# What's Wrong with CQC?

## A proposal to reform the regulation of social care

A DISCUSSION PAPER FROM THE CENTRE FOR WELFARE REFORM

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# Contents

# Foreword

John Burton has done adult social care and the CQC a great service with this important analysis of CQC's failures in adult social care. He demonstrates that an approach to quality of care that focuses on standardised processes is doomed to failure. There simply is no consistent positive correlation between the processes that are being assessed and the kind of relationships and care that we should hope to see in care and nursing homes. You can no more regulate care in this way than you could regulate family life. The idea is absurd.

What is more we pay an enormous cost for deluding ourselves that we are successfully regulating care. The financial cost of £100 million is extreme, but the much greater cost is the harm that is done to organisations who try to make themselves compliant to this meaningless regime, and to all those who are put off from providing care because they do not want to be part of this system.

There are good reasons for having some kind of inspection system. There are dangers that are particular to care homes that demand that we check how things are. If someone is thinking about leaving their home and entering a care home then they should be given good advice and reliable information. But the bureaucratic maze that is the CQC is never going to be able to deliver on those reasonable expectations.

The key, as John Burton recognises, is to get more local and to humanise the whole process. The funding currently wasted on CQC could be reinvested in a locally rooted system where inspectors have real relationships with people and homes. In addition I'd suggest that the use of Quality Checkers, people who've got real experience of care, should be central to the whole process. This system would also be able to work in partnership with local social workers who have the primary responsibility for assessment and advice.

This should be an issue that politicians, nationally and locally, advocacy groups, trade unions and service providers could all get behind. John Burton has done the difficult task, he has dared to point out that the Quality Emperor has no clothes. It's time that we

recognise the facts, turn back from the damaging path we've been on and start to really take care of those who choose to residential care or regulated domiciliary care.

Dr Simon Duffy

Director of the Centre for Welfare Reform

# 1. Introduction

**In this essay I argue that the regulation and inspection of social care in England is doing more harm than good. The Care Quality Commission is not effective or responsive; it doesn't understand how social care works; it rarely uncovers neglect and abuse, and it responds too slowly when they are brought to its attention; its judgements are flawed and its ratings inaccurate and unhelpful; its inspections reports are poorly written and constructed; it costs much more than it should and imposes vast unnecessary costs on social care providers; it dominates and distorts the whole social care sector, and the organisation is blinkered, risk averse, top heavy and hopelessly bureaucratic.**

However, I conclude by arguing that since social care is a local service, with care homes and care at home provided and organised for neighbourhoods, inspection should also be organised locally and inspectors should be responsive, responsible and accountable to local communities. This would be more effective; it would give the public direct access to and relationship with the inspector of their care; it would free users, teams and managers to collaborate in creating their sort of care together, and it would cost less.

# 2. CQC is not effective

**The job of the regulator is to set standards and check that people's paid-for care is good enough. The standards and their interpretation have become far too complicated and prescriptive, so, rather than checking that the care itself is good enough, the CQC concentrates on the more easily measured standards and how they are being followed in the provider's written records and procedures. (It's like checking that a carpenter's tools are all present and correct, that the carpenter's rule is accurate, that the drill bits are in order in the right containers, and that all this is recorded frequently and in great detail. Most good carpenters would find this intolerable but they would like what they make to be assessed and appreciated by someone who knows what they're looking at. The tools and the records may be in perfect order but it's the resulting woodwork that needs checking.)**

The complexity and technicalities of regulatory demands shift the focus of the work to compliance with the CQC - "passing" inspections and getting a good "rating" - rather than meeting residents' needs. This results in the provider matching the regulator's obsession with records and procedures at the expense of relationship based care. Instead of enhancing the quality of care, the effect of regulation and inspection is to come between and block the therapeutic relationship between care worker and resident.

In practice, the CQC cannot inspect most homes annually and are moving (back) to a previously failed practice of inspecting homes with higher ratings ("good" or "outstanding") every two or three years. When the previous "star" rating system existed, the period between inspections was supposed to correspond to the stars - one star meant annual inspections and so on. However, the regulator failed to stick to the plan, and many homes were not inspected for at least a year more than was intended. This resulted in a build up of homes that were clearly failing to give adequate care - even amongst two- and three-star homes - but had not been inspected for several years.

