater than number of resources as some fitted more than one category

Care Home Managers: a scoping review of evidence

Of the relevant material identified and referred to here, it was notable that the number of reports was disproportionately high in comparison with journal articles. A good deal of material initially identified as potentially relevant was expert commentary or opinion pieces (which did not all cite sources for content) and management series articles in the professional press. 'New style' evidence, such as blogs, videos and internet pages, were also identified and referred to where appropriate. In order to address the research questions, secondary analysis (e.g. of National Minimum Data Set for Social Care data) was also carried out.

Table 6 gives further details of the research studies directly with or about care home managers which informed this review. Most informed more than one section in the review, and almost all were relevant to the section on challenges faced by care home managers. Several articles or reports had been published from most of the studies. The methods identified to study care home managers included literature reviews, action research, analysis of secondary data and the collection of primary data through interviews, observation, focus groups, surveys, and data from the piloting of training courses. However, most of the UK studies involving primary data were relatively small scale with the exception of My Home Life, a major programme funded by Age UK (formerly by Help the Aged), City University and Dementia UK. Those that focused on older people explored:

- leadership and quality (Owen *et al.* 2012a, Owen *et al.* 2012b);

- what residents want and what works well (National Care Homes Research and Development Forum 2007);

- motivations and perceptions of motivations of care home owners and managers (Kendall 2001, Matosevic *et al.* 2007, Matosevic 2008, Matosevic *et al.* 2008, Matosevic *et al.* 2011);

- dignity and the practice and training needs of the workforce around abuse, neglect and loss of dignity (Lupton and Croft-White 2013, Tadd *et al.* 2013);

- evidence to support improved care as the needs of older people intensify (Szczepura *et al.* 2008);

- operational challenges, links between type of ownership and management style and the characteristics of well- and poorly-managed homes (Chambers and Tyrer 2002, Chambers 2003a, Chambers and Tyrer 2003b).

Studies that focused on nursing homes and, therefore, are likely to be concerned with older people (but did not specify) explored:

- nursing home leadership style and its impact on staff and residents (Anderson *et al.* 2003);

- management education and practices and their impact on quality of care for residents and/or on staff turnover in nursing homes (Castle and Longest 2006, Castle *et al.* 2009, Donoghue and Castle 2009, Castle and Lin 2010, Castle and Decker 2011, Castle *et al.* 2014).

Care Home Managers: a scoping review of evidence

The studies in the last two bullet points listed above were carried out in the United States (US).

The remaining research investigated:

- how training for care home staff including managers can enhance the social care and health of residents, strengths/weaknesses of different approaches and the barriers/facilitators and challenges for future (Wild *et al.* 2010);

- registered managers' view of their careers, what support would be helpful for role, motivations, level of support received and appetite for further accreditation and education (National Skills Academy for Social Care 2012).

The bulk of relevant resources retrieved related to homes for older people, which may be a reflection both of the age profile of most care home residents and the shift towards supported community and independent living for people with disabilities aged under the state retirement age, and also of the proportion of provision for this group. Although there are three times more care homes than care homes with nursing, they each cater for approximately half of all care home residents, but those in homes with nursing have higher needs overall (and fees). Changing terminology has made it difficult to determine what the balance of evidence is relating to the different types of care home. Often, the literature does not distinguish between 'care homes' and 'care homes with nursing' (also noted by Szczepura *et al.*'s 2008 literature review), previously called residential and nursing homes. Of the relevant evidence that specified the type of home, 43 related to care homes, 15 to nursing homes and six to residential homes and some related to more than one type.

Many studies reported on specific interventions or initiatives that involved care home residents or staff, or were about care workers', residents' and relatives' views. In the absence of a large body of published work specifically about care home managers, these were useful in that some of their findings support the findings of the studies directly with or about care home managers, for example the importance of organisational culture in a care home, how a manager contributes to/creates a culture, or how managers can facilitate or obstruct developments/initiatives. Some of these studies are referenced in this review, but details not presented in tabular form. It was noticeable that where care home managers were not the primary object of the research, the search terms were excluded from the abstract.

Organisation of this review

As it aims to address several broad questions, each with several facets, this review has been constructed thematically and by type of evidence. Most sections start by presenting the findings of the studies outlined above. Where additional material has been identified as relevant, this is then summarised together with a short description of the type of evidence. Where other data (e.g. records held by Skills for Care) are the main source of evidence, these appear first. Some background has also been included to contextualise the evidence.

Strengths and limitations

This review is based on detailed searches of bibliographic databases, internet searches and analyses of secondary data. It was reviewed by members of an Advisory Group of experts in various fields who assessed it for completeness and highlighted areas that need further research. The study has identified the source and type of evidence and has drawn on a wide range of literature.

An important finding from this review is that comparatively more is known about those who manage care homes for older people than about other types of manager. Although, numerically, many more care home managers work with older people than other types of resident, it is possible that the discrepancy was widened by factors such as lack of attention to differing terminology in different sectors that meant that potentially relevant material was not retrieved. It seems far more likely that the experiences of managing a group care home for people with learning disabilities or mental health problems are under researched.

Another finding is the unspecific way in which 'managers' are referred to in articles and reports. Many referred to managers without qualifying if they were care home managers or another occupation, such as care managers. Accounts were often unclear about which managers had participated in studies and such materials were discarded.

A body of international material (Australia, USA, Sweden, Netherlands, Canada, Belgium, Italy – mainly journal articles) was generated by the search. However, most was not relevant, as it focused on residents (e.g. wellbeing, workforce qualities they value), clinical care and treatment (e.g. hip protectors and fractures, dental care, nutrition), practices (use of restraints, care planning), the rest of the workforce (e.g. nurses' views, knowledge or experiences, staffing or satisfaction), on space within care homes or relationships with/transfer from hospitals. A handful of the boxed examples are international (e.g. Astrom *et al.* 2004, Bostrom *et al.* 2012). That less evidence than expected was identified from Australia, where the system is closer to that of the UK than the US system, is likely to result from terminology differences. The relevant US literature was referred to, as it filled a gap in the UK evidence on qualifications and leadership.

This review focused specifically on managers' demographic characteristics, practice, experience and skills. As care home managers are so central to the business they manage, there is potential for new reviews that look more directly at the managerial contribution to quality of care or the role of relationship-based care.

Care Home Managers: a scoping review of evidence

Table 6: Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
My Home Life (MHL) – UK		
Owen and Meyer (2012a) Owen *et al.* (2012b)	To explore the lessons learnt from implementing best practice in care homes for older people and, in particular, to support the promotion of voice, choice and control and the development of leadership within the sector.	UK-wide three-year appreciative action research study. Over 250 care home managers were supported via its Leadership Support Programme, which used action learning sets.
National Care Home Research and Development Forum (2007) (sections: by Davies and Brown Wilson, Meyer, Dewar)	To identify what residents want and what works well in care homes.	Literature review.
Prevention of Abuse and Neglect in Institutional Care of Older Adults (PANICOA) programme – UK		
Lupton and Croft-White (2013)	PANICOA aim: to enhance the dignity of older people in institutional settings.	Summary of overall findings of 11 PANICOA studies.
Tadd *et al.* (2013)	To explore the needs, knowledge and practices of the care home workforce in relation to abuse, neglect and loss of dignity and to provide a preliminary evaluation of an evidence-based training package.	Postal survey of care workers (responses from 37 managers and 56 care workers). Ethnographic observation in 8 homes. Interviews with 33 care home staff in 8 homes. Validated questionnaires with 73 care home staff. Focus groups with care home managers (10), owners (6) and trainers, and members of the Relatives and Residents Association. Training materials piloted and evaluated in 7 care homes.

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Matosevic – England		
Matosevic (2008) Matosevic *et al.* (2007) Matosevic *et al.* (2008) Matosevic *et al.* (2011)	To examine: the main motivations of owners and managers of care homes for older people; local authority commissioners' perceptions of owners'/managers' motivations, and the level of agreement between owners'/managers' expressed motivations and commissioners' perceptions of those motivations; and changes in owners'/managers' motivations (1994–2003). To explore the commissioner-provider relationships and their possible effects on owners'/managers' motivations.	Data were collected from care home managers and owners in 2003, building on earlier data collected in 1994 and 1997 as part of a Dept. of Health-funded programme of research in PSSRU (see Kendall 2001 below). Participants were from 8 English local authorities (2 London boroughs, 3 Shire counties, 3 Metropolitan districts). Care-home managers/owners (n=58) were interviewed (9 LA managed, 21 voluntary/not for profit, 28 private/for profit). Of the 58 interviewees, 27 were from the original 1994 and 1997 samples. Ten commissioners from the 8 local authorities were interviewed. Where there were more than 2 for a local authority, joint interviews were carried out and treated as a single interview. Following the interviews, postal questionnaires were sent to interviewees to collect additional data (e.g. residents' funding sources, amount of time on dealings with local authority purchasers and inspectors). The response rate was 66% (n=38). Information about the personal motivations was gathered using a list of motives which, according to the social policy, sociology of professions and economic literatures, were likely to reflect the underlying motivations to be a care provider. Interviewees were presented with eight possible motives and asked to select which were personally relevant.

Care Home Managers: a scoping review of evidence

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Article based on earlier PSSRU and Nuffield Institute for Health studies (1994 and 1997) Kendall (2001)	To examine the motivations of providers of residential care for older people in England in 1994 and 1997.	Data were collected from care home managers and owners in 1994 and 1997 as part of a cluster analysis research study conducted by the Personal Social Services Research Unit. This article is based on data collected from 62 interviews carried out in 1994 and 53 in 1997 in a total of 40 homes in 8 English local authority areas. Owners of owner-managed private sector homes and managers of voluntary sector homes were interviewed.
National Skills Academy for Social Care – UK		
National Skills Academy for Social Care (2012)	With regard to registered managers, to explore: how they view their career in social care, and the changes required to better support them in their day-to-day roles; and their motivations for working in social care, the level of support and training they receive, their appetite for further accreditation and education, and the sector-wide changes they believe would have a tangible impact on their career.	Online survey sent to all managers registered with the Care Quality Commission – (n=c.17,500) – 16% response rate (n=2,886) and a series of follow-up focus groups with service providers and registered managers (n=36). Of these 2,922, 1,899 (65%) worked in residential care. Responses between registered managers in different settings were very similar.

Care Home Managers: a scoping review of evidence

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Chambers and Tyrer – England		
Chambers and Tyrer (2002) Chambers (2003a) Chambers and Tyrer (2003b)	To examine the key operational management challenges for people who own and/or manage nursing homes for older people. To identify the characteristics of well managed and poorly managed nursing homes. To explore whether the different patterns of ownership correspond with different styles of management. To explore the potential for innovation and excellence in this sector and how can it be released. To investigate whether nursing homes adequately resourced and if they should be used more by the NHS to ease pressures on hospitals. To consider how the National Care Standards Commission might influence improvements in standards.	Literature review. Interviews and focus groups with 46 stakeholders in the North West of England in 2001: residents (n=6), relatives (n=5), home owners (n=4), managers (n=10), managing director (n=1), social services staff (n=8) in Blackpool and Stockport; and health authority inspectors (n=12) across the North West.

Care Home Managers: a scoping review of evidence

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Wild and Szczepura – England		
Wild *et al.* (2010)	To consider how training care home staff (towards extended care roles and/or new clinical roles) can enhance social care and the health of older people in residential homes in England.	Three-year study of enhanced care approaches in three residential homes in England – one voluntary sector, one privately owned and one local authority – with 119 older residents. A comparator nursing home (32 residents) was used to benchmark some activities.
	To identify the strengths and weaknesses of different approaches.	Data gathering was in several stages and involved interviews (total 108), two surveys and focus groups. National and local stakeholders, residential home managers, care staff (n=56), and older residents and their relatives participated. Managers and care staff were interviewed repeatedly to identify impact over time.
	To identify barriers and facilitators.	
	To identify challenges for the future.	
Szczepura *et al.* (2008)	To identify research evidence to support improved care in residential care homes as the needs of older people intensify.	Literature review that underpinned Wild et al.'s research (see above).
Anderson *et al.* – USA		
Anderson *et al.* (2003)	To test hypotheses about the relationship between management practices and resident outcomes.	Cross-sectional, correlational, field study using primary data from directors of nursing and registered nurses in 164 nursing homes (via self-report surveys onsite) and secondary data from Medicaid Cost Reports and the Texas nursing home Minimum Data Set (MDS).

Care Home Managers: a scoping review of evidence

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Castle *et al*. – USA		
Castle *et al*. (2014)	To examine the associations between long-term care administrators' education and quality of nursing home care is examined.	Information collected from 3,941 administrators was matched with secondary data, including Nursing Home Compare (a government site that holds quality of care information about all Medicare and Medicaid-certified nursing home in the USA); an online survey, certification and reporting data; and the Area Resource File. The quality indicators were examined (restraint use, catheter use, inadequate pain management, low-risk residents with pressure ulcers, and high-risk residents with pressure ulcers).
Castle and Decker (2011)	To examine the association of nursing home manager leadership style and Director of Nursing leadership style with quality of care.	Leaders were categorised into 4 groups: consensus managers, consultative autocrats, shareholder managers, or autocrats. This leadership style assessment came from primary data collected from approximately 4,000 managers and Directors of Nursing and these data were linked to quality information and nursing home information.
Castle and Lin (2010)	To examine the direct and indirect relationships among top management turnover, the number of staff, the types of staff, and the quality indicators.	Primary data were collected from 2,840 nursing homes, and 14 quality indicators came from the Nursing Home Compare. Structural equation modelling methods were used to model direct and indirect relationships.

Care Home Managers: a scoping review of evidence

Table 6 (continued): Summary of key research studies about/with care home managers

Author Date Source	Aims	Type of study
Donoghue and Castle (2009)	To examine the associations between nursing home manager leadership style and staff turnover.	Data from a survey of 2,900 nursing home managers conducted in 2005 were analysed. A general linear model was used to estimate the effects of NHA leadership style, organisational characteristics, and local economic characteristics on nursing home staff turnover for registered nurses, licensed practical nurses and nursing assistants.
Castle *et al*. (2009)	To examine the impact of top management in nursing homes	Review of 13 empirical research articles published during the previous 18 years (1990–2008) that examined the impact of nursing home top management and previous research examining how turnover, tenure, and professional affiliation of nursing home top managers influenced outcomes, such as deficiency citations, quality indicators, and turnover.
Castle and Longest (2006)	To examine the association between deficiency citations for poor management practices and quality of care.	Data from the 1996–2004 Online Survey, Certification And Recording (OSCAR) data was used representing approximately 17,000 facilities per year.

LEGAL STATUS OF CARE HOME MANAGERS

Accommodation provision for people who require nursing or personal care, for people who require treatment for substance misuse, for the treatment of disease, disorder or injury and for those who need assessment or medical treatment after being detained under the Mental Health Act 1983 is a regulated activity.[5] Under the Health and Social Care Act 2008, all regulated activities are required to have a registered manager. Care home managers must, therefore, register with the regulator, CQC.

No fees are charged to become a registered manager and a person applies for their own registration. Registration can be cancelled by the registered manager or by the CQC, but not by a provider or employer. A person may be registered as manager for more than one regulated activity, may be responsible for more than one location and may apply to manage regulated activities at different locations for more than one provider. Separate applications are required for each provider and registration is linked to the registration of the provider. If a regulated activity is managed through a job-share arrangement, both managers need to register.

The CQC aims to complete the process from validation of a completed application to serving a Notice of Decision (including an electronic certificate and registration number) within eight weeks:

> In most cases, a provider will need to have one or more registered managers. As a registered person, they have legal responsibilities in relation to that position. A registered manager shares the legal responsibility for compliance with the regulations with the provider … After registration, a registered manager has a role in enabling and monitoring compliance with essential standards across your regulated activities (CQC 2013a).

Where ultimate responsibility lies appears to have been the topic of some concern. The Independent Commission on Dignity in Care (2012) asserted that:

> boards and management teams have ultimate responsibility for the provision of dignified care in their organisation. If that is not happening, they are failing in their legal and moral duties to those in their care (p.19).

In this regard, the CQC's proposed changes to the regulatory system include improved lines of accountability indicating:

> we will introduce a better system for providers applying to register with us to provide care. We will do this by making sure that … named directors or leaders of organisations are personally held to account for that commitment. This is in addition to making sure providers and registered managers are held to account for the care they provide (CQC 2013b, p.11).

---

5 Another regulated activity is personal care.

Care Home Managers: a scoping review of evidence

Over the last few years, it has become apparent that not all care homes have a registered manager. Data disclosed to Action on Elder Abuse in 2011 by the CQC under a Freedom of Information Act 2000 application showed that 2,200 care homes in England did not have a registered manager (Takatsuki 2011). Some providers reported delays of more than five months for registration to be processed, although this was partly due to the eight-week timescale set by CQC, which they could not meet (Takatsuki 2011). The Registered Nursing Homes Association (RNHA 2013) is of the view that eight weeks from notification of appointment to official registration is too long. With 200 applications a week being received by the CQC (RNHA 2013), an eight-week wait results in around 1,600 care home managers being in post but not yet officially registered.

The CQC Board was made aware of the scale of the problem when a report presented to its September 2013 meeting revealed that, in June 2013, more than 3,900 care homes were without a registered manager, notably, that a quarter of these had not had one in place for more than two years (Calkin 2013, Donnelly 2013). It appears that this number includes all registered homes and not just those for adults.

Around one in eleven care homes for adults do not have a registered manager. CQC (2014c) data showed that, on 13 February 2014, 2,018 care homes for adults were without a registered manager. Almost a quarter of these (24%, n=486) had been without a registered manager for two months or less, which equates to the eight-week timescale set by CQC. Almost a quarter (22%, n=445) had been without one for two years or more. Fifteen per cent (n=307) had been without a registered manager for three years or more. These figures do not include NHS/healthcare sector homes which account for 0.7% (n=121) of all care homes for adults.

The CQC has announced that it will be cracking down on persistent offenders and its Chief Executive has recognised that 'homes without registered managers have very high levels of non-compliance. It is not acceptable to run a home without a registered manager in place and to do so will result in a sanction, such as a fixed penalty notice, a caution or prosecution (Calkin 2013, Donnelly 2013). The CQC's proposed changes to the monitoring, inspection and regulatory system include a commitment to taking tougher action, such as prosecution of services without a registered manager (CQC 2013b).

NUMBERS OF CARE HOME MANAGERS

CQC (2014b) data showed that, on 13 February 2014, there were 14,432 registered managers[6], the majority (91%, n=13,174) of whom were registered to manage one home.

Some were registered for two (7%, n=1,056) or three homes (1%, n=160) and a tiny minority (0.29%, n=42) managed four to seven homes. Homes owned by individuals, sole traders or partnerships (2,293 locations) accounted for 15% (n=2,197) of all managers. Of this group, most (96%, n=2,112) were registered for a single home, accounting for 14.6% of all registered managers. See Table 7 for further details. Further analysis of CQC data would be needed to ascertain how many managers are registered for the various types of home and resident groups.

Table 7: Numbers and types of homes managed (CQC 2014b)

Number of homes	Number of managers	Percentage of managers
1	13,174	91%
2	1,056	7%
3	160	1%
4	28	0.19%
5	8	0.06%
6	5	0.03%
7	1	0.01%
Ownership type		
Individual, sole trader or partnership	2,197	15.2%
Single home	2,112	14.6%

---

6 Due to the way the data was interrogated, it is possible that there may in some cases be two or more different registered managers with the same name who would, therefore, be presented as a single individual.

Care Home Managers: a scoping review of evidence

The CQC holds basic data about who are the registered managers of care homes. More data is available from Skills for Care's National Minimum Data Set for Social Care (NMDS-SC), an online data collection system for the social care sector, which describes itself as the recognised leading source of robust workforce intelligence for adult social care (Skills for Care 2014b). Social care providers can register and maintain their information via an online portal. Data collected are the most detailed available on the social care workforce. The NMDS-SC currently holds data on approximately 700,000 workers from 25,000 providers for a variety of client groups (Skills for Care 2014c), but this is set to increase as, from September 2014 onwards, local authorities (but not other sectors) are required to complete a NMDS-SC return and provide data on at least 90% of their workforce.[7]

Data presented below – and in the sections 'Who are care home managers?' and 'Skills, qualifications and background' – on the characteristics of registered managers of care homes have mainly been taken from the NMDS-SC and from reports informed by it. The NMDS-SC holds data on 7,837 registered managers of care homes, care homes with nursing and 'other residential' homes.[8] Given that there are 17,350 registered care homes, it should be noted that the data is partial as it represents around 45% of the total provision.[9]

Data on registered managers in England whose data are held in the NMDS-SC are broken down by type of home and provider in Table 8.