In a recent case - BBC Panorama 20.11.16 - the CQC had inspected two or three times a year for the last three years, finding the Cornish home in question "required improvement" although it was rated "good" for effectiveness and caring. Meanwhile, neglect, abuse and widespread poor

practice continued. Only when Panorama secretly filmed inside the home, was the home closed. Yet the day after the TV exposure, the CQC website showed the home as still "requiring improvement". At the other end of the country in County Durham, a very good small home for five men with learning disabilities, a real family/community, is found to be "inadequate" for three years and it is closed because the owners and staff were much better at real care and relationships than at record keeping.

The CQC leave appallingly bad places to continue operating and it closes really good ones. This is not effective practice on the part of the CQC and it doesn't seem very caring either.

# 3. CQC is not responsive

**The CQC has a national helpline in Newcastle where thousands of calls are received every year. Some of these calls are serious complaints and worries about care, and some will be routed back to the central database of homes and to the inspector of the home. Very few of them will result in an inspector contacting or visiting the home, but the information will be put "on file" and fed into the "profile" that the inspector considers on their next inspection visit.**

For many years now, the national inspectorate has not dealt with people's complaints but has used them as information to add to the "safety and risk profile" of the home. This stance is incomprehensible to most complainants.

The public cannot have a conversation with the inspector for their home because residents and their relatives don't even know the name of their inspector. The inspector's name does not appear on the report and even when there is only one inspector, the report is written in the first person plural - "we" - in other words, the Care Quality Commission. The issues that a relative, for example, will want to speak to an inspector about are usually urgent, emotional and personal, but they are routed to a national call centre where the staff are struggling to listen but have no direct involvement with the service being spoken about, and have to say that this "information" will be passed on to the inspector for the home.

Nearly all serious concerns about care homes are raised by people outside the CQC, and it usually takes an accumulation of voices (residents, relatives, staff, visitors) and sometimes media attention to stir the CQC into action. The public face of the CQC is such that, when they find a home is failing, neglectful or abusive, they take the credit for exposing it, but this is rarely the case.

When challenged on this point, the CQC argue that it isn't possible to detect abuse or malpractice at an inspection so they rely on the public to bring such problems to their attention. In most people's minds the refusal to deal with individual complaints contradicts the message that the CQC wish to hear about any concerns that anyone has about care.

# 4. CQC doesn't get relationships

**A social and therapeutic setting such as a care home is immensely complex, and operates on several levels, many of which are hidden or beneath the surface.**

In spite of inspectors being trained to use the "short observational framework for inspection" (SOFI - University of Bradford) to help them to understand how well staff are communicating with and caring for residents with dementia, they rely very heavily on what is - or is not - recorded, in other words, written documents (care plans etc). The CQC continues to hold to the myth that "if it isn't recorded, it didn't happen" when, quite frequently, the very opposite is true. If the inspectors rely so heavily on records in their assessment of a care service, then the record becomes more important than the action. And, if time is limited and they have to make a choice, staff will record what did not happen but should have.

If inspectors fail to understand what is going both above and beneath the surface in a care home and why it might be happening, but instead rely on the "evidence" of the records, policies and procedures that they have demanded should be written for them, inspection becomes a version of marking homework - ticks and crosses and marks out of ten.

Having itself experienced the sustained effort and long time needed to reform its own operation (from near chaos to running the organisation "righter", although still doing the wrong thing), and admitting that it still fails in some areas, the CQC should understand how long it takes to improve a care home. It is a matter of years not months, yet the CQC expects "inadequate" homes to improve in six months. This demonstrates that the CQC is looking not for a deep change in culture, attitudes and practice through caring relationships, but for a "makeover" of paperwork, care plans, risk assessments, records, policies and procedures. (And there are plenty of consultants, often former inspectors, willing to offer that service - for a fee.)

# 5. CQC misses abuse

**One of the most basic problems with the way the CQC now operates and is organised is that it is actually quite unlikely that serious problems with care homes will be picked up by inspection itself. And, if CQC inspectors are not expected to be directly responsive - to a relative's concern when visiting a resident, for example - concerns are left to accumulate and, in theory, to build up a picture of a failing home which only then will trigger an inspection . . . and still, sometimes, the inspector fails to see what is wrong because the home appears to be compliant with measurable standards.**

While the media and wider public may get the message that the CQC is rooting out bad practice and hunting down abusers, those close to what is going on know that the bad practice and abuse has been going on right under their noses while they (the CQC) have been concentrating on whether the home's policies and procedures are up to date. It's all very well examining a whistleblowing policy that's been produced by a "quality consultancy", but if you believe (as the CQC so frequently states) that policies and procedures "ensure" that a home is "safe", the regulator will for ever be shutting the stable door after the horse has bolted.

# 6. CQC makes poor judgements

**Inspectors gather "evidence" and take it back to the CQC for the judgement to be calculated from the evidence they have gathered. A report goes through several processes before the draft is sent to the providers. It goes to the inspector's manager, to the manager's manager, and to the "quality control" section. Some have to pass through other specialist (and even regional and national) monitoring groups to reach its conclusions. Judgement about the rating is not made by the inspector, but emerges from what is claimed to be a "rigorous and robust" system of quality control.**

The CQC are naturally very anxious about getting their ratings accurate and consistent but this is impossible because there is no precise dividing line between each of the levels of rating - inadequate, requires improvement, good and outstanding. There will be many occasions when a rating is borderline and, depending on the CQC's subjective view of the provider, a rating will be chosen. Many of these judgements are challenged by the providers if they think that they can pressure the CQC to raise the rating. This has the effect of delaying the report. Interesting or individual observations by the inspector that could help the provider to think more deeply about their service, are forbidden because they will give ammunition to challenge a rating. It also gives power to those who already have it: to the regulator over the weaker, poorer, and more vulnerable care providers, and to the larger providers who have the resources to make legal challenges to the CQC, and are in a strong market position where the withdrawal of their service will create a crisis for the local authority. (With the very largest providers - some in the ownership of overseas venture capitalists - the breakdown of the service will create a national crisis for the whole of social care and the NHS, so the CQC have to tread very carefully not to trigger such a breakdown.)

The categories of "quality" (effective, safe, responsive, caring, well-led) are rated separately, and reports frequently rate the "caring" category higher than others. So, a care home that has an overall rating of "inadequate" often has a "good" for caring. How can that make sense to a resident or relative for whom a "good caring home" is just what they want? Surely, if a home is ineffective, unsafe, unresponsive and not well-led it cannot be caring.

# 7. CQC's reports are poor

**The CQC's inspection reports are poorly written: full of jargon and acronyms, repetitive, clumsy, long-winded and difficult to find your way around. Although the primary readership must be the existing and potential residents and their relatives, and of course the public, these reports don't seem to be written with them in mind. The inspector's name doesn't appear on the report, which is always written in the first person plural (we), and the inspector cannot be contacted directly by a member of the public (including residents and their relatives).**

Most inspectors don't like writing their reports. They are usually written under pressure and frequently not written until several days - sometimes weeks - after the inspection. An inspector, working from home, yet with little discretion as to the use of their time, will receive a list of homes that they must visit. They have access to all the current information on the home including previous reports. Their managers are also working to a regionally and centrally imposed target of inspections to be completed within the year, so there tends to be a backlog of inspections to do, but an inspection isn't finished until the final report is agreed and published. This leaves inspectors sometimes inspecting three or four homes in a week and then attempting to write all the reports the next week, struggling to recall from their notes which home was which.

Reports are written to a strict format and inspectors are encouraged to use standard phrases and paragraphs to make writing easier and quicker. However, this means that the reader, for example a relative looking for a suitable home, will find the reports for different homes contain such similar wording that they begin to doubt the authenticity of the inspection and report. There is little room for individuality, and many of the frequently used passages serve to obscure rather than reveal. There are sometimes vague suggestions that something may be wrong ("concerns raised", "we are carrying out checks using our new way of inspecting") but the reader is left to guess what the problem may be, and they are unable to speak to the inspector to find out. It's impossible to tell whether the inspector's concerns are really about abuse and neglect or simply about what most lay people would regard as technicalities.