Table 8: NMDS-SC records for registered managers (January 2014) (Skills for Care 2014a)

	Care home without nursing	Care home with nursing	Other adult residential	Total	
Private	4,052	1,614	208	5,874	74.9%
Voluntary/third sector	1,060	234	72	1,366	17.4%
Statutory (LA owned)	285	27	22	334	4.3%
Statutory: health	9	5	1	15	0.2%
Other	160	66	22	248	3%
Total	5,566	1,946	325	7,837	

---

7 Further information www.nmds-sc-online.org.uk/content/view.aspx?id=LA%20Adults

8 'Other residential homes' does not include shared lives (adult placement) services, sheltered housing, extra care housing or supported living services. Other types of residential provision for older people and adults aged 18+ include, for example, residential respite care if not part of a regulated service, and various types of hostels.

9 Assuming only one registered manager per care home.

TURNOVER, VACANCY RATES AND PAY

There is a higher turnover among managers of care homes with nursing, which generally have more residents and pay their managers around 30% more than other types of care home (see Table 9).

Table 9: Length of time in current role, turnover, vacancy and pay (Skills for Care 2014a)

	Care home without nursing	Care home with nursing	Other adult residential	Overall total	
Length of time in current role					
Number of records	4,330	1,620	271	6,221	
25 years or more (before 1990)	8.2%	3.8%	3.7%	427	6.9%
15–24 years (1990–1999)	21.3%	14.8%	20.3%	1,217	19.6%
10–14 years (2000–2004)	20.7%	16.2%	19.6%	1,212	19.5%
4–9 years (2005–2010)	32.2%	32.3%	39.5%	2,025	32.5%
3 years or less (after 2010)	17.6%	32.8%	17%	1,340	21.5%
Turnover rates					
Registered manager	11.3%	17.1%	11.4%		
Senior care worker	14.1%	14.3%	11%		
Care worker	23.7%	30%	15.6%		
Vacancy rates					
Registered manager	1.2%	2.1%	0.3%		
Senior care worker	2.1%	1.5%	2.6%		
Care worker	3.2%	3.7%	3.7%		
Pay					
Number of records (only those updated in last 12 months)	1,298	387	68		
Median annual pay	£28,500	£36,923	£27,634		

NMDS-SC figures for January 2014 show an annual turnover rate of 12.7% for registered managers across care homes for adults (Skills for Care 2014a). Homes with nursing experience a higher turnover rate of registered managers (17.1%) than homes without nursing (11.3%) and other adult residential homes (11.4%). This pattern is repeated for vacancy rates which were 2.1%, 1.2% and 0.3% respectively.

Around a quarter (26.5%) of registered care home managers have been in their current role for at least 15 years (7% for 25 years or more) and around one fifth (21.5%) for three years or less. Far more managers of homes with nursing have been in their current role for three years or less (33%) compared with managers of homes without nursing (18%) and other residential homes (17%). Far more managers of homes without nursing have been in their current role for 25 years or more (8%) compared with homes with nursing (4%) and other residential homes (4%).

The median annual pay for registered managers across social care services is £30,000. Median annual pay for managers of care homes with nursing is £36,923, £28,500 for managers of care homes without nursing and £27,634 for managers of other residential homes (Skills for Care 2014a).

Care Home Managers: a scoping review of evidence

'WHO' ARE CARE HOME MANAGERS?

Demographic profile

Registered managers of care homes in England whose details are recorded on the NMDC-SC (Skills for Care 2014a) are not a diverse group in terms of ethnicity (80% white[10]), nationality (87% British) and gender (84% female).

Around one-third (33%) of managers are fewer than ten years away from state pension age and just under one third are aged under 45. Almost three quarters (72%) of those who manage care homes with nursing and around two thirds (65%) of those who manage care homes without nursing are aged 45–64 years. Managers of other residential homes are slightly younger, with around two thirds (64%) aged 35–54. Overall, 5% are aged over 65, 28% are 55–64, 38% are 45–54, 21% are 35–44, 7.2% are 25–34, and 0.05% are aged 24 and under.

Only 1% of registered managers across social care services reports having a disability. Within care homes, the figure is 1.3% in those without nursing, 0.8% in those with nursing and 1% in other adult residential care services.[11]

Further details of this demographic data are presented in Table 10.

Smith *et al.*'s (2007) study of overseas-trained health professionals working in the NHS and nursing homes (n=93) reported anecdotal evidence that people from African-Caribbean backgrounds were more successful in terms of promotion than people from African backgrounds, but there was no statistical evidence to support this perception. The data on ethnicity on registered managers of care homes, available from the NMDS-SC includes these groups under one category, 'Black/African/Caribbean/Black British', which means that more detailed analysis of ethnicity is necessary, drawing on specific records if we are to have greater knowledge of possible ethnic influences. Focusing on British black and minority ethnic (BME) nationals (not migrants), Hussein *et al.* (2014) explored the relationship between ethnicity and employment in the social care workforce in England using NMSD-SC data. They found fewer Black British UK citizens were working in the social care sector than previously assumed and argued that ethnicity and migration status should be distinguished.

---

10 Compared with 68% of the entire care home workforce (ethnicity of 17% is unknown).

11 Based on a total of 6,363 registered care home manager records.

Table 10: Demographic data about registered care home managers (Skills for Care 2014a)

	Care home without nursing	Care home with nursing	Other adult residential	Total	
Gender					
Number of records	4,415	1,654	280	6,349	
Female	83%	87.1%	80%	5,329	83.9%
Male	16.9%	12.4%	19.3%	1,007	15.8%
Unknown	0.1%	0.5%	0.7%	13	0.2
Age					
Number of records	4,369	1,625	268	6,262	
24 and under	0%	0.1%	0.4%	3	0.05%
25–34	8.1%	4.1%	10.1%	448	7.2%
35–44	22%	17.5%	30.2%	1,325	21%
45–54	37.3%	40.1%	34.3%	2,372	37.9%
55–64	27.4%	32.2%	21.3%	1,779	28.4%
65 and over	5.2%	6%	3.7%	335	5.3%
Ethnicity					
Number of records	4,237	1,424	259	5,920	
White	80.7%	75.6%	84.2%	4,715	79.6%
Mixed/Multiple Ethnic Group	0.8%	0.9%	0.8%	48	0.8%
Asian/Asian British	3.7%	4.4%	1.2%	223	3.8%
Black/African/Caribbean/Black British	3.8%	4.3%	4.6%	233	3.9%
Other	0.6%	1%	0.8%	42	0.7%
Not known	10.4%	13.8%	8.5%	659	11%
Nationality					
Number of records	3,770	1,397	221	5,388	
British	88.9%	80%	91%	4,668	86.6%
EA (Non-British)	2.1%	2.1%	4.1%	120	2.2%
Non-EEA	3.2%	4.9%	3.2%	197	3.7%
Non-British (not known)	0.7%	1.1%	0.9%	45	0.8%
Unknown	5.1%	11.8%	0.9%	358	6.6%

Care Home Managers: a scoping review of evidence

What motivates care home managers?

Research suggests that, regardless of sector, care home managers are often dedicated individuals who are motivated by a sense of caring and the need for professional accomplishment and who feel that their motivations are sometimes misunderstood by commissioners, which could impact on the potential for building trusting relationships.

A recent survey of, and focus groups with, registered managers (n=1,899; 65% of the 2,886 respondents managed care homes) reported that their career choice had resulted from a strong desire to care for others and to improve the quality of life of their residents (National Skills Academy for Social Care 2012).

A decade ago, participants in Matosevic's earlier study of the motivations of managers and owners of care homes for older people declared themselves to be highly motivated, committed and passionate individuals (see Matosevic *et al.* 2007, Matosevic 2008, Matosevic *et al.* 2008, Matosevic *et al.* 2011). The study built on and encompassed the results of earlier work in the same eight local authority areas, carried out in 1994 and 1997 by the Personal Social Services Research Unit (PSSRU) and the Nuffield Institute for Health. In 2003, Matosevic interviewed commissioners from each of the local authority areas and 58 care home managers and owners from local authority managed (n=9), voluntary sector (n=21) and private sector homes (n=28). Of these, 27 were from the original samples. Interviewees were presented with eight possible motives and asked to select which were personally relevant. A survey of the home owners/managers provided supplementary data. Matosevic concluded that motivations, the dimensions of which grouped as follows, had remained relatively constant over time (1994–2003):

- professional (development and use of skills and expertise; professional accomplishment);

- client-specific caring (meeting the needs of older people; duty to society; independence and autonomy);

- client-generic caring (duty to society); and

- financial (profit maximising; achieving satisfactory levels of personal income).

Meeting the needs of older people was cited as a main motivation by 93% of owners and managers participating in this study.[12] This was closely followed by professional accomplishment (85%) and the development and use of skills and expertise (81%). Other motivations were: achieving a satisfactory level of personal income (72%), independence and autonomy (62%), a sense of duty to a particular sector of society (50%) or society as a whole (31%), and income and profit maximising (12%) (Matosevic *et al.* 2007, Matosevic 2008).

---

12 Matosevic's study was about the motivations and perceived motivations of owners/managers of homes for older people.

Care Home Managers: a scoping review of evidence

While significant differences in overall motivations over time (1994, 1997 and 2003) were not identified, some changes were noted. In all three years of data collection, meeting the needs of older people was cited as an important motivation (89% in 1994 and 1997; 92% in 2003), as was professional accomplishment (73% in 1994 & 2003, and 89% in 1997). Profit maximisation was the least cited motivating factor (12% in 1994 and 2003; 8% in 1997), although it is important to note that only 28 of the 58 participants were in the commercial sector. Motivating factors that became more prevalent from 1994 to 2003 were:

- developing skills and expertise (from 54% to 77%);

- achieving a satisfactory level of personal income (from 62% to 73%);

- independence and autonomy (from 42% to 62%); and

- duty to society as a whole (from 23% to 46%) (Matosevic 2008, Matosevic *et al.* 2011).

Important factors for job satisfaction included the provision of good quality care (98%), using and developing skills in daily work (92%), working with capable care staff (90%), having a good reputation among other providers of care homes (88%) and career development (56%) (Matosevic *et al.* 2007, Matosevic 2008).

Earlier studies identified other motivating factors. The most commonly reported reasons for opening and running a home among owners participating in Peace and Holland's study of small homes with less than four residential places (beds) were financial gain, control over the work environment and ability to work from home (Peace and Holland 2001).

Based on interview data from the 1994 and 1997 PSSRU's studies (which Matosevic's doctoral work later built on), Kendall (2001) reported that the motivations of care home providers were broader than the 'knights' (public spirited altruists) and 'knaves' (self-interested) categories described by Le Grand (1997) in his article about human motivation and behaviour. Kendall categorised care home managers in a typology of 'empathisers' (knights) who prioritised meeting the needs of older people in their care, 'income prioritisers' (similar to knaves) who attached particular importance to achieving a satisfactory level of income and a new category of 'professionals' who valued professional accomplishment and the development of skills. Independence and autonomy as motivators were consistently in the top four, labelled as 'mercantile' motivators. He observed that these motivators were not mutually exclusive, but existed alongside each other.

It is worth alluding to the potential for tensions. Differences between the motivations of owners, managers and owner-managers were not drawn out in Matosevic's and Kendall's studies which analysed data collected about owners and managers together as one group.

Andrews and Kendall's (2000) research study of 105 nurses who left employment in the NHS to open and run care homes in Devon found that the most common reasons for opening and running a home were to manage one's own business and achieve job

autonomy. This was at the time of closure of long-stay hospitals – many of whose patients were moved to care homes. Following these motivations was caring. Financial reasons were less frequently cited than other motivations. These independent sector providers' motivations were primarily empathetic, with professional motivations coming second and income prioritisation third.

Sector differences and similarities

Across all sectors, motivations were substantially altruistic, and professionalism was the primary motivator for participants in Matosevic's study. There were only small differences between sectors. Private (commercial) sector providers were most likely to have professional motivations and had the highest financial motivations score. Voluntary sector providers expressed greater client-specific motivations while local authority providers were more likely to express client-generic caring motivations (Matosevic *et al.* 2007, Matosevic 2008).

There was only one statistically significant difference between the private and voluntary sector providers: independence and autonomy were expressed motivations for 36% in the voluntary sector but for 87% in the private sector (Matosevic *et al.* 2008).

From 1994 to 2003, both private and voluntary sector providers interviewed became more motivated by developing skills and expertise, rising from 47% to 73% and 63% to 82% respectively. Achieving a satisfactory level of personal income rose in importance from 46% to 73%, the same level as for private sector providers across all three years. Meeting the needs of older people remained at 100% for those in the voluntary sector and increased from 80% to 87% among those in the private sector (Matosevic 2008, Matosevic *et al.* 2011).

Commissioner perceptions

In the eight study site areas, Matosevic also explored commissioners' perceptions of care by home managers and owners that, she considered, could potentially affect the relationship between the two groups. Three quarters (n=6) of the commissioners regarded provider motivations as important in the development of their local authorities' commissioning strategy.

Both the development of skills and expertise and independence and autonomy in running a home were far more important to providers than commissioners perceived them to be. While profit-maximisation was the reported lowest motivator for providers, commissioners perceived it to be their principal motivator. Statistical analysis revealed that perceptions of profit-maximisation and meeting the needs of older people as motivations both negatively affected the quality of commissioner-provider relationships (Matosevic 2008, Matosevic *et al.* 2008). This a key point as it has potential implications for providers and managers. Despite professionalism being reported as the primary motivator by care home managers/owners in her study, none of the commissioners interviewed perceived care home managers'/owners' first-ranked motivation to be professional accomplishment, although they did consider it to be important. Matosevic (2008) mooted that if

commissioners were to perceive care home managers/owners as professionals, they would be more likely to be trusting in their relationships with them and involve them more in care planning, for example.

Personal qualities needed

Care home managers suggest that they need a wide range of personal qualities to manage a care home successfully.

Through interviews and focus groups with 46 stakeholders (6 residents, 5 relatives, 4 home owners, 10 managers, 1 managing director, 8 social services staff and 12 health authority inspectors) in the North West of England, Chambers and Tyrer (2003b) found that:

- a high level of emotional intelligence was reported to be needed to intuitively empathise with residents, relatives and staff;

- approachability, informality and warmth were deemed crucial;

- managers needed to be strong characters, and resolute; and

- managers needed to be able to 'switch off' when not at work so that they would feel sufficiently rested and refreshed to carry out the role.

Having 'the right attitude' and genuinely caring for others were considered to be necessary in the PSSRU study: 'As one provider noted, you cannot care for people unless you care about people' (Matosevic *et al.* 2007, p.121, Matosevic 2008).

According to Burton, an expert commentator on management and practice with experience as a care worker, a manager, inspector, trainer, supervisor, consultant and head of a providing organisation, clear-sightedness and determination will stop a care home manager from allowing secondary issues to take priority over a care home's primary task of being caring and homely (Burton 2012).

Addison and Bunce (2013), both care home managers, argued that passion and empathy help a manager to understand the challenges they face and how best to motivate and encourage; and for residents, to best understand how to give them the highest possible quality of life. Their experience is that fulfilling the role of nurturing and maintaining staff morale requires considerable inner strength.

THE ROLE AND RESPONSIBILITIES OF THE CARE HOME MANAGER

Three influential bodies have described the role of a care home manager.

The regulator of social care, the CQC (2013a), stated that:

> A registered manager is the person who is in day-to-day charge of one or more regulated activity or activities…. After registration, a registered manager has a role in enabling and monitoring compliance with essential standards across your regulated activities. This link to the regulated activities means that the registered manager should not be viewed simply as an administrative management role.

Rouse (2013), the Director General for Social Care, Local Government and Care Partnerships at the Department of Health, said that:

> Registered managers are the pivot point between leading and inspiring the staff team to deliver great care and the day to day management of their service. Concentrating on the needs of people who use the service, managing the budget, dealing with staff issues, talking to families and friends, all this and more is required of registered managers on a daily basis.

The government funded National Skills Academy for Social Care (2012) asserted that:

> Registered Managers play a vital role in adult social care. As the lead professionals in most care settings, they not only interact with people who use services, but also help shape the way in which this support is delivered by their organisations, and influence the standards and regulations to which social care is expected to adhere (p.1).

Studies with care home managers have shown that the multi-faceted nature of their role involves balancing their 'managerial responsibilities with their desire to interact with and care for the people who are under their stewardship' (National Skills Academy for Social Care 2012, p.7; see also Chambers and Tyrer 2002, Chambers 2003a, National Skills Academy for Social Care 2012, Owen *et al.* 2012a). This means focusing on both the detail and the bigger picture and has been described as a balancing act between strategy and operations, internal procedures and external relationships, people and processes, direction and support (Chambers and Tyrer 2002, 2003b). Chambers and Tyrer's study of key operational management challenges for people who own and/or manage nursing homes for older people involved 46 stakeholders (residents, relatives, home proprietors, managers, social services staff and inspectors) in the North West of England.

It has been suggested that the role of the care home manager has changed considerably over recent years (Matosevic *et al.* 2007, Matosevic 2008). A more structured training pathway has been created and the job has become more business-focused with the balance of work moving away from caring provision (direct interaction with residents and

family members, care staff and local authorities concerning residents' welfare) to non-caring duties (remaining work including managerial and administrative tasks). Matosevic *et al.* (2007) found that, on average, more than half of a manager's time was spent on the latter: 51% in privately-owned homes, 59% in local authority homes and 60% in voluntary sector homes:

> It is likely that the relatively high intrinsic value attached to professional motivations enabled the providers to adapt to the changing nature of work. There was also a sense that a majority enjoyed these new responsibilities, partly because they increased the opportunities for professional development (p.123).

The studies referred to above identified the same elements of the role as those set out in a practice guide produced by the Social Care Association (SCA) (2011) as part of a joint campaign with the Association of Care Managers to enhance recognition for registered managers' leadership role in developing residential care. It stated that a

> Registered Manager is the key person who brings together all the elements of a happy and positive place to live. Registered Managers are the most influential people in determining the professional practice and atmosphere in a home. They are also the lead professional responsible for the quality of the care provided and the performance and standards of the workforce (p.34).

The Registered Manager of a care home is responsible to the regulatory body for the social care provision being managed by him/her. Their responsibilities are detailed in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (HM Government 2010a). Participants in Chambers and Tyrer's study of nursing homes, participants in the My Home Life appreciative action research programme, registered managers involved in the National Skills Academy for Social Care's research and the Social Care Association also identified various elements of the role. These are listed below, preceded by the legal responsibilities set out in boxes. For the purposes of this review, these have been grouped as follows:

- management of day-to-day operations;

- involving families and residents;

- external relationships;

- clinical and/or care;

- business strategy and management;

- leadership and culture;

- other.

It is notable that the elements identified under the groupings 'business strategy and management' and 'leadership and culture' are not reflected in the legal responsibilities.

Management of day-to-day operations

Compliance with regulations

Safety and suitability of premises

Complaints

Records

Safety, availability and suitability of equipment

Safeguarding service users from abuse

Staffing: ensuring that sufficient numbers of suitably qualified, skilled and experienced persons are employed

Supporting workers: providing appropriate support in relation to their responsibilities to enable them to deliver care and treatment safely and to an appropriate standard, including by (i) receiving appropriate training, professional development, supervision and appraisal, and (ii) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform.

(HM Government 2010a)

- To direct day-to-day operations (Chambers and Tyrer 2002, Chambers 2003a, Owen *et al.* 2012a; Owen *et al.* 2012b);

- To monitor organisational structure, provision and quality assurance (Owen *et al.* 2012a, Owen *et al.* 2012b);

- To develop and maintain operational policies, procedures and guidelines relating to the multiple agencies with which care homes are engaged (Owen *et al.* 2012a, Owen *et al.* 2012b);

- To ensure adherence to the legal implications of contracts and employment (Owen *et al.* 2012a, Owen *et al.* 2012b) and, to do so, to keep their knowledge up-to-date with regard to the relevant legislative and regulatory frameworks, particularly those related to quality and care home regulations, but also of responsibilities under the health and safety legislation, environmental health and employment legislation at a basic level (Chambers and Tyrer 2002, Chambers 2003a);

- To manage risks and safeguarding (Social Care Association 2011);

- To carry out/oversee facilities and stock management, maintenance, purchasing and supplier management (Social Care Association 2011, Owen *et al.* 2012a, Owen *et al.* 2012b);

- To recruit, manage, retain, reward, develop, support, supervise and deploy a staff team of an adequate number ((Chambers and Tyrer 2002, Chambers 2003a, Social Care Association 2011). Supporting care workers to meet the needs of residents involves

ensuring they are suitably trained and that there are opportunities for care workers to form relationships with individuals (Social Care Association 2011).