Writing the first draft of the report is only the beginning. Reports are written into a central IT network (rather like an on-line tax return) which guides

steady progress through the report and requires answers to questions before progressing to the next stage. Some of the report is already "populated" by information from the National Customer Service Centre (NCSC). If an inspector attempts to step outside the rigid process of report writing, progress will be halted until the approved steps are complied with. Newer inspectors will find that their reports are usually sent back to them by their managers for re-writing because they haven't yet found out how to write them to the approved formula. All reports go through the CQC "quality assurance" process which means that they will have been read by the manager and a series of what amount to quality committees.

# 8. CQC costs too much

**The CQC calculate that the regulation of adult social care next year will cost nearly £100m. In a small 4-bedded care home a resident (or the local authority) will pay about £4 a week for inspection. In a large home of 91 residents, each resident will pay about £3.50 a week. If these homes are rated as "outstanding", the plan is to inspect them only once every three years. That will mean that each resident in the small home will pay £627 and each resident in the large home will pay £530 for one inspection visit and report. That is not good value for money.**

In 2014 the 19 most senior staff in the CQC earned between £100k and £240k a year. In addition to the CEO and Chief Inspectors, there are posts such as "Executive Director of Change" (£110k), "Director of Strategy Unit" (£110k) and "Director of Strategy and Intelligence" (£150k), and a "Director of Corporate and Customer Services" (£150k). About five levels down the hierarchy there are the inspectors themselves, earning about £40k and working from home. The high central office and management costs of the CQC are excessive and divert the purpose of the organisation away from the inspectors and the core task (checking that care is good enough) and towards the management and survival of the organisation itself.

However, the direct costs of regulation - of running the CQC - are as nothing compared with the costs to providers of meeting the regulator's demands. The effect of diverting managers and staff from their real work has an incalculable cost on the quality of true care.

# 9. CQC dominates the sector

**The CQC now completely dominates social care and thereby the jobs of social care workers and managers, and people's personal, private and social lives when receiving care. Everything has to be done by the CQC book (a book that is forever being rewritten). It has dreadful effects, not least the disproportionate time and effort expended on recording that everything is done by the book (even when it wasn't). Much that has to be written down is untrue, and that makes liars out of people who are trying to do a good job. The re-introduction of quality ratings has made it even worse. We have allowed this to happen partly because criticism of the regulator has been seen as taking the side of the poor providers, but also because the larger providers and care organisations have learned how to get good ratings, and this gives them a commercial advantage over organisations that prioritise giving good care over getting good marks in their tests (ratings and inspections).**

Providers and provider organisations are understandably wary of criticising the CQC because they are nervous about challenging an organisation that is in a position to damage their businesses. But this collusion goes deeper and wider than that. Social caring as a profession and discipline has lost touch with its roots: its history, philosophy, literature and studies. Now, driven by the necessity of compliance with the CQC's demands, the study and the ethical and theoretical development of social care (and especially of residential care) has almost disappeared. The 34 pages of headings setting out a "Level 5" diploma in social care leadership and management hardly mentions the difficulties and dilemmas, the ideas and controversies, the personal, group and organisational complexities and challenges of the work. Regulation has brought about a culture of compliance throughout social care which is inimical to the individual and collective assertion of people's rights and self-determination. No, social care is now a profession not of complex relationships and therapeutic community, but of a set of right answers and of compliance with regulations.

This method of regulation and inspection has given rise to a gross distortion of organisational form. It's now rare to find care homes where the care, culture, ways of living and relating are a collaborative creation of the people living and working in the home. Even residents are subjected to regulations that patronise, restrict and limit, yet have ostensibly been

imposed for their safety and wellbeing. So much of the presentation of social care is false. For example, residents ("with capacity") in care homes are required to sign lengthy and complex "person centred" and "personalised" care plans written in jargon but using "I" as if this was written or at least dictated by the resident themselves. If an inspector finds that care plans have not been signed in this way, the home will be rated lower.

Large providers now have central quality and compliance departments, managers and personnel. They require monthly monitoring figures for every aspect of inspection. There are armies of people checking what the CQC will themselves check. Smaller and medium sized providers may use consultancy firms to look after their "quality" and to produce the evidence of their compliance. For example one well established consultancy firm promises "full care management systems", "risk assessment", "mock inspection toolkits", "safeguarding", "care plan templates", and "up to 2,300 pages of 200+ easy to follow adult social care policies and procedures". This is no way for a home - a community, a family - to live and care.