Involving residents and families

> Respecting and involving service users.
>
> (HM Government 2010a)

- To promote effective communication with residents and their families and to relate to residents (Chambers and Tyrer 2002, Chambers 2003a, Social Care Association 2011);

- To implement systems and processes that support individual choice and control (Social Care Association 2011) and encourage residents and families to be involved and express views (Chambers and Tyrer 2002, Chambers 2003a).

External relationships

> Cooperating with other providers.
>
> (HM Government 2010a)

- To promote effective communication with external partners/agencies and the local community (Social Care Association 2011);

- To develop and maintain good, open relationships and communication channels with individuals and with agencies and organisations in health and adult services (e.g. commissioners and inspectors – the latter are with CQC), including developing networks outside their homes (Chambers and Tyrer 2002, Chambers 2003a, National Skills Academy for Social Care 2012).

Clinical and/or care

> Assessing and monitoring the quality of service provision
>
> Care and welfare of service users
>
> Cleanliness and infection control
>
> Management of medicines
>
> Meeting nutritional needs.
>
> (HM Government 2010a)

Care Home Managers: a scoping review of evidence

- To be responsible for the care of residents (National Skills Academy for Social Care 2012);

- To ensure that good nursing care is provided (Chambers and Tyrer 2002, Chambers 2003a);

- If responsible for clinical care, to ensure that they are up-to-date with current nursing practice and quality improvement policies such as clinical governance (Chambers and Tyrer 2002, Chambers 2003a);

- To be a clinician (Chambers and Tyrer 2002, Chambers 2003a, Owen *et al.* 2012a, Owen *et al.* 2012b) or an expert practitioner in social care (Owen *et al.* 2012a, Owen *et al.* 2012b).

Business strategy and management

- To secure value for money, preferably making a return on investment (Social Care Association 2011);

- To work to a realistic business plan, develop and maintain the financial viability of their home and achieve high bed occupancy (Chambers and Tyrer 2002, Chambers 2003a);

- To carry out marketing (Chambers and Tyrer 2002, Chambers 2003a, Social Care Association 2011) while carefully planning admissions to ensure that resident needs can be met within the statement of purpose (Social Care Association 2011);

- To manage the budget and other resources to ensure that plans can be achieved, implementing systems to monitor progress (Social Care Association 2011);

- To ensure there is investment in continuing professional development (Social Care Association 2011).

Leadership and culture

- To be a visionary, inspirational and relational leader who shares their vision and works together to deliver it (Social Care Association 2011, National Skills Academy for Social Care 2012, Owen *et al.* 2012a, Owen *et al.* 2012b);

- To be an innovator and creative leader of change (Owen *et al.* 2012a, Owen *et al.* 2012b);

- To be visible, being regularly seen around the home by staff and residents rather than being hidden behind an office door (Social Care Association 2011);

- To create of an ethos and culture that enables people to exercise control and choice, in which residents are treated with dignity and respect and as individuals and in which staff are free of bullying by management (Social Care Association 2011) and to develop and maintain relevant policies (Chambers and Tyrer 2002, Chambers 2003a);

- To set an example (Social Care Association 2011), modelling the behaviour they expect from staff in their interactions with the broader community of the home, particularly important in communicating an ethos of positive risk-taking (Owen *et al.* 2012a, Owen *et al.* 2012b) and championing values and principles, such as equality, diversity and inclusion, including challenging discriminatory or exclusive practice (Social Care Association 2011).

Other

Further unseen and generally unacknowledged elements of role (Owen *et al.* 2012a, Owen *et al.* 2012b) consist of being:

- first point of contact for emergencies or out of hours issues;

- advocate, negotiator and mediator;

- emotional supervisor, mentor and 'counsellor' to residents, relatives and staff; and

- intuitive and flexible problem solver.

According to the Cavendish Review (2013), an independent review into the work of healthcare assistants and support workers in the NHS and social care settings also explored leadership, management and supervision:

> the role of the first line manager – whether a ward sister, midwife or community lead, or registered manager in a care home – is critical to ensuring that workers are properly valued, supervised, and held to account (p.65).

The review was set up in the context of the Francis inquiry report on Mid-Staffordshire NHS Hospital (Francis 2013).

Records of calls to The Relatives & Residents Association's Helpline suggest that there may be some lack of clarity, or concern, with regards to the care home manager's role and responsibilities and its fulfilment. Approximately half (51%) of the issues discussed with callers between July and September 2013 were directly linked with managers' core responsibilities with respect to their registration requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Greenidge – The Relatives & Residents Association 2014). Although most calls to the Helpline are from residents, relatives and friends of older people in residential care, calls are also received from care home staff and managers. Issues discussed relating to care home management were staff shortages (n=44), staff training (n=18), access to records (n=10) and general management issues (n=65). Staff attitudes accounted for 14 discussions. Topics relating to concerns about care provided included standards/quality (n=64), safety/risk (n=54), review/assessment (n=24), medication (n=20), medical (n=11) and multiple concerns (n=150). Human rights of residents (n=68), of relatives (n=55), human rights complaints against the home (n=36) and abuse (n=55) were also the subject of calls. Issues around daily life within the care home included the ethos/ambience of the home (n=6), mealtimes/food (n=10) and activities (n=13).

> **Box 3: Examples of the care home manager's centrality to culture and ethos**
>
> Racial discrimination: promotion was seen to be unlikely for overseas-trained healthcare professionals; race was often viewed as the culprit regardless of the circumstance of a problem; and managers did not provide support. Conclusion: care home managers must ensure that procedures are clear and enforced (Smith *et al.*'s 2007 study of overseas-trained healthcare professionals working in the NHS and nursing homes; also see Stevens *et al.* 2011)
>
> Sexuality: open cultures in which sex and sexual orientation can be discussed openly by staff, residents and visitors are facilitated by appropriate training and organisational practices and procedures, such as waiting to be invited into a resident's room after knocking, privacy for conjugal visits and the acknowledgement of sexuality in care plans (see Knocker 2006, Health 2011, Heath 2012).

The role of the care home manager as leader is covered later on in this review; however, it is worth noting here some examples of the centrality of their role to the creation of an overall culture and the prevailing ethos within a care home (see Box 3).

Differences in role and responsibilities relating to the size and type of provider

That the role of the care home manager varies according to the type and size of operation has been highlighted. Responsibilities were reported to differ according to the size of the organisation (Chambers 2003a). Little research was found to evidence any differences in roles and responsibilities according to the size and type of provider. Dimon (2005a) and Burton (2007) have expressed the view that, despite sharing legal responsibility for compliance with regulations with the provider, in practice it appears that the registered manager of a care home is totally responsible for the whole care home and what happens in it, yet the role itself may vary. The manager may also be the owner if the care home is a small business. He or she may be solely in charge of a home or accountable to a regional manager. There may be differences according to whether the home is owned by an individual, a private company or a charity (Dimon 2005a). Although resident care may be said to be a care home manager's main priority since the purpose of a care home is to provide care (Dimon 2005a, Burton 2012) managers are also accountable to owners, regional managers, commissioners and inspectors. This range of accountabilities may result in conflicts, such as an owner refusing to buy special equipment, yet it is the manager who is responsible for health and safety (Dimon 2005a). Dimon (2005a) questioned who is responsible for the quality of care if a manager is obliged by the owner to be mainly a financial manager, and noted that several debates about this have occurred.

SKILLS, QUALIFICATIONS AND BACKGROUND

Skills

According to the Government's National Careers Service, the following are necessary for the role of care home manager:

- strong 'people' skills and communication skills;

- good observational skills;

- experience of assessing an individual's care and support needs;

- the ability to negotiate and manage a budget;

- the ability to maintain accurate records;

- knowledge of relevant legislation, local services and resources;

- a good understanding of the medical conditions affecting service users;

- the ability to build effective working relationships with residents, their families, staff and other professionals (National Careers Service 2013).

Expert commentators have argued that managing a care home demands a range of skills in addition to those listed above. Care home managers Addison and Bunce (2013) are of the view that it is also vital to possess exceptional organisational and time management skills, including the ability to prioritise, excellent listening skills and, for the business to thrive, business acumen. A further key skill is delegation, according to the Social Care Association (2011). A care home manager is also said to need the skills necessary to promote change and creativity in addressing challenges (Dimon 2005a).

Chambers and Tyrer's (2003b) small-scale qualitative study of operational management styles and challenges for managers and owners of nursing homes confirmed the need for a collection of skills to fulfil such a varied role, yet many interviewees noted that many new managers have scant experience of managing staff or budgets and many lack a management qualification. Perspectives of residents (n=6), relatives (n=5), home owners (n=4), managers (n=10), managing director (n=1), social services staff (n=8) and health authority inspectors (n=12) were gathered in this study. Participants felt that having proven management skills should be essential, although this may not have been the case in years gone by. If managers were seen to be capable, the view was expressed that respect would come more readily from staff and particularly if managers made it evident that they valued and appreciated staff, were keen to involve them in the running of the home and invested in training. A valuable skill was the knowing of what is, and planning for, an appropriate skill mix of care staff. The ability to develop external networks was felt to be a necessary ability by many participants. Experience of working in nursing homes, in unspecified roles, was seen by participants as excellent preparation for the role of home manager as giving insight into both the system and into staff needs (Chambers 2003a).

Almost all participants felt that the manager of a nursing home should hold a nursing qualification (Chambers and Tyrer 2002).

According to residents and relatives who participated in Chambers and Tyrer's (2003b) study:

> effective managers were the ones who were also: good organisers, problem solvers, able to deal with issues promptly, good communicators at all levels, not afraid to share information or ask others for advice (p.389).

Registered managers who responded to the National Skills Academy for Social Care's (2012) survey also felt that there was room for development in certain skill sets. The top four named were: working with commissioners, soft skills (e.g. managing people, negotiating, and assertiveness), leadership, and budgeting and finance. Other skills that they said needed to be developed were marketing, small business skills, and communication skills.

Qualifications

Registered managers are required by Regulation 6(2) of the Health and Social Care Act (Regulated Activities) Regulations 2010 to have the 'necessary qualifications, skills and experience' to carry on the regulated activity (CQC 2012b). A 'Registered Manager' is a (level 7) role defined by the Care Standards Act 2000. Under the Act, the Registered Manager should have the right skills, knowledge and experience relevant to their job/ role and care setting and is required to have a minimum qualification that includes a vocational qualification. This should be the QCF[13] Level 5 Diploma in Leadership for Health and Social Care and Children and Young People's Services with the pathway on Management of Adult Services or Management of Adult Residential Services, a qualification which combines and replaces two Level 4 NVQs. Earlier qualifications that remain valid and relevant are the Registered Manager's Award (RMA), the two Level 4 NVQs that have been replaced (Leadership and Management for Care Services; Health and Social Care), a relevant nursing, physiotherapy or occupational therapy qualification and registration, or a relevant social work qualification together with registration with GSCC[14] (CQC 2012b).

As mentioned in the earlier section about the legal status of care home managers, managers must provide proof of relevant qualifications and professional registration. In its supporting note on qualifications, the CQC (2012b) stated:

> If this documentation shows that a person applying to become a registered manager does not have the relevant qualifications or is not registered on the Level 5 diploma course then, as in the guidance set out by Skills for Care, it would be reasonable to expect them to register on the Level 5 course and achieve it without delay (p.3).

---

13 Qualifications and Credit Framework (QCF) has replaced the National Qualifications Framework (NQF).

14 Now the Health and Care Professions Council (HCPC). Registration transferred from the GSCC to HCPC the in August 2012 following Royal Assent of the Health and Social Care Act in March 2012.

This means that existing registered managers with recognised qualifications are not obliged to have, or to be working towards, the Level 5 qualification even if they move to another care home or setting. However, there is no statutory regulation regarding the achievement of the Level 5 qualification. However, if inspection outcomes are poor, a CQC inspector might apply the guidance and may request or suggest that a manager undertakes a Level 5 qualification (Burtney 2014). These are important clarifications of the statutory requirements, as there appears to have been widespread confusion in relation to the Level 5 qualification.

Most (83%, n=2,349) of the registered managers about whom relevant data were held by the NMDS-SC in January 2014 possessed a Level 4 or above qualification. Level 3 was the highest qualification held by 12%, Level 2 for 2% and Level 1/entry level for 0.1%. A further 2.4% held another relevant social care qualification and 0.5% held 'any other' qualification. As 'Level 4 or above' is a single category, it is not known how many of this group hold a Level 5 qualification.

Most (86%, n=2,498) managers were not working towards any qualifications, but some were working towards Level 4 or above (7%), Level 3 (4%), Level 2 (0.8%) Level 1/entry level (1.4%), another relevant social care qualification (1.4%) and 'any other' qualification (0.7%) (Skills for Care 2014a).

Common Induction Standards for the care workforce are required to be undertaken within 12 weeks of employment. Of the registered managers whose data was held in January 2014 (n=5,895), 67% had completed their induction, 8% were undergoing their induction and induction was not applicable for 25% (Skills for Care 2014a). Table 11 provides further breakdown of this data on qualifications and induction status.

In an attempt to raise standards and increase professionalism, a Code of Conduct and National Minimum Training Standards[15] were developed in 2013 and, at the time of writing, Skills for Care was working with the Department of Health to clarify next steps regarding implementation and expected to make an announcement in 2014.

---

15 See www.skillsforcare.org.uk/Standards/National-minimum-training-standards/National-minimum-training-standards.aspx

Table 11: Qualifications and induction status (Skills for Care 2014a)

	Care home without nursing	Care home with nursing	Other adult residential	Total	
Highest qualification level					
Number of records	1,911	327	111	2,349	
Level 4 or above	82.4%	90.5%	67.6%	1,946	82.8%
Level 3	13.4%	4.3%	20.7%	294	12.5%
Level 2	1.8%	0.6%	1.8%	39	1.7%
Entry level or level 1	0.2%	-	-	3	0.1%
Other relevant social care qualification(s)	1.7%	4.3%	8.1%	56	2.4%
Any other qualification(s)	0.4%	0.3%		11	0.5%
Qualifications in progress					
Number of records	1,882	501	115	2,498	
Level 4 or above	6.9%	5.6%	9.6%	168	6.7%
Level 3	4.1%	3.8%	3.5%	101	4%
Level 2	0.9%	-	1.7%	19	0.8%
Entry level or level 1	0.1%	-	-	2	0.08%
Other relevant social care qualification(s)	1.4%	1.6%	-	35	1.4%
Any other qualification(s)	0.8%	0.4%	-	17	0.7%
Not working towards qualifications	86.3%	88.6%	85.2%	2,156	86.3%
Workforce induction status					
Number of records	4,209	1,434	252	5,895	
Achieved	67.8%	63.4%	76.6%	3,956	67%
In progress	6.3%	13.2%	2%	461	7.8%
Not applicable	25.9%	23.4%	21.4%	1,478	25%

Care Home Managers: a scoping review of evidence

Recruitment source, leaver destination and reasons for leaving

From the records for registered managers of care homes and care homes with nursing held on the NMDS-SC in December 2013 (n=5,637), it is evident that half (50%) of care home managers were recruited from within the adult social care sector: of which 37% were from the private or voluntary sector, 7% were from a local authority and 7% had come from internal promotion/transfer or career development. A further 7% were recruited from the health sector. It was not reported where almost one third (28%) came from. The remaining 15% were recruited from the retail sector, the children's sector (private/voluntary, local authority) and other sectors, from voluntary work, abroad, student placements, agencies, were returners, were not previously employed or from other sources. Some of these appear curious categories (e.g. students) but are small in number (see Table 12 for details).

Table 12: Recruitment source of registered managers of care homes and care homes with nursing (Skills for Care 2013c)

Recruitment source	Number	Percentage
TOTAL	5,637	100
Adult care sector: private or voluntary sector	2,068	37
Adult care sector: local authority	320	6
Internal promotion or transfer or career development	399	7
Health sector	393	7
Other sector	137	2
Agency	109	2
Retail sector	49	1
Returner	41	1
Not previously employed	32	1
Children's sector: private or voluntary sector	30	1
Student work experience or placement	22	0
From abroad	22	0
Children's sector: local authority	17	0
Volunteering or voluntary work	10	0
Other sources	420	7
Not known	1,568	28

Interestingly, the top four destinations of leavers and the top five reasons for leaving were consistent between registered managers in care homes, registered managers in other adult social care services and across all managers (i.e. registered, senior, middle and first line managers) in all adult social care services despite the different levels of responsibility and pay.

The top four leaving destinations, accounting for 28% of registered managers in care homes were: private or voluntary adult care sector (12%), not to another job immediately (7%), the health sector (5%) and to a sector other than adult, children's, health or retail (4%). It is not known to where 60% moved – a surprisingly high proportion.

The top five reasons for leaving given by registered managers in care homes, accounting for just over half (53%) of all reasons given, were: personal reasons (15%), transfer to another employer (12%), resignation for other/undisclosed reasons (11%), career development (11%) and dismissal (6%). Retirement accounted for only 4% of reasons. It is perhaps noteworthy that pay and the nature of the work accounted for a total of only 5% of reasons reported by employers for their senior staff leaving which may affirm the research findings outlined earlier, that care home managers report their motivations to be caring and professional. However, the remaining 14% (reasons unknown for 24%) left because of competition from other employers and conditions of employment (both of which may be reward related), as well as redundancy or being at the end of a contract term. It is important to note that the data in NMDS-SC are reported by employers, so given reasons may be at risk of bias or inaccuracy. Moreover, information is only available from half of the NMDS-SC sample, itself a sub-group of all care home employers. Further details are given in Table 13.

That half of the care home managers whose details are held on the NMDS-SC were recruited to the role from other adult social care roles and that three quarters (78%) have been in the role for 4 or more years (46% for 10 or more years) may go some way towards explaining why so many either held level 4 qualifications or higher (83%) or were not working towards any qualifications (86%).

What Table 11 does not appear to capture is what proportion of managers have progressed to managerial level starting from roles such as care worker and senior care worker by acquiring vocational qualifications, and what proportion have entered the social care sector through another career or professional route such as nursing or occupational therapy. As it is the highest qualification held that is recorded, rather than the specifics of all their qualifications, it is not known what proportion of all care home managers hold a clinical or other relevant qualification.

However, in order to ensure that care home managers are suitably equipped to fulfil the multi-faceted role and ensure that the increasingly complex care needs of the residents are met, it would be reasonable to expect that continuing professional development training courses might be undertaken to refresh knowledge and skills. A large proportion of managers have been in the role for a long time and there may have been advances in knowledge and other changes since they qualified. For example, an assessment of care

Table 13: Destination of leavers and reasons for leaving (adult social care in England)
(Skills for Care 2013c)

	Care homes		All services			
	Registered managers	%	Registered managers	%	All managers	%
Destination of leavers						
Total	51,775	100	96,065	100	306,098	100
Adult care sector private or voluntary	5,998	12	11,898	12	35,894	12
Not to another job immediately	3,418	7	5,765	6	7,411	6
Health sector	2,831	5	5,010	5	15,634	5
Other sector	1,875	4	4,188	4	13,144	4
Adult care sector local authority	1,288	2	2,787	3	8,597	3
Elsewhere within the organisation	1,247	2	1,856	2	5,337	2
Abroad	1,126	2	1,781	2	5,372	2
Retail sector	560	1	1,260	1	3,801	1
Children's sector local authority	147	0	349	0	1,086	0
Children's sector private or voluntary	156	0	94	0	1,210	0
Other destinations	2,281	4	4,405	5	15,458	5
Destination not known	30,848	60	56,372	59	183,154	60
Reasons for leaving						
Total	54,556	100	101,366	100	320,095	100
Personal reasons	8,397	15	15,552	15	46,586	15
Transferred to another employer	6,608	12	12,332	12	38,737	12
Resignation for other or undisclosed reasons	5,903	11	9,984	10	28,770	9
Career development	4,803	9	7,842	8	24,423	8
Dismissal	3,531	6	5,934	6	17,199	5
Retirement	2,000	4	3,023	3	10,013	3
Nature of the work	1,416	3	4,433	4	13,524	4
Pay	1,197	2	2,862	3	8,277	3
Competition from other employers	978	2	2,411	2	7,794	2
Conditions of employment	623	1	1,350	1	3,803	1
Redundancy	561	1	1,411	1	5,936	2
End of contract term	732	1	1,221	1	4,419	1
Death	188	0.3	291	0.3	978	0.3
Other	4,678	9	8,092	8	22,564	7
Reason not known	12,941	24	24,628	24	87,072	27

home staff knowledge of oral care found that managers with poor knowledge or attitudes towards oral care of residents were likely to manage nurses with similarly poor attitudes and knowledge. Oral health affects quality of life, adequate nutritional intake and can have other health implications (Young *et al.* 2008).

There was an appetite for training among respondents to the National Skills Academy for Social Care's (2012) survey of registered managers of social care services and there is an indication that many undertake training. One third (31%, n=894) attended courses once a month, a quarter (27%, n=779) attended once every six months. Only 1% (n=28) never attended a course. Almost all respondents (96%, n=2,770) attended non-mandatory courses. The commitment to managers' development came out strongly with four fifths (n=2309) of managers saying that their employer covered the costs of these courses (leaving the position of 20% apparently out of pocket following training or updating or undertaking non-charging courses in local authorities, such as adult safeguarding). Half of these supportive employers were reported to invest at least £500 per person every year in training and development. A qualifying note about these findings is that only 65% (1,899) of respondents worked in residential care. However, responses differed little between care settings. Almost half of the total respondents (49%, n=1414) held Level 4–5 qualifications, and the average time spent working in the adult social care sector was 17.6 years.

Further evidence will be generated by the Social Care Workforce Research Unit's Longitudinal Care Workforce Study[16] (LoCS) which aims to contribute to the body of knowledge about recruitment, retention and reasons for leaving. This longitudinal panel survey of a sample of social care providers and their workforce in four parts of England is currently carrying out a second wave of data collection.

---

16 See www.kcl.ac.uk/sspp/kpi/scwru/res/capacity/locs.aspx

PROFESSIONAL STRUCTURES AND STATUS

Care home managers in England do not enjoy the same professional structures or status as others working in health and social care, such as nurses, occupational therapists and social workers. Indeed, the adult social care workforce in general has not been held in the same regard as the health service workforce in terms of perceptions of being 'professionals'. Matosevic's study found that while over half (57%) of managers/owners who participated described their work as recognised and valued in society, others thought that the role of care home manager was under-valued and had a low professional profile. Some thought that this may be due to a lack of understanding of what social care work involves (Matosevic *et al.* 2007, Matosevic 2008). Some of the research reviewed in this section illustrates these perceptions.

Apart from registering their employment with the regulatory body, mandatory membership of a professional regulatory body, such as the Health and Care Professions Council (HCPC), is not a prerequisite for working as a care home manager. One might speculate that their perceived professional status may be a reflection of this combined with the type of qualifications required for the role, in that vocational qualifications, regardless of the level, are judged by some to be inferior to traditional academic qualifications (e.g. a degree or postgraduate certificate). The findings detailed below suggest that perceptions of professional status vary and that the situation could be improved.

The Government's current view is that in England a system of assured voluntary registration for professionals and occupational groups that are not currently subject to professional regulation is adequate (HM Government 2011); however there is currently no provision for registered managers of care homes. The Professional Standards Authority (PSA), accountable to the UK Parliament, oversees the statutory bodies that regulate health and social care professionals in the UK. It also sets standards for organisations that hold Accredited Voluntary Registers for people working in a variety of health and social care occupations (such as the British Association for Counselling and Psychotherapy, a membership organisation and charity that set standards for practice).

The system in Scotland and Wales is different. Managers of care homes for adults are required to hold a leadership/management qualification in addition to a topical qualification.[17] They are required by the Scottish Government to gain registration with the Scottish Social Services Council, or with another regulatory body, within six months of starting in post (Scottish Social Services Council 2014). If a care home manager does not

---

17 SVQ 4 Social Services and Healthcare at SCQF level 9, BA (Hons) Social Work (or equivalent), BA Social Pedagogy, Degree or Diploma in Community Education or equivalent, a qualification meeting the registration requirements of the General Teaching Council (Scotland), Nursing and Midwifery Council, General Medical Council or the following professional groups regulated by the Health and Care Professions Council: Occupational Therapists, Art/Music/Drama Therapists, Physiotherapists, Speech and Language Therapists or Practitioner Therapists.

register within this time, the employer is committing an offence. In Wales, registration is mandatory for managers of care homes for adults and all applicants are required to agree to abide by the Code of Practice for Social Care Workers. The Register of Social Care Workers 'puts social care workers on a similar footing to other public service professionals such as medicine and teaching' (Care Council for Wales 2014). Using the data it holds, the body with which care home managers must register, the Care Council for Wales, publishes an annual 'Profile of the Adult Care Home Managers in Wales'.[18]

The Nationals Skills Academy for Social Care[19] was set up in 2009 and is an employer-led organisation that aims to transform the quality of leadership, management, training, development and commissioning related to adult social care. In 2012, it published the results of its research into how registered managers view their career and the changes required to better support them (National Skills Academy for Social Care 2012). An online survey was sent to all managers who were registered with CQC at the time (n=c.17,500), 2,886 (16.5%) of whom replied. Survey data was supplemented by data gathered in focus groups with 36 employers (service providers) and registered managers. Of these 2,922 participants, 1,899 (65%) worked in residential care. Analysis revealed that the responses of registered managers in different settings were very similar (Sorkin 2014a) but the data were not reported separately by setting and are not available for analysis. A large proportion of managers who responded to the survey (68%, n=1,962) said they would welcome the creation of a membership body for registered managers as 'accreditation would make us feel more professional and well respected' (p46) and would be a way of networking and sharing insights and solutions between peers. More than half (56%) believed the sector should create further accreditation for registered managers (National Skills Academy for Social Care 2012). The two words that respondents most associated with their working environment were professional and knowledgeable.

The Commission on Dignity in Care for Older People (2012) noted the lack of professional status experienced by care home staff and concluded that, if dignity in care is to improve:

> Care home managers should be recognised as experts in their field. They have demanding jobs, leading and motivating teams of low-paid staff doing difficult work. They often have little backup and are regularly faced with ethical issues, such as those concerning end of life. Supporting dignity in care for older people requires investment in the training and support of care home managers, within a proper training framework. They need a network from which to learn new approaches and to share ideas (p.18).

It recommended that the care sector should consider establishing a College of Care to promote the status of its workforce.

---

18 See www.ccwales.org.uk/profiles-of-the-registered-workforce/?force=1&bc=0:52%7C52:181%7C181:3963%7C

19 The National Skills Academy for Social Care and Skills for Care merged on 10 June 2014. Both brands and programmes of work continue.

In parallel with this observation, in recent years there has been increasing activity seeking to raise the professional status of social care registered managers. As detailed below, this has culminated in the creation of a national support programme for registered managers and continued promotion of the notion that professional registration or accreditation would be a positive step towards increasing the perceived status of registered managers. These activities are centred on the key leadership role of care managers, which is the subject of the next section in this review.

In 2011, after the government rejected proposals for mandatory registration of social care staff in England, the Association of Care Managers, the Social Care Association[20] (SCA), the National Skills Academy for Social Care and the National Care Forum started to campaign for registered managers to be seen as professionals of a similar standing as doctors, nurses and social workers (Dunning 2011). The SCA produced a draft guide setting out the vision for the role of Registered Manager of Residential Care for Adults, which it hoped would become a graduate-level profession. SCA (2011) suggested that universities should consider the required Level 5 Diploma in Leadership for Health and Social Care and Children and Young Person's Services (pathway for managers and residential managers) to be equivalent to a foundation degree and advised managers to discuss options for gaining further credits with the aim of achieving a full degree. However, the guide was not finalised or published as SCA went into liquidation in November 2012.

By 2012, the Department of Health had recognised that little had been done to support and develop managers of care homes – despite the key role of leadership in people's experiences of care and support – and it commissioned the National Skills Academy for Social Care (the Skills Academy) to set up the Leadership Forum it had referred to in the White Paper *Caring for our Future: Reforming Care and Support* (HM Government 2012, p.52). The Skills Academy launched the Registered Managers' Support Programme[21] in March 2013, which comprises leadership development programmes, online and face-to-face networks, and a series of resources (e.g. legal helpline) and events (Rouse 2013). A specialist network for black, Asian and minority ethnic leaders was developed in recognition of the importance of having a more representative leadership profile. The Director General for Social Care, Local Government and Care Partnerships at the Department of Health, Jon Rouse, asked the Skills Academy to work to a target of 5,000 members of the Registered Managers' Support Programme. The Academy has taken up the challenge, and is aiming for 3,000 members by April 2015 and 5,000 by April 2016. Membership in early January 2014 stood at 1,275 (Sorkin 2014b). More than half the members (56%) work in residential care, 33% in domiciliary care and 11% in mixed settings. The programme will continue following the merger of the Skills Academy with Skills for Care.

---

20 A UK-wide professional association for care practitioners, managers and those supporting them.

21 See www.nsasocialcare.co.uk/registered-managers

Care Home Managers: a scoping review of evidence

The Skills Academy is also promoting the idea of professional registration and/or accreditation for CQC registered managers, and the Registered Managers Support Programme may enable levels of interest in this to be measured. The Skills Academy reports that it is also engaging with employers in making the business case for supporting registered managers (Sorkin 2014a).

To develop behaviour-based leadership in the sector, a programme of 'Systems Leadership' is being piloted in 25 areas around the country supported by the National Skills Academy for Social Care in partnership with local government, the NHS and others as part of the Department of Health's Systems Leadership – Local Vision initiative.[22] This is described as an approach particularly suited to the social care sector and its multiple complexities as it is about spreading the leadership load across individuals and communities. It is based on trust and relationships and is, therefore, grounded in behaviours.

Following the services it has already established, the Skills Academy also plans to build on the Social Care Association's work by producing an annual Guide for Registered Managers. The guide will aim to support and strengthen managers in their leadership role and will aspire to provide an easy-access source of information and guidance on key issues. The first edition is planned for summer 2014, and it is planned to have annual hard copy editions alongside continuous online updates. The guide will be part of the Registered Members' Support Programme, and will be available for purchase by non-members.

It is interesting to note here that the Care Council for Wales has produced *The Social Care Manager. Practice Guidance for Social Care Managers registered with the Care Council for Wales*.[23] This guidance describes what is expected of managers of care homes for adults (and other managers) and what good practice looks like in Wales, and will form the basis for more detailed guidance in the future. It builds on the Code of Practice for Social Care Workers (to which all registered managers must agree to abide) and may be used by the Care Council to illustrate a breach of the Code.

Prior to the above developments, other initiatives supporting care home managers were already in place such as the national My Home Life programme and a Community of Practice in Cumbria (see Box 4).

Finally, by way of international comparison and the potential for transfer of learning, it is interesting to note the situation in the US in terms of qualifications and professional requirements and how research has shown that these appear to be associated with the quality of care provided in care homes.

Castle *et al.* (2014) investigated associations between quality of care and education levels of long-term care administrators (n=3,941), the equivalent to a care home manager and with equally wide-ranging responsibilities. Qualifying requirements differ across states,

---

22 See www.localleadership.gov.uk/place/localvison for further information.

23 See www.ccwales.org.uk/practice-guidance-for-managers/?force=1&bc=0:52%7C52:3827%7C181:3963%7C

Box 4: Initiatives supporting care home managers

- My Home Life has supported over 500 care home managers across 20 local authority areas in the UK through action learning sites for a few years. It started when Help the Aged commissioned the National Care Home Research and Development Forum to review the evidence about factors and practices that can impact on older care home residents' quality of life (The National Care Homes Research and Development Forum 2007). The review informed a programme of work to support care home managers, staff and commissioners to maximise the quality of life of their residents. A short film, 'My Home Life Manager's Voice' featured care home managers talking about how its monthly Leadership Programme has helped them in their work and changed the feel of their care home (My Home Life 2012);

- One of the participating organisations in the My Home Programme, Essex County Council, went on to financially sponsor a one-year leadership support programme in the county. All care home managers were invited to participate and over 100 engaged with the programme. Its success led to the creation of My Home Life Essex Community Association which has charitable status;[24]

- Cumbria's Community of Practice (CoP) was conceived in 2012 when a local employer-led partnership, Care Sector Alliance Cumbria (CSAC), received innovation funding from Skills for Care to develop a training module for front line social care staff on Challenging Poor Practice. Included within this was funding for a local 'community of practice' for registered social care managers that would focus on supporting the development and piloting of the training pack and to consider issues more broadly around delivering compassionate care. The Commission on Dignity in Care for Older People (as quoted earlier in this section) provided the underpinning rationale for testing how a 'community of practice' might work. The CoP has met four times since it started in October 2013 and is attended by eight registered social care managers from domiciliary, residential and day care organisations that provide services to people with learning disabilities or older people. It is supported by a representative from the North West (NW) Dignity Leads Network (who reports the views of 'community of practice' members to higher level strategic forums) and a researcher from the Social Care Workforce Research Unit (SCWRU) at King's College London (who acts as a 'knowledge broker' ensuring the group has access to the latest research evidence). Feedback from CoP members (ascertained through a focus group led by SCWRU) has been very positive. There has been scope for improved practice and progress in tackling the sense of isolation often reported. The CoP has provided structured opportunities for reflective practice and more collegiate styles of working. The initial funding has now ended, but members have expressed a wish to continue meeting in this way as they have found the meetings valuable (Cornes and Manthorpe 2013).

24 See www.mhleca.org

but most require a bachelor's or a master's degree. All states require that a person holds a nursing home administrator licence. An administrator may also have ownership interests in a home. Castle *et al.* found a significant positive relationship between levels of education and quality of resident care. Quality indicators included those that were judged to change quickly and, therefore, could be associated with the current administrator. They were restraint use, catheter use, inadequate pain management, low-risk residents with pressure ulcers, and high-risk residents with pressure ulcers. Additionally, a better quality of care was associated with states that had more advanced training requirements. Half (55.3%) of the participants had a bachelor's degree and a third (33.2%) had a master's degree or higher. Castle *et al.* were careful to point out that the research, while showing the importance of education, did not infer that higher education levels influence the quality of care.

THE CARE HOME MANAGER AS LEADER

Being a leader is one part of a care home manager's role. Leadership is described in the care home context as the part that involves inspiring, directing and guiding (Dimon 2005a, Burton 2012, National Skills Academy for Social Care 2013a). The need for managers to 'become conversant with the management component of their role and the leadership elements and how they intertwine' has been highlighted by the National Skills Academy for Social Care (2013a, p.22). High-quality leadership was recognised as critical in the implementation of the proposals contained in the 2012 White Paper *Caring for our Future: Reforming Care and Support*, although this may be at high or theoretical level for care home managers.

Why leadership matters

Although not large in scale and rarely aligned to outcome data, the literature outlined in this section is unanimous in concluding that the care home manager is central to the type of organisational culture that operates within their home, that leadership style and culture have roles to play in the implementation of change (including improvement), staff retention and recruitment, relationships, residents' outcomes, and inspection outcomes.

It has been argued that 'well-run care homes depend crucially on the skills and leadership attributes of the managers' (Chambers and Tyrer 2002, p.344) and that care home managers and effective leadership are pivotal to high quality care (Castle and Decker 2011, Owen *et al.* 2012b, Tadd *et al.* 2013). Carers (n=1,589) involved in an Alzheimer's Society study frequently commented 'how important care home managers are in setting the ethos of the home and giving care staff the confidence and skills required to work well with relatives' (Sharp 2007, p.33). Care home consultancy Run a Care Home has blogged that:

> the registered manager of a care home is a crucial team member and their appointment has a profound effect on a home, from the way it is run, to the way it is perceived by residents, staff and the local community. A care home can often be seen as a reflection of the personality of the registered manager! (Atkinson 2013).

Through its appreciative action research study, the My Home Life Programme identified nine outcomes of good leadership in the care home sector:

1. a confident, resilient manager who holds a vision for the home, can inspire and drive forward change and can reflect on, and question, their own role and the culture of the home

2. a confident, committed and stable workforce …

3. greater engagement with, and confidence from, external bodies and communities, where the care home team feels and acts like equal partners in

the wider health and social care system and as experts in their own right …

4. a workforce that is more reflective, more questioning, more confident in taking the initiative and ownership …

5. a home that positively welcomes complaints …

6. a more vibrant community of older people …

7. greater spontaneity and responsiveness …

8. greater emphasis on positive risk-taking and challenging the boundaries of practice, allowing positive informed risks to be taken within a structure of safety and accountability

9. supporting greater community inclusion … (Owen *et al.* 2012b, p.35).

Better leadership is believed by many (20% of 2,886 respondents to the Skills Academy's survey) to be a key factor that could transform the social care sector (National Skills Academy for Social Care 2012).

An important empirical study that investigated associations between the quality of care received by older people and features of the care homes in which they were living, by analysing inspection data relating to registered care homes in Surrey, found that when managerial standards were higher, there were fewer failures on other standards (Gage *et al.* 2009). Although in a different context, this confirmed US data reported in Castle and Longest's literature review (2006), which identified an association between poor management practice and quality of resident care, and Castle and Lin's study (2010) which concluded that high nursing home manager turnover in the US was associated with poor quality care around pain in permanent and short-stay residents, pressure sores, and use of physical restraints.

Reed and Payton's (1997) study of the adaptation processes engaged in by older people moving into care homes indicated that a home's culture directly affects the quality of life of those living and working in it (see Meyer 2007). In researching 'wandering' (walking) among older residents with dementia living in nursing homes, Dewing (2009) observed that culture also affects a home's sense of purpose, how adaptable and flexible it is, the systems and processes in place to support practice and meet residents' needs, the consistency between its prevailing values and how and whether these are acted upon. Leadership style creates a sense of the 'way we do things around here' and, in a case study of three care homes, was found to be an important factor in shaping the way relationships between residents, families and staff develop (Brown Wilson 2009a). In her report on meeting the needs of older lesbians, gay men and bisexuals living in care homes and extra care housing, Knocker (2006) stated that:

the most significant influence in any care home or extra care housing setting is the leadership of the manager and the ethos that they promote (p.22).

Care Home Managers: a scoping review of evidence

Effective leadership was described in some studies as being a crucial factor for change. An action research project to implement person-centred care planning for people with dementia in care homes identified management culture to be an influencing factor (Wilkinson *et al.* 2009). Demonstrable managerial commitment, such as supporting staff to make time available to engage in project-related activities, was reported to make staff development and the implementation of new approaches more possible and helped staff to feel valued.

The exercise of leadership by home managers has been declared to be fundamental to the embedding of good practice around dignity (Independent Commission on Dignity in Care for Older People 2012). A systematic review found that support from care home managers and protected time for staff training facilitated integrated working with health care services (Davies *et al.* 2011). Clear leadership has also been cited as one of ten key factors for successful medicine management (National Prescribing Centre 2008).

Leadership styles and behaviours

Many have put forward theories, assigned various names to different leadership styles and recommended certain styles for certain environments. This review does not aim to summarise the comprehensive literature about leadership styles, but highlights some points that are relevant to research findings about care home managers.

Leadership style has been defined as 'how you relate to employees' (Lewin *et al.* 1939 cited in Castle and Decker 2011, p.21). It is also argued that leadership is about behaviour and attitudes. The National Skills Academy for Social Care (2013a, 2013b) has developed a Leadership Qualities Framework for Adult Social Care that forms the basis of its programme to support registered managers. The Framework is based on the needs, values, principles, personal qualities and behaviours – as identified by registered managers – that are necessary for good leadership (National Skills Academy for Social Care 2012). It consists of seven dimensions: demonstrating personal qualities, working with others, managing services, improving services, setting direction, creating the vision and delivering the strategy. Within each dimension, what leadership at different levels looks like is defined. The operational leadership level is relevant to registered managers and strategic leadership is relevant for those senior leaders, directors and managers responsible for directing and controlling an organisation (National Skills Academy for Social Care 2013b).

No reviews of the impact of different leadership or management styles in UK care homes were found. In their review of the evidence on the impact of 'top' management in US nursing homes, Castle *et al.* (2009) used the Bonoma-Slevin leadership model, as this assesses how much input leaders encourage, and then act upon, ideas from their staff. The model is formed of four styles:

Consensus – employees are allowed to and asked for input from their staff and team decision-making is encouraged;

Consultative autocrat – input sought from staff but decisions are made by leader;

Care Home Managers: a scoping review of evidence

Shareholder – no consultation before making decisions, no provision of relevant, information for others to take decisions, but staff have a high level of independence;

Autocratic – decisions taken by leaders without input or participation from staff; very little independence in how staff conduct their work.

What works best in care homes?

Transformational leadership – whereby a leader seeks to motivate by facilitating engagement and involvement (Packard 2009) – is advocated by My Home Life, which works with managers of care homes for older people (Owen *et al.* 2012b).

In a review of leadership theories that also drew on their earlier 2002 research on operational challenges for nursing home managers/owners, Chambers and Tyrer (2003b) noted that the nature of the role of care home manager demanded an awareness of the appropriateness of the different leadership styles. As the role of care home manager is so broad and can vary enormously between settings, they suggested that no single style was best; that a contingency approach, in which styles adapt to different circumstances and levels of detail, was apt. Their conclusion supports the findings of Moiden's (2002) review of research on leadership styles which suggested that staff were happier when a combination of leadership styles was practised. The review concluded that 'the key to effective leadership is knowing how to use the right styles in each situation'. Moiden also observed that many leaders were aware that their leadership style could affect job satisfaction, health problems and absenteeism among staff and trust between leader and staff.