Almost every conference and seminar, even managers' workshops, are dominated by representatives from the CQC coming to tell the audience about the latest tweaks to their inspection regime; in other words, what they will have to do to provide "evidence" that the service they run qualifies as "good" or "outstanding". The audience listens in timid (but resentful) silence as senior CQC managers read Powerpoint slides, all of which already appear on their website. This may be followed by someone from Skills for Care or the Social Care Institute for Excellence (sic) telling them about their training schemes or new research papers that will help them to achieve a "good" or "outstanding" rating.

The whole process of registration, regulation and inspection has become so complicated and demanding that it can't be accomplished without making a major investment of time and money, and the involvement of professional consultancies, solicitors, and other advisers. (This provides lucrative employment for former inspectors.) It has become more difficult - now almost impossible - for a single operator, for a small group of colleagues forming a co-op, or for a partnership of carers and cared-for to set up a local service whether it is a care home or care in people's own homes, or a combination of the two. This is so wrong because such initiatives have often been the very best sort of care. One of the heaviest but least recognised costs of the CQC is a steady erosion of the small, local, places and teams where closeness and familiarity made paid-for care much more like familial, neighbourly and friendship - or true community - care.

# 10. CQC is hopelessly stuck

**One has only to watch a couple of the monthly CQC board meetings to see how constipated and stuck this organisation is. Having been dogged by scandal and under severe parliamentary scrutiny, they are terrified of making mistakes. When one of the more critical members of the board asks a particularly penetrating question, the chief executive and chief inspectors congratulate them on their perspicacity, and then absorb the energy of the point in defensive layers of bureaucratic waffle and a web of fine adjustments. Even those who have been recruited to the board to demonstrate how open the CQC is to criticism become entangled and ineffectual.**

After so many years of parliamentary scrutiny and criticism (in committees) finding that the CQC is "not fit - or not yet fit - for purpose", the organisation struggles on. It survives because it occupies the space between a central government that is starving social care of money and the results of that underfunding. While it is instrumental in creating the crisis of poor, underfunded, standardised care, its official purpose is to "ensure" that social care meets the standards it sets. The CQC is charged with an impossible task, and it is blamed when there is sufficient public outcry to pressure MPs and government about a particular scandal (such as Mid-Staffs or Winterbourne View) or about a more general deterioration in standards linked with the CQC's failures. MPs then to turn on the regulator, publicly humiliate the leadership, and demand reform of the organisation. A change of leadership (as with the transition from CEO Cynthia Bower to CEO David Behan) resulted in the CQC just (still) doing the wrong thing but doing it a lot better . . . and, for a while, government feel better, and the CQC becomes better defended, more and more complex, hierarchical and bureaucratic, more destructive to care based on relationships, and more centrally embedded in a system of care that resembles its regulator rather than being designed to fulfill its true purpose.

Haunted by past failures, the CQC are themselves on trial, so they've designed social care regulation and inspection to prove their own effectiveness. They tell providers what inspectors must see to gain a good or outstanding rating, and providers produce the right evidence, most of it written. Providers that persistently fail to comply will close.

The CQC mark their own homework. Each national social care regulator (starting in 2002 with the National Care Standards Commission followed by

the Commission for Social Care Inspection and then the CQC) has claimed - and purported to demonstrate by rising ratings - that it has improved care (although they repeatedly and correctly say that improving care is the job of the providers). However, if you set the standards and then measure "improvement" against those standards, it isn't difficult to show that care is improving, especially if you are measuring how good providers are becoming at giving the right answers and filling in forms correctly (such as the Provider Information Return).

To go back to the analogy of the carpenter, used at the beginning of this piece: if all carpenters had to have a complete set of tools, ordered, maintained and recorded according to rigid rules, otherwise they would not be allowed to ply their trade, then all working carpenters would have to comply and those that didn't would stop working. The carpentry regulator would then be able to demonstrate that "carpentry" had "improved" with no reference to the quality of what was being made, built or repaired, or to the opinions of the customers. The carpentry regulator could claim success but there would probably be fewer carpenters, a lot less woodwork being done and its quality would be as variable as before the regulator took control.