In a study of the quality of life of people with dementia in care homes, Sharp (2007) made reference to the literature around management styles that involved staff in decision-making. This was said to be a strong predictor of resident-oriented care for people with learning disabilities and reduced negative staff/resident interactions in care homes for older people.

The Independent Commission on Dignity in Care (2012) made recommendations aimed at tackling the underlying causes of poor care of older people in care homes and hospitals. One was that:

> hospitals and care homes need to embrace a devolved style of leadership that values and encourages staff and respects their judgement. This means enabling staff to do the right thing for the individual patient or resident, not simply to follow process (p.19).

Management commentator, Dimon (2005a), in her article on the challenging role of the care home manager, concurred with management theory that the preferred style of leadership in this case will include involving staff in decision-making and not being authoritarian. According to Burton (2008), the primary purpose of a care home is to be homely and caring and a manager will need to lead, enable, protect and support in order to achieve this. His experience is that trusting, valuing and involving staff and encouraging

them to take initiative improves the ability of a home to be homely and caring. He used a case study of person-centred care to illustrate how supportive leadership could contribute to positive outcomes for residents and staff in a care home within which staff must cope with the reality of the residents' needs at close quarters.

This has been found to ring true in practice in that the American studies outlined below have found that leadership style is associated with staff turnover and with quality of care and have noted a correlation between a culture that is strongly based on relationships and positive resident outcomes. In Anderson *et al.*'s study (2003), management practice that influenced how staff related to one another resulted in improved outcomes for residents. Lower use of restraints was related to the existence of open communication patterns in which members of staff were able to speak without fear of retribution. Aggressive behaviour was less widespread when registered nurses participated more in decision-making. Homes whose residents had greater immobility and complicated needs experienced greater formalisation and adherence to rules and procedures. Castle and Decker (2011) observed that the provision of better quality care was associated with consensus managers – that is, those who ask for and act upon input from their staff and enable workers to make decisions. Donogue and Castle (2009) found turnover of nurses and nursing assistants was lower under consensus managers and highest under shareholder[25] managers (7% against 32% for Registered Nurses; 3% against 56% for Licensed Practical Nurses; and 44% against 168% for Nursing Aides). Castle and Lin's study (2010) concluded that high nursing home manager turnover was associated with poor quality care around pain in permanent and short-stay residents, pressure sores and the use of physical restraints.

The findings of Kokkonen *et al.*'s (2012) systematic review of the international literature on the management of older people's homes in the context of long-term care challenges – mainly studies from North America (61%, n=36) and Europe (30%, n=18) – echoed what has been summarised above. There was lower staff turnover where reward-based, consensus and supportive management was present, although it was also reported that there was no relationship between turnover and leadership style. Low turnover of managers, manager support for staff and good communication between manager and staff improved quality of work and quality of resident outcomes. The role and attitude of managers were important for staff training to be successful. One study found that good resident outcomes were associated with leadership that willingly embraced quality improvement, group processes and good quality basic care.

In the context of the Francis inquiry report on poor care in Mid-Staffordshire hospital, the Cavendish Review (2013) also suggested that being intolerant of poor performance is another part of leadership.

---

25 Those who do not consult before making decisions or provide relevant information for others to take decisions, but whose staff have a high level of independence.

There is also a body of literature about relationship-based approaches to care (see Nolan *et al.* 2006a, Nolan *et al.* 2006b), but which is outside the scope of this review; however, it is worthy of attention because of the contribution that leadership style can make to building positive relationships. Relationships between staff, residents and their families have emerged as fundamental to the experiences of life within the community of a care home, and all parties need the opportunity to be involved in decision-making, to feel secure and that their contribution is valued if a care home is to become a community. Nolan *et al.* (2006b) affirmed that, for high quality care to be achieved, staff and residents must experience a sense of security, continuity, belonging, purpose, fulfilment and significance. The encouragement of social exchange has been found to be an effective way to increase participation in the community (Davies and Brown Wilson 2007a). The findings of Brown Wilson's study (2009a) which explored relationships within care homes suggest that, when the leadership and organisation of care support reciprocal relationships, the contribution of residents, families and staff are valued within the organisation allowing reciprocal relationships to develop. Key factors influencing the development of relationships were leadership, continuity of staff, personal philosophy of staff and contribution of residents and families. Enabling leadership traits were leading, by example, with involvement of senior staff, flexible and responsive patterns of working and communication, including sharing stories and anecdotes. One of the areas the My Home Life Programme focused on was relationship-based care (see Owen *et al.* 2012a) and its findings confirmed Nolan *et al.*'s theories about the importance of relationships.

SUPERVISION, SUPPORT AND CONTINUING PROFESSIONAL DEVELOPMENT

Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development (Burton 2008, Independent Commission on Dignity in Care for Older People 2012) and quality improvement (Independent Commission on Dignity in Care for Older People 2012). It also informs managers and puts them in a better position to take informed decisions. This applies at all levels of management. Supervision and support for care home managers are no less important than the supervision and support they provide for their workers; yet, as demonstrated by the research findings appearing in the next section about the challenges that care home managers face, some care home owners and providers overlook this aspect of their own role as a care service provider.

There are regulatory expectations with regards to supervision and support. Within Outcome 14 'Supporting Workers', CQC's (2010) guidance on compliance cites Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

> 23.—(1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by—
>
> (a) receiving appropriate training, professional development, supervision and appraisal; and
>
> (b) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform (p.134).

In the guidance, listed within the prompts for providers to consider related to supervision (within 'effective leadership') are the following three points that suggest that responsibility for supervision and support extends beyond the care home manager to the providing organisation:

- Staff are supported and managed at all times and are clear about their lines of accountability;

- Supervisory or peer support arrangements are in place, monitored and reviewed, for all staff involved in delivering care, treatment and support. This is in line with relevant national guidance from professional regulators and/or professional bodies, and is monitored and reviewed. These supervisory arrangements mean that:

  – staff can talk through any issues about their role, or about the people they provide care, treatment and support to, with their line manager or supervisor

– a support structure is in place for supervision which includes one-to-one sessions or group meetings. They are undertaken at a time and frequency agreed between the line manager or supervisor and the staff member, and they are recorded;

• The development of staff is supported through a regular system of appraisal that promotes their professional development and reflects any relevant regulatory and/or professional requirements (p.137, para 14C).

The Independent Commission on Dignity in Care (2012) concluded that:

securing dignity is not just about staff doing a better job, it is about chief executives, boards and management teams running their organisations in a way that enables staff to do the right thing for the people in their care (p.19).

It recommended that 'care home providers should invest in support and regular training for their managers' and put some of the responsibility onto local authorities: 'as commissioners of care, local authorities have an important role to play in facilitating this' (p.18).

The Social Care Association's (2011) draft guide on the role of registered manager of care homes argued that professional development is as important for registered managers as it is for their workforce in developing and improving their skills. It suggested that:

owners, particularly of single or small numbers of homes, may wish to consider mentoring as a cost-effective way of supporting their Registered Managers (p.33).

Expert commentator Burton (2008) examined and challenged practice, articulating the view that, if the provider/owner wishes there to be a suitable environment and sufficient resources for caring to be provided, they need to see themselves as being in a supportive role. According to Burton (2007, 2012), provider/owner leadership is as crucial to the survival and success (in terms of providing person-centred care) of the business as is the leadership of the care home manager:

If the manager of a care home is aware of and understands the unconscious forces beneath the surface of the homes, the more she or he can support, lead, and enable the staff to give care (give of themselves). To do this, the manager must also be supported with the same level of awareness and understanding from the outside (p.63).

Some of these unconscious forces and complexities surrounding the environment of a care home were articulated by Burton (2013) in his own analysis of a consultancy role he undertook. He argued that the morale of staff at all levels and the care provided to residents can be affected when the following factors are at play: (1) confused and conflicting roles, boundaries and responsibilities between the management and leadership, (2) the various backgrounds of the staff, residents, care home manager and external management, and (3) the complex social networks and relationships that are not unlike those of families. He noted that:

all the overt and covert psychological and social pressures, defences and trends

that occur in the wider society, for individuals, families, groups and communities are also to be found in care homes and in the organisations that run them. They are not isolated from these forces, indeed,[...] the forces are intensified in the 'hot house' environment of a care home and, if ignored, avoided and denied, result in the exploitation, abuse and neglect of both staff and residents (p.407).

We have seen that the expectations of a care home manager are diverse and sizeable. Given their role in the realisation of quality, they are said to need on-going external professional supervision. From its engagement with care home managers (n=124), the My Home Life programme concluded that those who have support, trust and backing from their provider or owner are more confident, resilient and better able to enable and support a positive culture of practice, and that the benefits cascade to their staff who also feel more confident (Owen *et al.* 2012b).

A 'supportive management culture where staff have positive role models, are mentored and supervised' was declared essential for effective team-working in the Prevention of Abuse and Neglect in the Institutional Care of Older Adults (PANICOA) study (Tadd *et al.* 2013, p.255). This noted how demoralising, stressful and frustrating it can be for staff if managers do not understand the challenges they face. The study concluded that 'effective leadership and ongoing supervision of staff was considered critical to the delivery of high quality, dignified care' (Tadd *et al.* 2013, p.154). While this refers to the responsibilities of care home managers with respect to their staff, supportive – and unsupportive – management also impacts on the care home manager in various ways, something that is covered in the next section.

The following paragraphs illustrate some of the positive effects that supervision and supportive management may have within care homes, for both the workforce and residents.

Two studies showed how strong and supportive management within care homes may be able to address racism which, if not addressed, may impact on staff retention or the quality of care provided. The first was Smith *et al.*'s (2007) study of overseas-trained nurses and health professionals working in the NHS, the independent sector and care homes. Racism was a common experience for those who worked, or had worked, at low grades in care homes. Few had complained, often because they thought their situation would worsen. Many of those who did reported that their complaints had been brushed aside. One care home manager, an overseas-trained nurse, remarked that the loneliness of management can lead to poor management practice whereby weak managers are reluctant to challenge staff's attitudes, behaviour and assumptions, and, on occasions, residents' behaviour. The second was Stevens *et al.*'s (2012) investigation into the contribution made by migrant workers to the care workforce in England. Across six sites, employers (n=26), UK born human resources managers (n=12), migrant workers (n=96) and UK born care workers (n=27) were interviewed along with social care service users and carers (n=35). Management support was reported to be less forthcoming when expressions of racism originated from colleagues or employers than from service users.

Care Home Managers: a scoping review of evidence

Seventy per cent of the migrant workers (n=68) had experienced what they perceived to be racist attitudes and behaviours from employers, colleagues and, most commonly, service users. Stevens *et al.* noted the importance of support from management as experiences of racism can impact on workforce retention and individual wellbeing as well as, potentially, on quality of care.

The Social Care Association (2011) asserted that:

> high quality supervision is one of the most important drivers in ensuring positive outcomes for people who use social care. It also has a crucial role to play in the development, retention and motivation of the workforce (p.32).

This is evidenced by Broadhurst and Mansell's study (2007) of residential homes for people with learning disabilities, which surveyed care home managers (n=39). Better management support was provided in the homes that were more successful at maintaining placements than those in which placements commonly broke down. Members of staff were more likely to participate in monthly staff meetings and receive monthly supervisions.

Tuffin (2011), a care home manager, was of the view that regular staff training (including for housekeeping and catering staff) was at the heart of a successful home when combined with a supportive environment, a robust supervision and appraisal system, and shared goals.

CHALLENGES FACED BY CARE HOME MANAGERS

Due to the nature of their role and the environment in which they are working, care home managers face several challenges, some of which act as barriers to good leadership. Challenges that have been identified by reviews, through research studies and inspections are outlined in this section. It is noteworthy that there appears to be a larger body of research evidence in connection with challenges faced by care home managers than any of the other subjects covered by this paper.

Some of the many and varied challenges faced by care home managers were recognised in three national reviews. The Cavendish Review (2013) noted that registered managers in social care face many challenges as a result of experiencing a much higher staff turnover and the employment of fewer professionally qualified staff than managers in health care services. It concluded that registered managers are not recognised and supported as they should be, and that they experience a heavy 'paperwork' load. The Review underlined that it is the employer's responsibility to ensure that workers are trained and able to perform as required. Therefore, where the registered manager is not the owner or employer, this responsibility may be accompanied by a set of difficulties. The Commission on Dignity in Care for Older People (2012) observed that care home managers often lack support. A few years earlier, Wanless *et al.*'s review of social care (2006) suggested that constant change and fragmentation were challenging, making it difficult for providers to keep up-to-date, meet changing responsibilities and plan for the future. Their evidence rested upon two research papers and a series of background papers on a range of topics that were commissioned to inform the review.

In research about care home managers, the role has been characterised as:

- lonely (Chambers and Tyrer 2003b, National Skills Academy for Social Care 2012, Owen *et al.* 2012a, Tadd *et al.* 2013);

- highly pressured, stressful and frustrating (Chambers 2003a, Chambers and Tyrer 2003b, Matosevic *et al.* 2007, 2008, 2011, National Skills Academy for Social Care 2012, Owen *et al.* 2012a, 2012b);

yet at the same time:

- rewarding and fulfilling (Matosevic *et al.* 2007, 2011, Matosevic 2008, National Skills Academy for Social Care 2012).

Chambers (2003a) noted that pressures (e.g. introduction of the national minimum wage, to take people being from hospitals to reduce 'bed blocking') were growing across the social care sector, and the My Home Life programme proposed that the associated stress and burn out may lead to the use of a poor management style (Owen *et al.* 2012a). Stresses for the care home manager were reported to have both internal and external origins as demonstrated by the remainder of this section.

The isolation felt by care home managers and the stresses involved have also been

acknowledged elsewhere (see Dimon 2005a, HM Government 2012, Cavendish 2013). However, this review was unable to identify any research on manager stress that used validated screening scales or measures as used, for example, in Evans *et al.*'s (2006) study of mental health social workers.

Yet, despite the many challenges they face, there is some affirmation that the rewards outweigh the difficulties involved in being a care home manager. Two thirds (66%, n=1,905) of those who responded to the National Skills Academy for Social Care's (2012) survey thought they would still be working in social care after five years. The Skills Academy saw this as 'further affirmation that despite the obstacles identified, and the stress and frustration that a career in care can cause, for many the rewards still make it well worth pursuing' (p.13). However, their responses may also be understood to mean that they were not necessarily making a positive choice to continue in the sector.

The remainder of this section outlines the challenges identified in research about care home managers and research that mentions them. Challenges have been grouped as follows:

- negative portrayal of care homes;

- lack of recognition and support;

- staffing and workforce issues;

- excessive bureaucracy, change and fragmentation;

- financial issues;

- external relationships;

- clinical/care issues;

- involving residents and families;

- the creation of homeliness;

- challenges relating to the size and type of provider.

Negative portrayal of care homes

A poor perception of adult social care, and especially care homes, both by the general public perhaps influenced by negative press and within the sector. has left care home managers feeling mistrusted, which can negatively affect their ability to get on with their jobs (National Skills Academy for Social Care 2012, Owen *et al.* 2012a). These views were conveyed by respondents to a survey carried out with registered managers by the National Skills Academy for Social Care (2012):

> One of the most demoralising parts of being a Registered Manager is the constant battle against the negative perception of living in a care home (p.40);

> One of my greatest frustrations is the media portrayal of care homes being terrible places, especially in comparison to NHS services (p.39).

Lack of recognition and support

Lack of recognition is reported to provoke feelings of isolation (Chambers 2003a, Owen *et al.* 2012a), of being excluded from the mainstream care system (Chambers 2003a) and of being without support (National Skills Academy for Social Care 2012). Of the 2,886 respondents to the National Skills Academy for Social Care's (2012) survey, a quarter of registered managers said they felt isolated and less than half (43%, n=1,241) felt supported in their role. Less than half (40%, n=1,154) felt that their role was recognised or acknowledged by individuals and institutions within the social care sector and only one fifth felt that their role was recognised or acknowledged by individuals and institutions outside the sector.

This lack of support has been reported to extend to a care home manager's own provider organisation or the home's owner (National Skills Academy for Social Care 2012, Owen *et al.* 2012b). An appreciative action research study by Owen *et al.* (2012a) found that difficult or unsupportive relationships were common, and that these affected a manager's attempts to improve care and build a positive culture. The study also noted that staff felt more confident when the care home manager was confident as a result of being trusted and supported by the owner/provider (Owen *et al.* 2012b).

This challenge relates to the role's professional structures and status and has been identified as such a significant one that efforts are underway nationally to address it, as reported earlier.

Staffing and workforce issues

The recruitment, retention, day-to-day management, motivation and training of the right staff or team to deliver care to residents with increasingly complex needs have been found to present major challenges for managers who considered that having the right workforce was a primary factor in the provision of good care (Owen *et al.* 2012b, Tadd *et al.* 2013).

Matosevic *et al.* (2011) and Owen *et al.* (2012b) acknowledged that problems with recruiting and retaining staff were associated with low pay and poor working conditions. Difficult market conditions and keen competition have exacerbated this problem, with fewer staff with qualifications and experience being recruited than a decade ago (Chambers and Tyrer 2002). Low literacy levels and poor writing and language skills among care staff, both first and second language English speakers, presented challenges for the design of training and for motivating staff to undertake training, and the sheer number of training providers and apparent lack of quality control compounded this problem (Tadd *et al.* 2013). Motivating the team was noted as a particular obstacle. 'Given the limited status and pay of staff working in care homes, and the physically and emotionally exhausting nature of the work' this was to be expected (Owen *et al.* 2012a, p.46).

The top three challenges to providing good dementia care identified by care home managers (n=772) involved in an Alzheimer's Society study were (1) attracting staff with the right skills (for 60%), (2) funding training (for 46%) and (3) maintaining staff morale and motivation (for 44%) (Sharp 2007). According to Tadd *et al.* (2013), consequences of

problems with recruitment and retention that impacted on the delivery and quality of care included:

- inability to release staff from usual work to participate in training;

- working longer hours to cover shortages;

- junior staff working without supervision during shortages;

- difficulty providing a more personalised and higher standard of care.

Cornes *et al.*'s study (2010) of agency or temporary workers found that some privately owned care home providers generally managed staff shortages by asking existing staff to cover. Although a cheaper option that ensured residents were not being cared for by unqualified workers, this risked putting too much pressure on workers and creating retention problems. Tuffin (2011), a care home manager, mooted that employing agency workers compromises continuity of staffing, leaving residents unfamiliar with their carers.

The evidence outlined in Box 5 illustrates how training, or its lack, affects staff wellbeing and job satisfaction, residents' health and wellbeing, and the culture of a care home.

Box 5: Examples of evidence about staff training

- Few staff involved in an oral health training programme for staff in care homes were still employed by the homes after one year (Kay 2000);

- Lack of skills and knowledge were the most frequent contributing factor to medication administration errors (Lim *et al.* 2008, Independent Commission on Dignity in Care for Older People 2012);

- Management of continence and pressure sores needed attention (Independent Commission on Dignity in Care for Older People 2012);

- Training can reduce the impact of resident violence, which can lead to staff burnout (Astrom *et al.* 2004, Bostrom *et al.* 2012)…

- … and 'has a negative impact on staff morale, motivations, retention and absenteeism, perception of staff value and stress levels in the workplace' (Skills for Care 2013d, p.ix);

- Train *et al.* (2005) recommended that training for staff (including managers) working with people with dementia would improve the management of problem behaviour and would be likely to increase job satisfaction;

- Staff training was one factor contributing to the maintenance of successful community placements (Broadhurst and Mansell 2007);

- Staff training can impact on how open a culture is with regard to sexuality and intimate relationships[26] (Bouman *et al.* 2007, Heath 2011, 2012).

---

26 According to research carried out by campaigning organisation Stonewall, 50% of older gay people are not comfortable being out to care home staff (see Taylor 2012).

Excessive bureaucracy, change and fragmentation

Over-burdensome 'bureaucracy' has been identified as a major challenge and a disincentive to running a care home (Matosevic *et al.* 2011, Owen *et al.* 2012a, Tadd *et al.* 2013). A decade ago, some managers reported feeling professionally frustrated as a result of the increasing proportion of time they spent on managerial and administrative tasks which meant they lacked time to spend on the 'floor' (Matosevic *et al.* 2011). Others felt professionally fulfilled, partly due to the increased opportunities for professional development. A decade later, such conflicting priorities seem to remain and were considered by managers to be a barrier to providing high quality care (National Skills Academy for Social Care 2012). Almost half (47%, n=1,356) of registered managers who responded to the National Skills Academy for Social Care's survey said that the biggest barrier that impeded their day-to-day ability to provide high quality care was bureaucracy, which encroached too much on their time. For two thirds (66%, n=1,904), busy schedules left less time to allow for the considered approach necessary to ensure that quality care was provided. Such bureaucracy or paperwork came from a number or sources, including:

- NHS and local authority commissioning and contracts (Matosevic *et al.* 2011, Owen *et al.* 2012a);

- responding to social work assessments and reviews;

- participating in continuing care assessments and responding to coroners' investigations;

- meeting fire service requirements, following safeguarding protocols, undertaking health and safety assessments, fulfilling training requirements and carrying out internal risk assessments (Owen *et al.* 2012a); and

- fulfilling the need to keep up-to-date with changing requirements, regulations and fragmented systems (Tadd *et al.* 2013).

There have been reports of some concern that regulators inspected paperwork rather than the actual care provided (see Tadd *et al.* 2013). Paperwork also originates from staff training needs. A care home manager interviewed in a study of perceptions and use of NVQs said that NVQs involved excessive paperwork that needed to be reduced (Roe *et al.* 2006).

A review of the care home sector by the Department for Business Innovation and Skills (BIS) (2013) found major concerns were expressed about duplication and a perceived lack of liaison between the CQC and local authority and health commissioners, resulting in additional bureaucratic burden. Lengthy application forms, contracts, data requests and additional inspections were all said to take managers away from providing care. There was also a feeling that too great an importance was placed on paperwork, rather than the care provided, in the context of inspections. The review noted that care homes also contend with contracts and regulations covering health and safety, fire safety, and environmental health/food.

Care Home Managers: a scoping review of evidence

A recent Joseph Rowntree Foundation report of its inquiry into the impact of paperwork confirmed the research summarised above, including the findings of the BIS review, and found that the situation has not changed (Warmington *et al.* 2014). The inquiry carried out a desk-based review of paperwork gathered from three care homes for older people. Focus groups were held with care home staff and carers/volunteers. Care home staff, residents and carers were observed and staff were shadowed for two days. Supplementary data was gained from interviews (n=25) with four care providers, care sector membership and umbrella bodies, members of adult safeguarding boards, local authority staff (commissioners, strategic lead for adult social care, quality manager, social care lead assessor) and the CQC. The need to keep up-to-date with best practice guidance, together with duplication of paperwork resulting from a lack of coordination between regulators and commissioners and uncoordinated internal processes, meant that managers spent a disproportionate amount of time completing, checking or helping others to complete paperwork. There was a feeling that some of this time would be better spent being visible within the home, on leadership activities and building relationships with residents and staff. Too much of the paperwork was said to be fuelled by fear of blame or litigation and too little about enabling residents and managing risk. Of the 97 types of paperwork collected, 65 were completed by managers. Seventy per cent of the paperwork was related to legal or regulatory requirements, 50% to delivering best practice and 6% to funder requirements. This report formed one strand of John Kennedy's Care Home Inquiry,[27] a year-long programme that published its final report in 2014. The inquiry also covered how approaches to risk in care homes can support good relationships and quality of life.

Constant change means that care home managers must either spend time ensuring their knowledge is up-to-date or risk the consequences of not being fully aware of new legislation and its implications for them as care home managers. It also means ensuring that information about any new or changed requirements is cascaded down to care workers in the home. For example, an investigation into the use of the Mental Capacity Act 2005, which came into force in 2007, found notable variations in the understanding of the terms and principles of the Act. Managers felt they needed more training (Manthorpe *et al.* 2011). Managers were more confident in a follow-up investigation four years later (Manthorpe and Samsi 2014). They had learnt from other professionals, from inspection requirements and reading about it in trade/professional press, and some had built the principles of the Act into daily working practices (e.g. paperwork). However, knowledge that wilful neglect and ill-treatment had become criminal offences under the Act was deficient (generally among all staff). The boundaries between poor practice and abuse were not clearly understood and there was a lack of awareness that evidence may be required for investigations. Manthorpe and Samsi suggested that care home managers may benefit from increased interaction with safeguarding practitioners. Following a study of professional practices in best interests decision-making under the Mental Capacity Act

---

27 See www.jrf.org.uk/work/workarea/care-homes-risks-relationships

Care Home Managers: a scoping review of evidence

2005, Williams *et al.* (2012) recommended that care home managers initiate weekly meetings to review assessments of capacity and best interest decisions relating to everyday matters and that they should ensure that their staff are suitably trained.

Other challenges faced by care home managers are likely to influence the recommendations of these last two studies in that external relationships are known to be challenging and difficulties around staff training include motivation, literacy levels and turnover.

Financial issues

Lack of budget was the second most common barrier to provide the required services and to deliver quality care for half of the survey respondents to the National Skills Academy for Social Care's survey (2012). Funding was considered to be insufficient to maintain high quality care for residents with high dependency levels, to meet expectations associated with legislative frameworks, and to provide a good environment as well as offering appropriate pay, education and training for staff (Chambers 2003a). Funding for staff training was reported to be of particular concern to owners (Tadd *et al.* 2013). Care home inspectors noted the history of inconsistent funding from local health authorities in the past; on occasions, funding had been granted, spent by the care home and then withdrawn (Chambers 2003a). Interestingly, it appeared that morale was relatively high among managers and owners despite these financial challenges (Matosevic *et al.* 2007, Matosevic 2008), although this data precedes the current austerity climate.

External relationships

Care home managers were reported to experience multiple challenges relating to external relationships that can impact on the quality and delivery of care to residents (Owen *et al.* 2012a, 2012b). Under pressure to compensate for shortcomings elsewhere in the wider health and social care system, they found themselves in the unenviable position of, for example, accepting new residents who were being discharged from hospital with very little notice or support, accompanied by out-of-date assessments and problems with medication that need to be dealt with. The effects of being expected to respond quickly might have been somewhat alleviated if the speed of response was reciprocated when care home managers needed to access certain professionals and practitioners quickly, yet this was not always the case.

Fear of repercussions after making mistakes could result from receiving mixed messages and contradictory advice from family members, health and safety officials, council officers and inspectors (National Skills Academy for Social Care 2012, Owen *et al.* 2012b). Care home managers were reported to be unclear about what was acceptable in terms of supporting positive risk-taking (Owen *et al.* 2012b). They could feel blamed if things went wrong and some consequently adopted a task-focused, 'mothering' style of management that was disempowering for staff and prevented them from taking initiative (Owen *et al.* 2012a). Some of the anxiety around positive risk-taking could be reduced if local safeguarding processes were improved, according to Owen *et al.* (2012a), and if care

home managers felt positively supported and trusted by practitioners and professionals across the sector.

The relationship with health services is one external relationship that has been the subject of research, although the studies found only related to care homes for older people. For example, a third of the 772 care home managers involved in an Alzheimer's Society study about quality of life in care homes said they received very limited or no support from their local older people's mental health service, and accessing advice from external services was one of the top three challenges for a quarter (26%) of them (Sharp 2007). Variations in NHS support for care homes were noted by the British Geriatrics Society's inquiry into the quality of healthcare support for older people in care homes (Martin *et al.* 2011).

Good relationships with dieticians, speech therapists and hospices were commonly reported in a study involving care homes for younger adults (Wood 2011). However, some care home managers said that less support by comparison was received from NHS mental health teams which, in some cases, was reported to have resulted in deterioration of a resident's condition

Clinical/care issues

Where the role of lead clinician and manager were combined, challenges or problems in balancing the two roles were reported in the study by Chambers (2003a). In terms of clinical care, particular challenges related to continence issues, nutrition (National Care Homes Research and Development Forum 2007) and the management of medication and pain (Szczepura *et al.* 2008).

Involving residents and families

Despite the potential benefits for both homes and relatives of residents, some homes involved in a study for the Alzheimer's Society reported that they had tried to set up relatives' groups but families had not attended. Such groups 'require good local leadership to encourage people to attend and to sustain attendance' (Sharp 2007, p.32).

The creation of homeliness

Tadd *et al.* (2013) noted that it was difficult to make a care home feel like 'home' rather than an institution given that activities were not always optional, the tendency to lock some doors, and the lack of privacy and private facilities. Chambers and Tyrer (2002) found that small homes were most likely to be homely.

Brown Wilson (2009a) reported that many care home managers strived to make their homes home-like. Peace and Holland (2001), whose study of whether small homes can replicate a homely environment, noted tensions between regulatory requirements, residents' frailty and the ideal of a family home, some of which are illustrated by the following quote:

> The fire officer went in and gasped, 'What have you got stuff in the corridors for?
> It will burn!' The way I saw it was that if she [the resident] was at home she could

have this stuff like that – this is her home and you've sometimes got to stand up and say that to someone. It's a challenging area though … You've got to be sensible, you can have things on the walls, but you can't block a fire exit. There's no reason why you can't make a place look homely, instead of like an institution; nobody wants to live in that, but when the authorities come in, it's hard to stand there and say 'I don't want to do that' Care-home manager (Warmington *et al.* 2014, p.25).

Burton (2008) argued that many practices aim to meet organisational rather than residents' needs. For example, uniforms, segregated staff and resident toilets and mealtimes and public medicine administration seem to detract from the homeliness of a home. In his view, a care home in which staff do not wear uniforms, eat with residents, administer medication privately, and in which toilets are shared between staff and residents is still able to be accountable and meet regulations.

Challenges relating to the size and type of provider

Some managers working for large groups or chains found their autonomy limited (Lupton and Croft-White 2013). Group or chain structures have been reported to be a hindrance at times – for example, a national building maintenance director who is centrally-based may not be immediately available to deal with a building maintenance issue which would not be an issue for owner-managers (Chambers and Tyrer 2002). Larger chains were also those that focused most on containing costs.

Small groups were able to offer only limited internal support (Chambers and Tyrer 2002). In contrast to larger homes which might employ staff dedicated to quality and policy, the Joseph Rowntree Foundation inquiry into the burden of paperwork by Warmington *et al.* (2014) found that, in smaller homes, keeping up-to-date with regulatory, legislative or funding changes must fit in with other imperatives by the chief executive or a senior manager. It also observed that:

> balancing paperwork completion with care responsibilities presents particular pressures for providers with limited staffing or those struggling to achieve economies of scale and/or viability (p.20).

Chambers and Tyrer (2002) found that managers working for single, independent homes with no external management or monitoring struggled with resources, lacked robust management processes and reported feeling even more isolated than those in groups or chains.

On the subject of autonomy, participants in a regional management development programme for managers:

> observed that those running managerial programmes need to be mindful that care home managers have only limited scope to implement change (for example, in care planning and supervision practices) without approval from their own managers or home owners at local or corporate levels (Cornes and Manthorpe 2013, p.663).

Burton (2012) is of the view that the performance of managers who lack autonomy may suffer, as will their home's ability to fulfil regulatory requirements.

Worden and Challis's study (2007) of factors associated with quality of assessment in care homes (n=182) in Manchester and Cheshire exemplified the impact of such differences. The size of home was found to be associated with the quality of systems and standards in the homes: larger homes and those in groups or chains had assessment tools and processes of higher quality than those used in smaller homes. The authors suggested that the former were likely to have access to internal professional support and management review processes that smaller homes did not have. Assessment processes were found to be better in homes that provided staff training. Worden and Challis theorised that less availability of training and funding for training in smaller homes may have contributed to lower quality of assessment processes in those homes.

Finally, one respondent to a Royal College of Nursing (2012) survey of its members on the views and experiences of frontline nursing staff in care homes said that the home's 'absentee owners' demanded far too much from staff and 'fail[ed] to see the link between a successful home and excellent care' (p.20). Of the 584 survey respondents, most were sisters or staff nurses (47%), matrons and senior nurses (21%), while there were also replies from managers (22%), but the level of management was not specified, and from an unspecified number of owners/senior directors. However, the persistent challenges to providing quality care reported matched those identified by care home managers as summarised in this section. These were staffing levels, ensuring an appropriate skill mix, recruitment and retention, low levels of morale and high pressure, lack of training, lack of equipment, inspections and bureaucracy, and difficulties working with professionals from other sectors.

Care home managers' perceptions of the key challenges

The following were identified by the care home managers participating in the key studies about care home managers as the most important issues for them:

- Negative press about care homes and consequent lack of public trust (National Skills Academy for Social Care 2012);

- Insufficient recognition from the health and social care community (National Skills Academy for Social Care 2012);

- Recruitment, retention, management, motivation and training of staff (Owen *et al.* 2012a, 2012b, Lupton and Croft-White 2013, Tadd *et al.* 2013);

- Over-burdensome bureaucracy (National Skills Academy for Social Care 2012);

- Insufficient funding (National Skills Academy for Social Care 2012, Lupton and Croft-White 2013, Tadd *et al.* 2013).

Challenges as reflected in inspection reports

The CQC's inspection reports show how well care homes are meeting standards and are the only evidence available about a care home's performance as a whole. They have highlighted some of the same issues identified by care homes managers that are outlined in this section and confirm the reality and consequences of the challenges they say they face. Table 14 displays some of these, which relate to issues around staffing, the care, welfare and safeguarding of residents, respect, dignity, involvement, information and the management of quality and processes.

In 2012–13, 20% of nursing home inspections revealed safety concerns (e.g. failing to give out medicines safely; not carrying out risk assessments when starting to care for someone; ongoing staffing pressures). Over 10% of residential home inspections uncovered problems with either safeguarding and safety, staffing, or the care and support received by residents (e.g. insufficient assistance with eating and drinking) (CQC 2013d).

The situation for people with learning disabilities was more extreme with 41% of the homes inspected for a themed review failing the standard on safeguarding (CQC 2012a). As outlined in the background about care homes section, CQC has since put in place new requirements for registered services for people with learning disabilities. The learning disability sector has also acted in the wake of the Winterbourne View private hospital abuse scandal. An alliance of umbrella groups of providers of services to people with learning disabilities, the Driving up Quality Alliance, has developed an optional code[28] for providers and commissioners to sign up to by way of demonstrating their commitment to quality service provision.

Table 14: Issues arising from Care Quality Commission inspection reports

Staffing	**Health and social care inspection reports 2011–12 and 2012–13** (Care Quality Commission 2012a, 2013d)
	2012–13: Problem area across social care settings – overall 13% did not meet standards.
	2011–12: Inspectors reported that complex case-loads impact on ongoing support and training. Ensuring there are enough staff to provide a good service is an issue: 23% of nursing homes and 16% of residential care homes inspected did not meet the standard.
	Nursing homes: 24% did not meet the standard in 2011–12, 18% in 2012–13.
	Residential homes: 15% did not meet the standard in 2011–12, 12% in 2012–13.

---

28 See www.drivingupquality.org.uk

Care Home Managers: a scoping review of evidence

Table 14 (continued): Issues arising from Care Quality Commission inspection reports

Staffing	**Themed review: meeting health care needs of older residents and those with learning disabilities** (2012d)
	Attendance at health care training in continence was lower than training in medicines over the previous 12 months (36% compared with 59%).
	Some health care areas were neglected in staff training. Only 52% of nursing and residential homes provided stroke training compared with 93% that provided dementia training.
	In 25% of homes, some or all staff interviewed felt partially or not at all confident that they understood 'the health care needs of people living in the care home and what they need to do to help meet these.'
	Guidelines in place for processes and procedures were not always used. For example, only 42% of Do Not Attempt Resuscitate (DNAR) decisions in case files were consistent with the homes' policy.
Staffing	**Second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards 2010–11** (2012c)
	A significant proportion of care homes have still not fully trained their staff in the Safeguards. Of the reports carried out in the in the first six months of the year, approximately one third of those that mentioned training on deprivation of liberty or mental capacity stated that no training had been carried out or that there were no plans for training. The figure for reports carried out in the second six months was one quarter.
	It was not uncommon for some staff, but not all, to have received training.
	Staff who received training were not always confident about their level of understanding of the DoL Safeguards, which suggests a need for their knowledge to be updated regularly.
	Where training is given, providers should check that it covers all the appropriate staff and that knowledge is kept up-to-date.
Care and welfare of residents	**Health and social care inspection report 2011–12** (2012a)
	Compared with 14% of domiciliary care and 14% of community services.
	37% of the 32 residential care homes inspected for CQC's themed review of learning disability fell short of the general standard on care and welfare.
	20% of nursing and 11% of residential care homes did not meet the standard on meeting nutritional needs.
	Nursing homes: 28% did not meet the standard in 2011–12, 17% in 2012–13.
	Residential homes: 18% did not meet the standard in 2011–12, 11% in 2012–13.

Care Home Managers: a scoping review of evidence

Table 14 (continued): Issues arising from Care Quality Commission inspection reports

Care and welfare of residents	**Themed review: meeting health care needs of older residents and those with learning disabilities** (2012d) Although 85% of nursing and 78% of residential homes provided information on continence care to residents, 38% of residents felt that they lacked choice on how their needs were managed. For example, 25% of those with continence needs felt they lacked choice with regard to the sex of the person helping them to use the toilet. Only 55% of residents knew there was a care plan in place setting out their needs. Despite 59% of homes stating that they offered the choice of self-administration of medicines to their residents, only 4% of case files evidenced medicines being self-administered. More than two-thirds of nursing homes have a Do Not Attempt Resuscitation (DNAR) policy (70%) yet only 37% of staff had been formally trained in its use. Almost a quarter of homes (23%) were unable to evidence that they undertook person-centred care planning. Many were unable to demonstrate that they had listened to the views of relatives and carers.
Safeguarding and safety	**Health and social care inspection reports 2011–12 and 2012–13** (2012a, 2013d) 2012–13: common problems were: Failing to give out medicines safely and not maintaining adequate records of who needs which medicine. Staff not having guidance on how to administer medicines that had been prescribed "as required". Not carrying out risk assessments at the start of people's care, or regularly reviewing them. 2011–12: 41% of the 32 residential care homes inspected for CQC's themed review of learning disability did not meet the standard on safeguarding, which is high compared with other sectors. Less than half (48%) met both safeguarding and care and welfare standards. Nursing homes: 17% did not meet the standard 2011–12, 18% in 2012–13. Residential homes: 12% did not meet the standard in 2011–12, 13% in 2012–13.
Safeguarding and safety	**Themed review: meeting health care needs of older residents and those with learning disabilities** (2012d) Only 59% of homes caring for people lacking mental capacity to make decisions had best interest decisions in place for them. 35% of homes sometimes had a problem giving residents medication on time and 4% often had problems in this area. 51% of homes record the actual time of medicine administration.

Care Home Managers: a scoping review of evidence

Table 14 (continued): Issues arising from Care Quality Commission inspection reports

Safeguarding and safety	**Second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards 2010–11** (2012c) Around 10% of care homes sampled used restrictions or restraints, mostly being locked doors or bed rails. What constitutes deprivation of liberty is not universally recognised.
Respect and dignity	**Health and social care inspection reports 2011–12 and 2012–13** (2012a, 2013d) Nursing homes: 15% did not meet the standard in 2011–12, 12% in 2012–13. Residential homes: 7% did not meet the standard in 2011–12, 5% in 2012–13. (Compared with 5% of domiciliary care agencies and 6% of community social care services.)
Involvement and information	**Themed review: meeting health care needs of older residents and those with learning disabilities** (2012d) Although staff training on the sharing of personal information was provided in most homes, and despite that 74% were happy that their information was kept private, 42% of residents felt that they were not asked for permission before information was shared more widely. Information around which health care services were covered by their basic fees was not given to residents in 54% of homes.
Managing quality/ records/ processes	**Health and social care inspection reports 2011–12 and 2012–13** (2012a, 2013d) 30% of nursing and 22% of residential care homes inspected did not meet standard on quality of records and record-keeping (compared with 19% of domiciliary and 14% of community care services). Poor record keeping is noted to be an early warning sign of ability to perform in other areas. Nursing homes: 13% did not meet the standard in 2012–13. Residential homes: 11% did not meet the standard in 2012–13.
Managing quality/ records/ processes	**Second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards 2010–11** (2012c) Practice was variable. Although there were good practice examples, poor practice was also evident: out-of-date authorisations; restrictions on residents without evidence of assessments or applications; inconsistencies between limitations on applications and those in practice.
Managing quality/ records/ processes	**Second annual report on the Mental Capacity Act Deprivation of Liberty Safeguards 2010–11** (2012c) Where poor practice was identified, recurrent situations were: (i) staff not requesting the involvement of IMCAs and local supervisory professionals, and (ii) staff not having received training.

KEY MESSAGES FROM THE EVIDENCE

Care home managers are:

- an under researched sector of the social care workforce;

- are slightly older and less ethnically diverse than the social care workforce as a whole;

- perform a role that is regulated but, in England, are not regulated by a professional body;

- earn less, on average, than other social care professionals such as social workers and occupational therapists.

They mostly consider that they:

- are often faced with conflicting demands;

- have a broad range of skills;

- are dedicated and knowledgeable;

- are not always recognised as professionals;

- are the people primarily responsible for how a care home feels and operates.