Yet, even though the CQC set and assess their own standards of inspection, they regularly fail to meet the most basic of standards such as keeping to the 10-week deadline for the publication of reports. Care homes are inspected late, some are missed altogether and still a large number of reports fail to be published within the over-generous 10-week deadline. A new resident in a care home in which an inspection took place within their first week would have to wait a long time to discover how the home that they lived in was rated by the national regulator of care; meanwhile, they would have a pretty good idea of how they would rate it themselves.

# 11. Reforming CQC

**Can these problems be put right?**

**Yes.**

Any reform and reorganisation of the CQC should make it more effective and responsive, and should enable inspectors to understand how social care works. Inspectors need to be closer and more in touch with the services they are inspecting, so that they can pick up problems before they become serious, and so they can respond quickly to complaints and information from users, staff and public. The CQC should serve the public and therefore should engage directly with the public, without bureaucratic barriers. The costs of inspection should be realistic and understandable to the public who will be the judges of whether the regulator is giving value for money. The CQC should step down from regarding itself as the leading authority in social care practice and management. This can be achieved by dispersing and devolving the CQC and setting up local inspection teams to which users, staff and the rest of the public can have direct access and input.

The legislation for the regulation of social care does not force the CQC to function as it does. There is nothing to prevent the CQC operating on a local basis while retaining an overall but "hands off" and much reduced central management and administration. The CQC regulates all health and social care provision, and the services vary hugely in size and purpose, for example a large hospital and a small care home. However, shortly into the new regime (when the existing chair and CEO were appointed) the important change was made from having generic inspectors to having specialist inspectors for each sector (e.g hospitals, GPs, dentists, care homes). So, to begin with, it would be possible to set up local inspection units to regulate local social care - care homes and domiciliary care (the focus of this paper).

# 12. How to reform CQC

**The purpose of inspection is to check on behalf of the public that social care is good enough, and if it isn't the regulator will require the provider to improve until it is good enough, or to cease providing care. A care service will be required to produce only those records that are needed for the best care of the users. Therefore to check that care is good enough, inspectors will sometimes need to check records and documentation, but nothing additional should be required solely for the purpose of inspection. Inspection itself should never create additional work for a care home.**

The **method** is to inspect **care in action**, to observe and listen to the experience of users, relatives, staff, managers, and anyone who has a professional or personal connection with the service. The purpose of checking records and documents is to follow up observations of care in action. The inspector must become familiar with the home and all aspects of life and care in the home. The inspector must be **accessible** to all those involved in the service so, as long as they are the inspector for the service, their name and contact details will be readily available. The inspector must make an unannounced full inspection of the home at least once a year and must produce **a comprehensive and plainly written report** which gives all those concerned with the home (residents, relatives, staff and so on) a detailed evaluation of the care provided. Depending on the type of service, the inspection visit should cover most of a whole day in the life and work of the home; so, arriving before breakfast would be usual. **The report will be a public document** and will be sent to local papers and other media as well as being readily available on line. The focus of the inspection will be the care in action, and this will be backed up by selective examination of records.

The existing **standards** are valid, and **enforcement** powers can be used when they are needed.

While being concerned with detail, the inspector must link details and understand underlying processes thereby **evaluating the service as a whole**.

If the inspector has any concerns about the service and if concerns are brought to their attention, they must check them without delay. This will usually mean visiting the home unannounced, and this is likely to be "out of hours".

The inspection unit or team should be **known to the public** and seen as a **local resource**. There should be an annual report presented to a public meeting. Someone looking for a home should be able to talk with an inspector and seek their advice. (Care homes are very different. For example, after talking with the enquirer, an inspector may recommend that they should visit three small "family" type of homes, whereas, after establishing that someone would prefer a home that is more like a hotel with care, the inspector may recommend visits to some larger homes with more elaborate facilities.) If the inspector knows the homes well, and knows the strengths and weaknesses of them, they are in a position to advise and discuss at a time when people need this sort of support. This gives the local inspection unit a **positive role** in the community (to which they are answerable), and it gives them the right sort of authority with the homes they inspect.

## Inspectors

Inspectors could be employed on a freelance or employed basis, full or part-time. It would be good to have a mixture of experience and background. Ex-inspectors and ex-social care workers/nurses and managers have a lot to offer, but so do people with other backgrounds. While some freelance inspectors may work from home, it is essential to work as a team, with a shared ethos and clear remit, to meet regularly as a team for professional development and learning, and for all inspectors to have professional supervision. Ineffective and incompetent inspectors will lose their job.

## Workload

A full-time inspector could have a "caseload" of up to 25 care homes, but of course this has to be adjusted according to the size and complexity of the homes. If reports are to be written immediately after each inspection, no more than two inspections can be completed in a week. This form of inspection requires flexibility and responsiveness, and some "out of hours" work.

## Cost

The direct costs of inspection should be met by the providers and will ultimately be met from users' fees . A service that requires additional inspection should pay additional costs. However, the costs attributable to the national CQC elements of the local service, such as statistical returns and analysis for Department of Health purposes should be met by central

government, as should all the costs of the central organisation. (Currently Healthwatch is organised and financed in this way.) Local inspection units and the costs for each home will be considerably less than those set out in the current fee structure. It would be fair to base fees (as now) on the number of residents in the home. All homes would have to pay their inspection fees at the beginning of the year to remain registered, and homes that required substantial additional visits and work would incur proportionate additional costs.

## Management

Local inspection units do not all have to be run in the same way. Normally units would have a local chief inspector to lead and manage the team, plus administrative staff in proportion to the number of homes (and therefore the number of inspectors) covered by the unit. But there should be room for units to innovate. For example, an inspection unit can be run by a chief inspector engaging only freelance (self-employed) inspectors who are paid per home or per completed inspection (including report). Another unit might be all full-time employees. Different units should be able to use different formats for their reports, and to experiment and innovate in inspection methods.

**Sooner or later, the CQC will be seen to be failing. This is most likely to occur when some major event or scandal of poor social care becomes public. At that point, government must take the opportunity to reform what they have themselves created, used and maintained. This essay points to a practical and ethical way forward.**

# ABOUT THE AUTHOR

**John Burton** has worked in social care since 1965. He has worked with people of all ages mostly in residential care, and has led therapeutic communities for children and young people and for older people. He has also been a social care inspector for local authorities and briefly for the CQC. He is a writer, consultant and campaigner. He trained in organisational consultancy at the Tavistock, has a master's degree in public policy, advanced social care qualifications and a diploma in counselling. He is an OPUS associate and a Fellow of the School for Social Entrepreneurs. His latest book is *Leading Good Care: the task, heart and art of managing social care*. Jessica Kingsley Publishers 2015.

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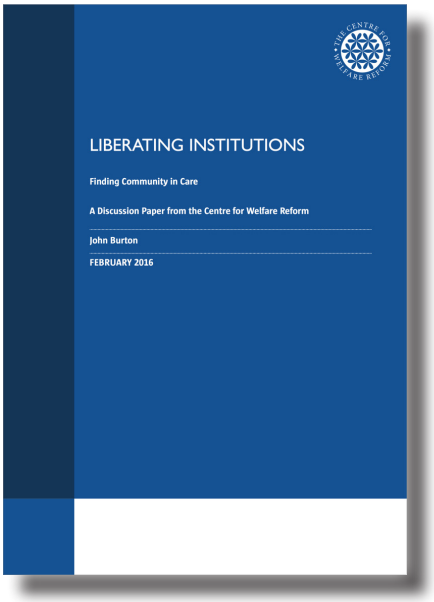


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## Liberating Institutions

John Burton describes the way in which care homes and the people who live and work in them are subjugated and constricted by a social care system run and regulated for the benefit, protection and preservation of an elite of - mostly well-meaning - politicians, bureaucrats, care organisations, and in a large part for the profits of owners and shareholders.

This paper is available to read at:

http://bit.ly/liberating-institutions

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# THE CENTRE FOR WELFARE REFORM

The Centre for Welfare Reform is an independent research and development network. Its aim is to transform the current welfare state so that it supports citizenship, family and community. It works by developing and sharing social innovations and influencing government and society to achieve necessary reforms.

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