Message for policymakers, regulators and commissioners

- Care home managers feel they spend a disproportionate amount of time completing 'paperwork' that could be reduced if reporting systems were less fragmented (little is known about their administrative support);

- Research indicates that supported managers feel they are better managers.

Messages for health services

- Policy changes have meant that care home residents are likely to have increasingly complex needs;

- Care home managers aspire to mutually supportive relationships with local health service professionals so that both parties can work together for the benefit of their residents.

Messages for care home owners and providers (including regional managers)

- Owners/providers have joint legal responsibility for the care their homes provide;

- Care home managers feel they can do their jobs better if they know what they can expect from owners and to what extent they have autonomy;

- Care home managers feel they can do their jobs better when they are trusted;

- Care home managers consider they work most effectively when they are supported: receiving regular supervision helps people feel valued, facilitates the sharing of responsibilities and enables joint solutions to problems to be reached;

- Care home managers also benefit from training and learning opportunities;

- Owners and corporate providers can nurture leadership skills.

Messages for care home managers

- Time spent supervising staff regularly is an investment that is likely to reap rewards;

- Training (for care workers and home managers) can lead to improved outcomes for residents and greater staff stability;

- It is important that managers support the training of staff;

- Leadership skills can be nurtured by investment in local/corporate peer support;

- The potential for modelling good practice remains unexplored (e.g. personal demonstration of abiding by guidelines with regard to treating residents with respect).

Messages for people living in or considering care homes and their carers

- If the manager has set up a 'friends of the care home', get involved as these can support relatives' communication and involvement with the home and act as a network to help carers to cope with possible negative feelings about their relative being in a care home;

- If there is no such body, speak to the manager about whether it might be possible to set up a group, a newsletter or similar ways that might involve families;

- Let the care home manager know if they are doing a good job.

DISCUSSION AND RESEARCH GAPS

Care home managers are an overlooked group when it comes to research about their role and practices. The research evidence is limited and tends to focus on those who manage care homes for older people. Where possible, this scoping review drew on findings from other related studies. Despite this, there remain many unanswered questions.

The themes covered by primary research about care home managers (and owners) covered in this review were leadership, quality, motivations, dignity, workforce practice and training needs, the potential impact of training, improvement of care, operational challenges, management styles and practices, registered managers' view of their careers, levels of support, and the appetite for further accreditation and education. Most studies related to managers of care homes for older people. Most of the UK studies involving primary data were relatively small scale with the exception of My Home Life. The methods identified to study care home managers included literature reviews, action research, analysis of secondary data and the collection of primary data through interviews, observation, focus groups, surveys, and data from the piloting of training courses.

Care home managers have substantial legal, managerial and commercial responsibilities and their role is often described as broad and varied. The style of management and leadership employed is reported to have a great impact in many areas, including the overall ethos and culture of the home, staff retention and quality of care provided. A care home manager's role involves a range of accountabilities and is said to be stressful. A common picture is painted of a group that valiantly and regularly contends with major challenges but who is not afraid of hard work, even delivering hands-on care when necessary.[29] There is no doubt that it the role is a formidable one.

Research suggests that, regardless of sector, care home managers are often dedicated individuals who are motivated by a sense of caring and the need for professional accomplishment and whose motivations are sometimes misunderstood by commissioners, which could impact on the potential for building trusting relationships. Care home managers suggest that they need a wide range of personal qualities, in addition to skills and knowledge required, to manage a care home successfully.

The status and nature of the role were recurring themes. These mainly related to the perceived lack of recognition from within and outside the social care sector and a lack of support from care home owners/providers. Despite the requirement to be registered with the regulatory body as responsible for the care home, no professional registration or accreditation is available for managers, and the role is not recognised as a 'profession' in the same way as that of an occupational therapist and a social worker, although a minority may hold a professional qualification such as nursing. The qualifications required

---

29 Cornes et al. (2010) interviewed one who had worked for four consecutive nights and days without proper time off.

are vocational and there are no set continuing professional development requirements. A lack of professional recognition may be one factor that contributes to the perpetuation of the perception that social care work is of low status. Certainly, in the light of ever-changing regulations, knowledge around social and medical care and evidence relating to certain practices in care homes and the length of time in role, it would appear to be a shortcoming in the system that continued learning is not a mandatory requirement, particularly since an appetite for it amongst registered managers has been identified and many do undertake non-mandatory courses despite the time pressures they face. Registered managers also appear to be keen for some sort of accreditation to be put in place and there are currently national efforts to take this forward.

Leadership styles that value relationships, involve, value and encourage staff and that enable and respect staff and residents are said to be appropriate for the care home environment; although, it has also been suggested that the style should vary according to the circumstances. Support for and training in leadership was identified some years ago as a need, and the Skills Academy's Registered Managers Support Programme may go some way to address this. The Programme is reported to be subject to independent evaluation alongside other work, and local networks are already reporting on the impact of their work on managers' practice on the ground and on service quality. That national leadership development and support programmes have been so well-received by care home managers who access them is, perhaps, a reflection of the passion for caring that care home managers have reported and, perhaps, also of their qualifications and background.

A failure of many different types of organisation seems to be a process whereby those who are good at their job are promoted into a more senior position that moves them away from the area in which they have excelled and for which they may be unprepared. National data do not capture the various routes to care home management, nor does it capture what proportion of care home managers have progressed through social care and health; furthermore, capturing the specifics of all qualifications held, rather than capturing the highest qualifications only, would provide a much richer picture.

Consideration could be given to altering the qualification and registration requirements given how crucial the role and leadership of the care home manager is throughout a home and for its outcomes (see the section on professional structures and status for information about the Scottish and Welsh system, and for US findings concerning how qualifications and professional requirements appear to be associated with the quality of care provided). The responsiveness of other services and commissioners may, too, be affected by the lack of recognition of care home managers as consummate professionals within health and social care. Based on the findings of this review, it is also clear that little is known about the impact or significance of a care home manager having, or not having, a clinical or other qualification. It might first be interesting to investigate the 'sociology of the care home manager' (the behaviour expected of a person in the role) and whether it is a profession or an administrative managerial role.

Care Home Managers: a scoping review of evidence

Demographic and other data available from the National Minimum Data Set for Social Care (NMDS-SC) was available for a maximum of half of the registered care home managers, meaning that it is not possible to gain a complete overview of their characteristics. However, based on the demographic profile of current care home managers, it appears that there will soon be many more vacancies that need to be filled. Little is known about how people currently working in social care (in a variety of roles) or health perceive the role of care home manager in terms their own career progression, how likely they may be to apply for the role and what it is that either attracts or discourages them from doing so. Such data may be valuable for future planning.

A body of literature was identified about relationship-based approaches. While this did not fall within the scope of this review, and given that care home managers are so central to the business they manage, there is potential for future reviews to look more directly at the managerial contribution to quality of care and resident wellbeing and the building of relationships.

The evidence reviewed here has brought to light that care home managers face a variety of challenges relating to problems associated with lack of professional recognition and support, workload, financial and staffing issues, developing relationships and networks, keeping up-to-date with regulations and policies, facing and addressing negativity from the outside world, balancing roles, creating a homely environment, the increasing complexities of residents' needs and responding to the circumstances relating to the size of home and type of ownership. Many of these challenges are inextricably intertwined and can impact in different ways, for example on the implementation of policies. In exploring the implementation of aspects of the care home manager's role and the challenges they face, the areas in which the review found the least evidence were around finances, involving residents and families and clinical/care issues, and almost nothing was identified about complaints.

With regard to their role (and challenges faced) in involving residents, the lack of evidence was unexpected, as this is one of a registered manager's areas of responsibility as specified by the regulations, and empowerment is a subject around which there might have been research, particularly in care homes for younger adults. In following this up, it might be of benefit to explore whether there are significant differences in the literature on the management of homes for older people and those for younger adults, as this may reveal prevailing assumptions about differences in the role of care and support for younger and older people. The role of communication and the manner in which this is carried out may also be investigated within this context.

In terms of managers' responsibilities and challenges in managing budgets, accounts and funding issues within their homes, there was little about, for example, balancing local authority-funded places with self-funded places and cross-subsidies. Challenges are likely to increase with the introduction of personalised funding to care homes relating to both paperwork and relationships with health bodies. Following the 2011 the Law Commission's proposal to introduce direct payments for local authority funded care home

residents – as a way to encourage choice and control among residents – the Government expressed its commitment to trying this in a set of pilot local authorities in its White Paper *Caring for our Future: Reforming Care and Support* (HM Government 2012). A Department of Health funded Direct Payments in Residential Care Trailblazer programme is now running in 18 areas. Personalisation of health care funding is also being rolled out with the right to request a personal health budget introduced for people eligible for NHS Continuing Care in April 2014.

An area of interest about which there was little research is the role and responsibilities of owners and providers. An unsettling finding was that, around one in eleven homes do not have a registered manager, despite being legally required to do so. Almost 500 have been without a registered manager for more than two years. Although it is the manager who must apply for their own registration, it is worrying that there is a small pocket of owners/providers who do not ensure that their home is compliant with regulations by having a registered manager, particularly when funding challenges are not uncommon and the penalty for not complying may be financial. This is not to say that there is no permanent manager in place, but it serves to demonstrate that some seem not to prioritise recruiting a permanent post holder. Clearly there may be some issues of clarity around roles and responsibilities that would be interesting to investigate.

Related to this are distinct gaps in evidence on the supervision and support available for managers and the differences relating to the size and type of operation and about what each party expects, or should be able to expect, of the other.

The CQC clearly sets out what is covered by the role of the Registered Manager, including that they share legal responsibility for regulation compliance with the providing organisation or owner. CQC's proposals are to extend this to named Board members. However, whether there are distinct differences in the care home manager's role depending on the size and type of provider is not known. This is important because, to maximise effectiveness, each party needs to know what they can expect of the other. Gaps in knowledge relate to the level of awareness and understanding the provider/owner has of the challenges faced by care home managers, the level and type of support that the different types and sizes of provider or owner make available to care home managers and how these impact on care home managers. In this context, support might include managerial aspects (e.g. supervision, ensuring that training needs are identified and met), business needs (e.g. adequate budget, staffing levels) and practicalities (e.g. ensuring that essential equipment is available, meeting legal requirements in a range of areas, resolving personnel problems, contracting, providing professional advice about medication and nutrition). Since 15% (n=2,197) of care home managers were registered to manage homes owned by individuals, sole traders or partnerships (CQC 2014b), in filling the research gaps it will be important that data about managers and the different type of owners/providers can be separated since, for example, owners and owner-managers' motivations and credentials may differ from those of managers. Addressing these gaps will be important since 'change in care homes comes from within but it is unlikely to survive it is not

enabled, resourced and supported from outside' (i.e. all the outside world) (Burton 2007, p.228). Burton (2012) noted that what is missing is:

> the combined commitment and support of the policy-makers, providers and employers, commissioners, and regulators to enable registered managers to take the lead (take authority) in their own career development, the development of residential care, and the broader perception of adult social care... Real change will not happen without a self-critical reappraisal from those who ordain the direction of policy and currently control care homes from the outside (p.66).

It will certainly be challenging to carry out further research about care home managers given the pressures on their time and the extent of the problems they face. Some appear to be willing to be involved in research activity.[30] Many have supported research about aspects of life or work in care homes or care home residents. However, it is important to add to the body of knowledge reviewed here and to give some consideration to alternative or creative ways of engaging them. It was interesting to note that one of the few national surveys, the National Skills Academy for Social Care's survey, of registered managers of adult social care achieved a response rate of 16% (2,886). While not unexpected, other methods may help achieve higher rates of engagement and the potential for data to be linked and shared could be explored.

---

30 The Enabling Research in Care Homes (ENRICH) toolkit is a practical guide for researchers, care homes and residents supporting improved engagement and the delivery of research www.enrich.dendron.nihr.ac.uk

RECOMMENDATIONS FOR FURTHER RESEARCH

■ **Contribution of care home manager to quality of care**

A future review could explore how care home managers contribute to quality of care provided and resident wellbeing within the context of their leadership style and the development of relationships between staff, residents and their families.

■ **Mental health, stress and burnout**

Data for (1) care home managers and (2) care home owner-managers obtained through the use of validated scales that measure levels of stress, burnout and mental health more generally would be useful to give a better understanding of the impact of the challenges they face and enable the measurement of change.

■ **The role of the care home owner or provider**

An investigation of (1) the level of awareness and understanding providing organisations or owners have of the challenges faced by care home managers, (2) the level and type of support that the different types and sizes of provider and owners give to care home managers, and (3) the experiences of care home managers with regard to these would provide a base on which to build and test a package of support for them.

■ **Support for care home owners and providing organisations**

Following on from the above study, if not already covered by the National Skills Academy's programme, a training/support package/best practice guidelines for owners/regional managers could be developed, piloted and evaluated. Evaluation would need active engagement from care home managers.

■ **The requirements of the care home manager role**

An investigation into the sociology or labour market of the care home manager – what parts of the role are administrative, which require a social care or nursing professional qualification and how its various elements relate to the qualification requirements – may help to clarify the way forward with respect to, for example, future recruitment and the suitability of training requirements.

■ **Future care home managers**

An exploration of the views of people already working in social care/health, or studying with a view to working in social care/health, on being or becoming a care home manager may help the sector to identify and address perceived barriers and facilitators to career progression.

Care Home Managers: a scoping review of evidence

■ **Reduction of unnecessary 'bureaucracy'**

The potential for 'paperwork' regarding local commissioning (and national) inspection and monitoring systems to be linked could be identified, with the aim of reducing the bureaucratic burden for care home managers.

Joint (local and national) reporting systems could be piloted with care homes in a representative sample of local authority areas as part of the introduction of the new CQC inspection regime with a view to rolling them out on a mandatory basis dependent on outcomes in local areas. Evaluation of the pilots might measure the impact of combined systems on care home managers (e.g. time pressures, stress levels) and compare the outcomes of inspections in the area before and after the pilot.

■ **Communication about policy change**

New ways of communicating could be investigated and piloted with care home managers and owners/providers (e.g. webinars) with respect to the effective and rapid dissemination of details of policy or regulation change and the associated implications for care home managers. This could include a review of instances whereby this has been successful previously and what activities were involved (for example, national initiatives such as briefings, training packages, or attendance at events).

Responsibility for this could be more balanced between statutory bodies and not professional associations that do not have obligatory membership. However there may be a role for Skills for Care or the Social Care Institute for Excellence in monitoring the effectiveness of its communications and outputs.

■ **Involving residents**

Identifying literature about empowering residents and ensuring they have a say in running the care home they are living in and exploring whether there are significant differences on the management of homes for older people and those for younger adults may reveal whether there are prevailing assumptions about differences in the role of the management of care and support for younger and older adults.

■ **Evaluating impact of existing initiatives**

Evaluation of the impact of the National Skills Academy for Social Care's Registered Managers Support Programme and other initiatives, such as the My Home Life programme, may be facilitated by the collection of baseline data on:

• care home managers (e.g. stress level, length of time in post, reason for leaving);

• recruitment and retention of care workers in care homes;

• commissioners' and local health services' perceptions of care home managers;

• relationships between commissioners/local health services and care homes;

• public perceptions of social care generally and of care homes in particular; and

- the extent to which it may helpful for learning and experiences to be shared across managers of care homes for different types of residents, and the extent to which such cross-fertilisation of knowledge is already happening. Data sharing between different bodies could be explored – on an anonymous basis. The potential for making use of data collected by large corporate providers could be explored sensitively – some of these providers do release certain of their in house data covering staffing and customers, but little use is made of it collectively.

In developing possible research questions and priorities, it will, of course, be important for care home managers to contribute their ideas, views and expertise.

REFERENCES

Addison J, Bunce C (2013) The many faces of the job: boss, manager, friend, *Nursing & Residential Care*, 15 2, 11–114.

Anderson RA, Issel LM, McDaniel Jr RRR (2003) Nursing Homes as complex adaptive systems: relationship between management practice and resident outcomes, *Nursing Research*, 52, 1, 12–21.

Andrews GJ, Kendall S A (2000) Dreams that lie in tatters: the changing fortunes of nurses who left the British NHS to own and run residential homes for elderly people, *Journal of Advanced Nursing*, 31, 4, 900-908.

Arksey H, O'Malley L (2005) Scoping studies: towards a methodological framework, *International Journal of Social Research Methodology*, 8, 1, 19–32.

Astrom S, Skarlsson S, Sandvide A, Bucht G, Eisemann M, Norberg A, Saveman BI (2004) Staff's experience of and the management of violent incidents in elderly care, *Scandinavian Journal of Caring Sciences*, 18, 4, 410–416.

Atkinson S (2013) Care Home Registered Managers – their Importance in Running a Good Care Home, Run a Care Home, Retrieved from www.bbc.co.uk/news/uk-england-london-13908167.

BBC (2011) *Ash Court Care Centre worker held over 'assault'*, 15 November, www.bbc.co.uk/news/uk-england-london-13908167.

Bostrom AM, Squires JE, Mitchell A, Sales AE, Estabrooks CA (2012) Workplace aggression experienced by frontline staff in dementia care, *Journal of Clinical Nursing*, 21, 9–10, 1453–1465.

Bouman WP, Arcelus J, Benbow SM (2007) Nottingham study of sexuality and ageing (NoSSA II). Attitudes of care staff regarding sexuality and residents: A study in residential and nursing homes, *Sexual and Relationship Therapy*, 22, 1, 45–61.

Bowman C, Whistler J, Ellerby M (2004) A national census of care home residents, *Age and Ageing*, 33, 6, 561–566.

Broadhurst S, Mansell J (2007) Organizational and individual factors associated with breakdown of residential placements for people with intellectual disabilities, *Journal of Intellectual Disability Research*, 51, 4, 293–301.

Brown Wilson C (2009a) Developing community in care homes through a relationship-centred approach, *Health and Social Care in the Community*, 17, 2, 177–186.

Burtney E, Skills for Care (2014) *Question about qualifications*, K. Orellana

Burton J (2007) Care homes: Do they 'care' and are they 'homes'?, *Journal of Care Services Management*, 1, 3, 221–232.

Burton J (2008) Care homes: Caring and homely? But how?, *Journal of Care Services Management*, 2, 3, 227–238.

Burton J (2012) Behind the facade, beneath the surface: where registered managers need to look and what they need to know, *Journal of Care Services Management*, 6, 63–68.

Burton J (2013) Consultancy to a Care Home: The Influences of Family and Gender Roles, and of Race and Colonialism, *Journal of Social Work Practice*, 27, 4, 407–421.

Calkin S (2013) CQC plans care home crackdown, *Nursing Times*, 19 September, www.nursingtimes.net/nursing-practice/clinical-zones/older-people/cqc-plans-care-home-crackdown/5063405.article.

Care Council for Wales (2014) Registration, Retrieved 28 March 2014 from www.ccwales.org.uk/registration

Care Quality Commission (2010) *Care Quality Commission: Guidance about Compliance Essential Standards of Quality and Safety*, Care Quality Commission, London.

Care Quality Commission (2011) *Registration Under the Health and Social Care Act 2008. Guide to the Application Process: Guidance for New Registered Managers*, Care Quality Commission, London.

Care Quality Commission (2012a) *The State of Health Care and Adult Social Care in England: An Overview of Key Themes in Care in 2011–12*, Care Quality Commission, London.

Care Quality Commission (2012b) *Supporting Note: Training Qualifications – Adult Social Care*, Care Quality Commission, London.

Care Quality Commission (2012c) *The Operation of the Deprivation of Liberty Safeguards in England, 2010/11*, Care Quality Commission, London.

Care Quality Commission (2012d) *Health Care in Care Homes: A Special Review of the Provision of Health Care to those in Care Homes*, Care Quality Commission, London.

Care Quality Commission (2013a) *What is registration?*, Retrieved 16 October 2013, from http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/what-registration.

Care Quality Commission (2013b) *A New Start: Consultation on Changes to the Way CQC Regulates, Inspects and Monitors Care*, Care Quality Commission, Newcastle.

Care Quality Commission (2013c) *A New Start: Responses to our Consultation on Changes to the way CQC Regulates, Inspects and Monitors Care Services*, Care Quality Commission, London.

Care Quality Commission (2013d) *The State of Health Care and Adult Social Care in England 2012/13*, London

Care Quality Commission (2013e) *Introducing a New Statement of Purpose for Providers of Services for People with a Learning Disability*, Care Quality Commission, Online.

Care Quality Commission (2014a) *Care Homes*, Retrieved 8 January 2014, from www.cqc.org.uk/about-us/services-we-regulate/care-homes.

Care Quality Commission (2014b) *Registered Managers of Care Homes in England*, 13th February 2014.

Care Quality Commission (2014c) *Active Locations for Providers Registered under the Health and Social Care Act*, 13 February, Retrieved from www.cqc.org.uk/cqcdata

Castle NG, Decker FH (2011) Top management leadership style and quality of care in nursing homes, *Gerontologist*, 51, 5, 630–642.

Castle NG, Ferguson JC, Hughes K (2009) Humanism in nursing homes: the impact of top management, *Journal of Health and Human Services Administration*, 31, 4, 483–516.

Castle NG, Furnier J, Ferguson-Rome JC, Olson D, Johs-Artisensi J (2014) Quality of care and long-term care administrators' education: Does it make a difference?, *Health Care Management Review,* Published online 30 December 2013.

Castle NG, Lin M (2010) Top management turnover and quality in nursing homes, *Health Care Management Review*, 35, 2, 161–174.

Castle NG, Longest BB (2006) Administrative deficiency citations and quality of care in nursing homes, *Health Services Management Research*, 19, 3, 144–152.

Cavendish C (2013) *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, Department of Health, London.

Centre for Policy on Ageing (2012) *A Profile of Residents in Bupa Care Homes: Results from the 2012 Bupa Census*, Centre for Policy on Ageing, London.

Challis D, Mozley C, Sutcliffe C, Bagley H, Price L, Burns A, Huxley P, Cordingley L (2000) Dependency in older people recently admitted to care homes, *Age and Ageing*, 29, 3, 255–260.

Chambers N (2003a) The diverse role of the care home manager*, Nursing & Residential Care*, 5, 7, 342–344.

Chambers N, Tyrer J (2002) *Policy Issues and Management Challenges in the Nursing Home Sector*, Manchester Centre for Healthcare Management, University of Manchester, Manchester,

Chambers N, Tyrer J (2003b) What kind of leaders do we need in our care homes?, *Nursing & Residential Care*, 5, 8, 389–391.

Clegg A, Young J, Iliffe S, Olde Rikkert M, Rockwood K (2013) Frailty in elderly people, *The Lancet*, 381, 9868, 752–762.

Cornes M, Manthorpe J (2013) Evaluating a dementia focused performance management programme, *Dementia*, 12, 5, 661–665.

Cornes M, Moriarty J, Blendi-Mahota S, Chittleburgh T, Hussein S, Manthorpe J (2010), *Working for the Agency: The Role and Significance of Temporary Employment Agencies in the Adult Social Care Workforce*, Social Care Workforce Research Unit, King's College London, London.

Davies S, Brown Wilson C (2007a) Creating a sense of community, in Meyer J, Heath H (eds) *My Home Life. Quality of Life in Care Homes: A Review of the Literature*, Help the Aged, London, pp. 65–84.

Department for Business Innovation and Skills (2013), *Focus on Enforcement Regulatory Reviews: Review of the Care Home Sector*, Department for Business Innovation and Skills,. London.

Dewar B (2007) Promoting positive culture in care homes, in Meyer J, Heath H (eds) *My Home Life. Quality of Life in Care Homes: A Review of the Literature*, Help the Aged, London, pp.148–156.

Dewing J (2009) Making it work: a model for research and development in care homes, in , Froggatt K, Davies S, Meyer J (eds) *Understanding Care Homes: A Research and Development Perspective*, Jessica Kingsley Publishers, London, pp.222–241.

Dimon C (2005a) The challenging role of the care home manager, *Nursing & Residential Care*, 7, 12, 571–572.

Donnelly L (2013) 4,000 care homes have been allowed to break the law, *The Telegraph*, 23 September, www.telegraph.co.uk/health/healthnews/10328695/4000-care-homes-have-been-allowed-to-break-the-law.html

Donoghue C, Castle NG (2009) Leadership styles of nursing home administrators and their association with staff turnover, *Gerontologist*, 49, 2, 166–174.

Dunning J (2011) Campaign to boost status of care service managers launched, *Community Care*, 2 November, www.communitycare.co.uk/2011/11/02/campaign-to-boost-status-of-care-service-managers-launched

Emerson E (2010) *The Future Need for Social Care Services for Adults with Disabilities in England 2012–30*, SSCR Scoping Review, NIHR School for Social Care Research, London.

Evans S, Huxley P, Gately C, Webber M, Mears A, Pajak S, Medina J, Kendall T, Katona C (2006) Mental health, burnout and job satisfaction among mental health social workers in England and Wales, *British Journal of Psychiatry*, 188,1, 75–80

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Vol 1 & 2: Analysis of Evidence and Lessons Learned; Vol 3: Present and Future: Annexes)*, The Stationery Office, London.

Gage H, Knibb W, Evans J, Williams P, Rickman N, Bryan K (2009) Why are some care homes better than others? An empirical study of the factors associated with quality of care for older people in residential homes in Surrey, England, *Health and Social Care in the Community*, 17, 6, 599–609.

Greenidge T (2013) *The Relatives & Residents Association (2014)*. Quarterly helpline report July – September 2013. Personal communication.

Gridley K, Brooks J, Glendinning C (2013) Good practice in social care for disabled adults and older people with severe and complex needs: evidence from a scoping review, *Health and Social Care in the Community*, 22, 3, 234–248.

Heath H (2011) *Older People in Care Homes: Sex, Sexuality and Intimate Relationships: an RCN Discussion and Guidance Document for the Nursing Workforce*, Royal College of Nursing, London.

Heath H (2012) Supporting sexuality and intimate relationships, *Nursing and Residential Care*, 14, 475–477.

HM Government (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services*, Department of Health, Norwich.

HM Government (2010a) *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; National Health Service – England; Social Care – England; Public Health – England 781*, Care Quality Commission (reproduced by permission of Reed Elsevier (UK) Limited trading as LexisNexis), London.

HM Government (2010b) *A Vision for Adult Social Care: Capable Communities and Active Citizens*, Department of Health, London.

HM Government (2011) *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*, Department of Health, Norwich.

HM Government (2012) *Caring for Our Future: Reforming Care and Support*, Department of Health, Norwich.

Hussein S, Manthorpe J, Ismail M (2014) Ethnicity at work: the case of British minority workers in the long-term care sector, *Equality, Diversity and Inclusion*, 33, 2, 177–192.

Independent Commission on Dignity in Care for Older People (2012) *Delivering Dignity: Securing Dignity in Care for Older People in Hospitals and Care*, NHS Confederation, Local Government Association and Age UK, London.

Jagger C, Collerton J, Davies K, Kingston A, Robinson L, Eccles M, von Zglinicki T, Martin-Ruiz C, James O, Kirkwood T, Bond J (2011) Capability and dependency in the Newcastle 85+ cohort study. Projections of future care needs, *BMC Geriatrics*, 11, 1, 21.

Kay EJ (2000) Oral health training programme for the elderly, *British Dental Journal*, 188, 4, 200.

Kendall J (2001) Of knights, knaves and merchants: the case of residential care for older people in England in the late 1990s, *Social Policy and Administration*, 35, 4, 360–375.

Knocker S (2006) *The Whole of Me… Meeting the Needs of Older Lesbians, Gay Men and Bisexuals Living in Care Homes and Extra Care Housing*: *A Resource Pack for Professionals*, Age Concern, London.

Kokkonen K, Rissanen S, Hujala A (2012) The match between institutional elderly care management research and management challenges – a systematic literature review, *Health Research Policy and Systems*, 10, 35.

Le Grand J (1997) Knights, knaves or pawns? Human behaviour and social policy, *Journal of Social Policy*, 26, 2, 149–169.

Levac D, Colquhoun H, O'Brien K (2010) Scoping studies: advancing the methodology, *Implementation Science*, 5, 69.

Lievesley N, Crosby G, Bowman C (2011) *The Changing Role of Care Homes*, BUPA and Centre for Policy on Ageing, London.

Lim R, Anderson J, Buckle P (2008) Analysing care home medication errors: a comparison of the London protocol and work domain analysis, *Proceedings of the Human Factors and Ergonomics Society Annual Meeting*, 52, 4, 453–457.

Luff R, Ferreira Z, Meyer J (2011) *SSCR Methods Review 8: Care Homes*, NIHR School for Social Care Research, London.

Lupton C, Croft-White C (2013) *Respect and Protect: The Experience of Older People in Care Homes and Hospitals*, Prevention of Abuse and Neglect in the Institutional Care of Older Adults (PANICOA), London.

Manthorpe J, Moriarty J (2014) Examining day centre provision for older people in the UK using the Equality Act 2010: findings of a scoping review, *Health and Social Care in the Community*, 22, 4, 352–360.

Manthorpe J, Samsi K (2014) Care homes and the Mental Capacity Act 2005: changes in understanding and practice over time, *Dementia*, Published online 10 July.

Manthorpe J, Samsi K, Heath H, Charles N (2011) 'Early days': knowledge and use of the Mental Capacity Act 2005 by care home managers and staff, *Dementia*, 10, 283–298.

Martin F, Thorpe T, Heath H, Noble H (2011) *Quest for Quality in Care Homes. British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement*, British Geriatrics Society, London.

Matosevic T (2008) *Profit or Care: The Motivations of Care Home Owners and Managers in England*, PhD Thesis, London School of Economics and Political Science, London.

Matosevic T, Knapp M, Kendall J, Henderson C, Fernandez J (2007) Care home providers as professionals: understanding the motivations of care home providers in England, *Ageing and Society*, 27, 1, 103–126.

Matosevic T, Knapp M, Le Grand J (2008) Motivation and commissioning: perceived and expressed motivations of care home providers, *Social Policy and Administration* 42, 3, 228–247.

Matosevic T, Knapp M, Le Grand J, Fernandez J (2011) Changes over time: the motivations of independent-sector care-home managers and owners in England between 1994 and 2003, *Ageing and Society*, 31, 1389–1405.

Matthews F, Arthur A, Barnes LE, Bond J, Jagger C, Robinson L, Brayne C (2013) A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II, *The Lancet*, 382, 9902, 1405–1412.

Meyer J (2007) Keeping the workforce fit for purpose, in Meyer J, Health H (eds) *My Home Life. Quality of Life in Care Homes: A Review of the Literature*, Help the Aged, London, pp.130–147.

Moiden N (2002) Leadership in the elderly care home sector, *Nursing Management*, 9, 8, 24–28.

My Home Life (2012) My Home Life Manager's Voice, My Home Life.

National Care Forum (2014) *Ex-soldier's plight – more care homes should meet needs of under 65s*, 7 March, from www.nationalcareforum.org.uk/viewNews.asp?news_ID=1388.

National Care Homes Research and Development Forum (2007) *My Home Life. Quality of Life in Care Homes: A Review of the Literature*, Help the Aged, London.

National Careers Service (2013) *Job profile: Registered care home manager*, Retrieved 16th October 2013, from https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/registeredcarehomemanager.aspx.

National Prescribing Centre (2008) *Moving Towards Personalising Medicines Management: Improving Outcomes for People Through the Safe and Effective Use of Medicines*, National Prescribing Centre, London.

National Skills Academy for Social Care (2012) *Everyday Excellence: A Research Report into How Registered Managers View their Career in Social Care, and the Changes Required to Better Support Them in their Day-to-day Roles*, National Skills Academy for Social Care, London.

National Skills Academy for Social Care (2013a) *Leadership Starts with Me: The Why, What and How of Leadership in Adult Social Care*, National Skills Academy for Social Care, London.

National Skills Academy for Social Care (2013b) *The Leadership Qualities Framework For Adult Social Care*, National Skills Academy for Social Care, London.

Nolan M, J. Brown, Davies S, Nolan J, Keady J (2006a) *The Senses Framework: Improving Care for Older People Through a Relationship-centred Approach*, Getting Research into Practice (GRiP) Report No 2, Sheffield Hallam University, Sheffield.

Nolan M, Davies S, Brown J (2006b) Transitions in care homes: towards relationship-centred care using the 'Senses Framework', *Quality in Ageing*, 7, 3, 5–14.

Owen T, Meyer J, Cornell M, Dudman P, Ferreira Z, Hamilton S, Moore J, Wallis J (2012a) *My Home Life: Promoting Quality of Life in Care Homes*, Joseph Rowntree Foundation, York.

Owen T, Meyer J, Cornell M, Dudman P, Ferreira Z, Hamilton S, Moore J, Wallis J (2012b) *Promoting Coice, Choice and Control for Older People Living in Care Homes*, Joseph Rowntree Foundation, York.

Packard T (2009) Leadership and performance in human service organizations, in Patti R (ed) *Handbook of Human Services Management 2nd Ed.*,Sage Publications, Thousand Oaks, CA, pp.143–164.

Peace S, Holland C (2001) Homely residential care: a contradiction in terms? *Journal of Social Policy*, 30, 3, 393–410.

Quince C (2013) *Low Expectations: Attitudes on Choice, Care and Community for People with Dementia in Care Homes*, Alzheimer's Society, London.

Reed J, Payton VR (1997) Understanding the dynamics of life in care homes for older people: implications for de-institutionalizing practice, *Health and Social Care in the Community*, 5, 4, 261–268.

Registered Nursing Homes Association (2013) *Care regulators should speed up registration of newly appointed home managers*, says RNHA, Retrieved 15 December, 2013, from www.rnha.co.uk/web_images/news/News%20release%20on%20CQC%20care%20home%20manager%20registration%20delays.pdf.

Roe P, Wiseman J, Costello M (2006) *Perceptions and Use of NVQs: A Survey of Employers in England*, Department for Education and Skills, Nottingham.

Rouse J (2013) Supporting registered managers to build compassion in care homes, Government speeches. London, www.gov.uk (Department of Health). 2013: Jon Rouse writes in response to the BBC's Panorama programme 'Elderly Care: Condition Critical'

Royal College of Nursing (2012) *Persistent Challenges to Providing Quality Care. An RCN Report on the Views and Experiences of Frontline Nursing Staff in Care Homes in England*, Royal College of Nursing, London.

Samuel M (2013) Serious case review to commence into neglect that contributed to care home deaths, *Community Care*, 21 December, www.communitycare.co.uk/2013/10/21/serious-case-review-to-commence-into-neglect-that-contributed-to-care-home-deaths.

Scottish Social Services Council (2014) *Qualification criteria – all workers in care home services for adults,* Retrieved 28 March 2014 from www.sssc.uk.com/All-about-Registration/qualification-criteria-all-workers-in-care-home-services-for-adults.html.

Sharp S (2007) *Home from Home: A Report Highlighting Opportunities for Improving Standards of Dementia Care in Care Homes*, Alzheimer's Society, London.

Skills for Care (2013a) *The Size and Structure of the Adult Social Care Sector and Workforce in England*, Skills for Care, Leeds.

Skills for Care (2013b) *Job Roles: Guidance for Organisations and for People who Employ Their Own Care and Support Staff*, Skills for Care, Leeds.

Skills for Care (2013c) *National Minimum Data Set for Social Care Provisional File (Adult Social Care Managers who work in a Care home with or without nursing),* Skills for Care, Leeds.

Skills for Care (2013d) *Violence Against Social Care and Support Staff. Summary of Research,* Skills for Care, Leeds.

Skills for Care (2014a) *Open Access National Minimum Data Set for Social Care Dashboards*, January 2014, Retrieved from www.nmds-sc-online.org.uk/reportengine/dashboard.aspx.

Skills for Care (2014b) *The National Minimum Data Set for Social Care (NMDS-SC)*, Retrieved 15 January 2014, from www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/NMDS-SC/NMDS-SC.aspx.

Skills for Care (2014c) *What is the NMDS-SC?* Retrieved 15 January 2014, from www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/NMDS-SC/What-is-the-NMDS-SC.aspx

Smith P, Alla H, Henry L, Larsen J, Mackintosh M (2007) *Valuing and Recognising the Talents of a Diverse Healthcare Workforce*, Royal College of Nursing, London.

Social Care Association (2011) *Champion, Leader, Protector: The Role of the Registered Manager in Residential Care for Adults in England* (Pre-publication draft for consultation), Social Care Association, Kent.

Sorkin D. National Skills Academy for Social Care, (2014a) Responses to survey. Personal communication.

Sorkin D. National Skills Academy for Social Care, (2014b) Everyday Excellence information. Personal communication.

Stevens M, Hussein S, Manthorpe J (2012) Experiences of racism and discrimination among migrant care workers in England: Findings from a mixed-methods research project, *Ethnic and Racial Studies*, 35, 2, 259–280.

Szczepura A, Clay D, Hyde J, Nelson S, Wild D (2008) *Models for Providing Improved Care in Residential Care Homes: A Thematic Literature Review*, Annotated bibliography, University of Warwick, Warwick.

Tadd W, Woods R, O'Neill M, Windle G, Read S, Seddon D, Hall C, Bayer T (2013) *Promoting Excellence in All Care Homes (PEACH)*, Prevention of Abuse and Neglect in the Institutional Care of Older Adults (PANICOA), London.

Takatsuki K (2011) Care homes 'lack named managers', BBC, 8 August, www.bbc.co.uk/news/health-14449125.

Taylor J (2012) *Working with Older Lesbian, Gay and Bisexual People: A Guide for Care and Support Services*, Stonewall, London.

Thompson D (2001) Meeting the needs of people with learning disabilities, *Nursing & Residential Care*, 3, 8, 364-366.

Train G, Nurock S, Kitchen G, Manela M, Livingston G (2005) A qualitative study of the views of residents with dementia, their relatives and staff about work practice in long-term care settings, *International Psychogeriatrics*, 17, 2, 237–251.

Tuffin M (2011) A care home manager's view, in Dening T, Milne A (eds) *Mental Health and Care Homes*, Oxford University Press, Oxford, pp.21–27.

Wagner G C (1988) *Residential Care: A Positive Choice, Report of the Independent Review of Residential Care*, The Stationery Office, London.

Wanless D, Forder J, Fernandez J-L, Poole T, Beesley L, Henwood M, Moscone F (2006) *Wanless Social Care Review. Securing Good Care for Older People: Taking a Long-term View*, King's Fund, London.

Warmington J, Afridi A, Foreman W (2014) *Is Excessive Paperwork in Care Homes Undermining Care for Older People?,* Joseph Rowntree Foundation, York.

Wild D, Nelson S, Szczepura A (2010) A 'home for life' in residential homes for older people in England: exploring the enhancers and inhibitors, *Housing Care and Support*, 13, 26–35.

Wilkinson C, Meyer J, Cotter A (2009) Developing Person-Centred Care in an NHS Continuing Care Setting, in Froggatt KA, Davies S, Meyer J (eds) *Understanding Care Homes: A Research and Development Perspective*, Jessica Kingsley Publishers, London, pp.25–46.

Williams V, Boyle G, Jepson M, Swift M, Williamson T, Heslop P (2012) *Making Best Interests Decisions: People and Processes*, Mental Health Foundation, London.

Wood C (2011) *Tailor Made*, Demos, London.

Woodhouse KW, O'Mahony MS (1997) Frailty and ageing, *Age and Ageing*, 26, 4, 245–246.

Worden A, Challis D (2007) Factors associated with higher quality assessment tools in care homes, *Journal of Care Services Management*, 2, 1, 79–91.

Young BC, Murray CA, Thomson J (2008) Care home staff knowledge of oral care compared to best practice: a West of Scotland pilot study, *British Dental Journal*, 205, 8.

APPENDIX: MEMBERSHIP OF THE VIRTUAL ADVISORY GROUP

National Skills Academy for Social Care: Debbie Sorkin and Caroline Bernard

Skills for Care: Liz Burtney

Age UK: Stephen Lowe

My Home Life: Tom Owen

Joseph Rowntree Housing Trust: John Kennedy

The Residents and Relatives Association: Trevor Greenidge

National Care Forum: Des Kelly

Association for Real Change: Shirley Potter

Unison: Helga Pile

Sue Benson, Relative of care home resident and Managing Editor, Journal of Dementia Care

Cumbria Community of Practice: via Michelle Cornes, Social Care Workforce Research Unit, King's College London

Cambridge Nursing Home: Mr Rashid Ebrahimkhan, Care Home Manager and member of the School for Social Care Research's User Carer and Practitioner Group

Dorothy Runnicles, Resident of a 'housing with care' mixed tenure village and member of the SCWRU Service User and Carer Advisory Group

School for Social Care Research

Phase I (2009-2014) of the NIHR School for Social Care Research (SSCR) was a partnership between the London School of Economics and Political Science, King's College London and the Universities of Kent, Manchester and York. Phase II (2014-2019) of SSCR is a partnership between the London School of Economics and Political Science and the Universities of Bristol, Kent, Manchester and York, and is part of the National Institute for Health Research (NIHR) www.nihr.ac.uk/.

NIHR School for Social Care Research
London School of Economics and Political Science
Houghton Street
London
WC2A 2AE

020 7955 6238
www.sscr.nihr.ac.uk
sscr@lse.ac.uk